Witness Name: Dr Catherine McDonnell
Statement No.:
Exhibits:
Dated: 8 May 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Dr Catherine McDonnell

I, Dr Catherine McDonnell will say as follows: -

1. I am Dr Catherine McDonnell and I held the position of Medical Director of the Western Health and Social Care Trust (WHSCT) in Northern Ireland (NI) which included Altnagelvin Hospital from 1 March 2020 until I retired from post 23 June 2022. I write this statement in response to a request from the Inquiry dated 6 December 2023. The statement has been prepared with the assistance of staff from Altnagelvin Hospital who had knowledge, experience and access to documents pertinent to the information requested. This is my first statement to the Inquiry.

Background

2. Altnagelvin Hospital sits within the Western Health and Social Care Trust. The Trust provides a range of hospital based and community care services across a geographical area of 4842km to the West of Northern Ireland bordering the Republic of Ireland. It covers a mix of urban and rural settings. Altnagelvin Hospital is located in Derry/Londonderry and serves as District General Hospital to the Northern Sector of the Trust, a population of 183,000 people. It has 452 beds and provides Medical, Surgical, Paediatric and Women's services. Please see attached Altnagelvin Hospital In-Patient Bed Complement by Ward document exhibited to this statement as CMcD/1 – INQ000416858. It is the second Regional

hub for Trauma and Orthopaedics, Ophthalmology, Urology and Oro-maxillofacial surgery expanding the population served to 410,000. Altnagelvin Hospital incorporates the North West Cancer Centre, the second Cancer centre in Northern Ireland which provides a sub-regional and cross border service.

3. The WHSCT area scored highest in The Northern Ireland Poverty and Income Inequality report (dated January 2024) with 22% living in poverty in Altnagelvin catchment area as compared to 16%, the NI average. The health inequality is reflected in 24 out of 56 health outcomes falling below the NI average. Male life expectancy is 6.2 years less than the NI average. The district has the highest alcohol related mortality. It also has the highest number of elective inpatient admissions. 2% of population are Non–white. There are small Indian, Chinese, Filipino, Pakistani and Arab communities. The older population is growing with a 27% increase predicted in those aged 65-84 years and a 39% increase in the 85+ age groups by 2028. In contrast, the under 16 year population is decreasing.

4. The border with Republic of Ireland (ROI) brought unique challenges. Staff live in County Donegal, the neighbouring county to Derry/Londonderry, but within the jurisdiction of ROI. The border was effectively shut for periods of time during the pandemic. Staff required official paperwork form the Trust to authorise their travel to work in the Trust. The regulations across the two jurisdictions were different, causing additional confusion and uncertainty. Covid transmission trends in Derry/Londonderry were different to the NI Region placing additional pressures on local risk assessment and decision making. This was recognised in Regional decision making in October 2020 when local lock down was introduced 2 weeks before regional lockdown. At that time Derry/Strabane Local Government District was recording the highest Covid transmission rate in the UK.

5. The Department of Health (DoH) had established a Regional Silver meeting on 28 January 2020 which I and colleagues attended on behalf of the Trust. The Trust activated its Business Continuity arrangements to manage the pandemic on 4 February 2020. I and the Director of Finance chaired the internal Trust Silver

meetings, with support from fellow Directors which was the cornerstone for communication and decision making. The purpose of the daily Trust Silver meeting was to share information up and down and across the organisation as quickly as possible. The meetings were informed by daily data sets from within the Trust, regional and national data sets, emerging guidance and clinical updates. It was the centre for decision making and provided the necessary agility to do this effectively in a rapidly changing, uncertain environment. Please see attached Covid-19 Response Planning Framework March 2020 document exhibited to this statement as CMcD/2 – INQ000416861 and also please see attached WHSCT Covid-19 Winter Preparedness Plan 2020-2021 Command and Control Silver and Bronze Arrangements document exhibited to this statement as CMcD/3 – INQ000416862.

6. A Bronze team was established in Altnagelvin Hospital which connected to the daily Trust Silver meeting. Bronze teams were also established in South West Acute Hospital which serves the Southern sector of the Trust and a Community Bronze which included Mental Health, Community and Social services. Bronze teams had oversight of elective capability and capacity on a daily basis. When capacity and capability were limited clinical urgency for operative procedures were agreed with the Clinical Leads for the respective surgical specialty. This team was the operational hub through which wards and specialties reported daily and had oversight of service provision throughout. The team provided data for daily reports that were fed through Regional Silver to Gold Command at the Department of Health. It was a critical forum for highlighting outbreaks and ensuring early Infection Prevention Control (IPC) intervention. Administrative and managerial staff moved to 7- day working to support the Bronze teams.

7. Safety and Quality of Care and Treatment guided decision making within the Trust. Safety was a standing item on the agenda of Trust Silver which allowed problems to be raised quickly and solved quickly. A Corporate Safety Huddle was established to review and monitor trends in all Covid related incidents and high risk incidents. This Huddle met weekly and could escalate safety concerns to Trust

Silver or other Governance forums as required. A number of work - streams and task and finish groups were set up to focus on specific challenges. This was a Trust wide change management programme which required every single member of staff to change how they did their work. Infection prevention control became everyone's business.

8. The impact on Altnagelvin Hospital was a change in management structure and style. Connectivity across service areas, clinical and non-clinical staff, specialties, professional and non- professional groups grew. Silo working across the organisation was broken down. Problems were owned collectively allowing greater diversity in skills and perspectives to contribute to problem solving.

Staffing Capacity

9. The biggest challenge for Altnagelvin Hospital through the pandemic in the delivery of Covid and Non Covid services was staffing. Workforce numbers were the pivot point around which service delivery was determined throughout the pandemic. Covid related absences through surge created acute on chronic challenges across all workforces. There were particular challenges in maintaining safe nurse-patient ratios and maintaining medical rotas.

10. Altnagelvin had staffing shortfalls prior to the pandemic, particularly nurses and doctors, creating a high dependency on agency and locum staff. The Western Trust employs approximately 12,000 staff across its geography with just over 4,200 staff working on the Altnagelvin site. In Feb 2020 there were 1,749 nurses and 431 doctors working in Altnagelvin Hospital. Recruitment statistics are collated on a Trust wide basis. In March 2020 the Trust was actively recruiting into 1,015 posts across all employee groups. 346 posts, approximately one third were nursing. Of these 182 were for Band 5 and Band 6 General Nurses. In February 2020 Medical staff vacancies numbered 193 of which 50 vacancies were doctors in training. These gaps were managed through use of Trust locum contracts and locum

agency staff. 40 Medical posts were being actively recruited by the Trust in March 2020 of which 20 were Consultants. This reflects shortfalls in the healthcare workforce across NI. This was compounded locally by the close border proximity and the offer of more attractive terms and conditions to health care professionals in ROI. The Trust had a very active International recruitment scheme set up for both doctor and nurse recruitment. Travel restrictions limited this supply chain through the pandemic. A Graduate Entry Medical school opened in 2021 in Ulster University locally based with first graduates expected 2025. Nurse training places were also been increased across Northern Ireland in 2021 by 300 in response to the NI workforce crisis.

11. Covid had direct impact on staff availability to work. A number of staff with existing health conditions or vulnerabilities required risk assessment. Whilst this task was the responsibility of managers, support was offered through regional HSC guidance and the HSC Covid 19 Health Risk Assessment Form. This guidance helped to clarify individual risks and also helped identify environments and roles and activities that placed individuals at risk. Lower risk environments were those where there would be unlikely direct exposure to Covid positive patient and where the environment facilitated social distancing. High risk roles included those where there was face to face contact with patients and high risk activities such as Aerosol Generating Procedures (AGPs). The Trust Occupational Health team supported managers at the onset of the pandemic with completion of risk assessment forms. Data collected between 26/03/20 to 09/04/20 confirms 854 assessments took place which resulted in 1 redeployment to a low risk role, 609 to continue in role with appropriate PPE, 177 to work from home and 29 pregnant staff to work from home. After this initial period risk assessment information was held by managers at individual department level and in staff's individual health records. Records were held on the number of staff shielding on a Trust wide basis. In July 2020 473 staff were identified as Clinically Extremely Vulnerable (CEV) and were shielding. Of these 174 staff were supported to continue to work at home. This included stepping into new roles such as contact tracing and providing telephone support to the bereaved. 299 could not be redeployed because of their skill base and the patient face to face nature of their work. Active Covid infection had a high impact on

staffing levels through surges. Staff contracted Covid requiring them to be absent from work. Staff were also required to isolate when identified as close Covid contacts. By June 2020 staff absence rates across the Trust had increased by 60%. This trend was mirrored in following Covid surges. The highest monthly staff absence in 2020/2021 was 13.62% as compared to 7.68% in 2019/2020, an increase of 77%. The commonest cause of non Covid absence was mental health issues.

12. Staff shortages were less acutely felt during the Emergency status of First Surge when some elective services had been suspended and the footfall through Emergency Department (ED) for non-Covid conditions dropped dramatically. This changed in later surges when the hospital was resetting and rebuilding services alongside managing Covid 19 surges and the increasing demand for hospital care. Staff availability for reset and rebuild was compromised and slowed progress in tackling backlogs. Additional staff were also required for new Covid linked services. These included Covid Testing, provision of nursing staff to Hospital based Primary Care Covid Centres, the Track and Trace team and Phlebotomy Centres to support Virtual Clinics. The Trust set up 3 Mass Vaccination Centres with a supporting Mobile service that required 300 staff. Whilst this was supported by recruitment of retired staff, there were also a pull on the existing nursing, medical, pharmacy, clerical and ancillary workforce. The Neutralising Monoclonal Antibodies services (NMABs) was set up in December 2021 to provide effective Covid treatments, oral antivirals to people identified as highest risk from Covid in the community. The workforce to provide the service had also to be sourced from within existing complements of medical, nursing and pharmacy staff.

13. Covid 19 diagnostic testing Polymerase Chain Reaction (PCR) and Covid 19 antibody testing Lateral Flow Test (LFT) both contributed to safety for staff and patients. The Trust followed guidelines as per Regional guidance. Reliance on PCR testing in the earlier part of the pandemic and the constraints within the PCR testing system which will be discussed later lead to lost days at work for staff. The approval for LFT in December 2020 was welcome because of the benefits of the

immediacy of result. Its inclusion in Staff testing guidance was equally welcome. It allowed staff who were close household contacts to monitor their Covid status and to continue to work if LFT negative. Guidance for Staff Testing within Outbreak management guidance still recommended PCR testing which delayed results and contributed to lost days. There was an ongoing tension between managing Covid safety to protect patients from hospital acquired infection and managing staff absence whilst ensuring ongoing provision of safe services.

14. The creation of temporary staffing registers was welcome with a number of doctors and nurses being facilitated to return to clinical practice. Training and support were provided through Professional lines to upskill staff to fulfil roles. Returning staff included a retired Medical Director, a retired Public Health consultant and Consultants from a range of other specialities.

15. The biggest constraint on the ability of the Trust to increase staffing capacity was the limited pool of workforce across the region and in the West. The Trust was an active participant in the regional Health and Social Care Workforce Appeal which was launched on 27 March 2020. Please see attached HR Submission to Health Committee Reference CMcD/4 – document exhibited to this statement as INQ000416863. In total 1,700 applications were processed by the Trust yielding 580 staff. These included 29 retirees, 42 medical students who trained as medical technicians and 122 nursing students. 40 Final Year Medical students joined the workforce on 14 May 2020 prior to formally starting their Foundation Training year in August 2020. The Human Resources team developed slick on-boarding processes to fast track staff from receipt of application to commencing work. Training and support programmes were developed to support these new workers through Nurse training programmes and the Medical Education team. The Doctors Hub was a new service set up to manage and support doctors through the pandemic. It was based within Medical Education department. It was central to organising redeployment, providing a single point of contact for all doctors in relation to Covid matters including access to testing.

16. The IT team provided remote working facilities which helped to maintain CEV staff at work, allowing services to be delivered effectively in new ways. This arrangement also supported administrative staff to work from home where office space did not accommodate safe social distancing. Video conferencing facilities were expanded to safely connect groups of people internally and externally. The Trust benefited from capital funding via a Digital Rebuild Programme via a regional Business Services Organisation (BSO) business case to support staff mobilisation. Funding provided 965 additional laptops and 773 mobile phones. An additional 1102 staff were facilitated to work remotely bringing the total number of staff with remote access to 4,500, approximately a third of all staff.

17. The workforce had to develop a new fluidity which responded to changing demands from patients and families whilst balancing the vulnerabilities and needs of staff. The First surge focused on creating capacity for an increase in numbers of patients presenting with Covid. The needs of these patients were respiratory support hence enhancement of staffing to Respiratory wards and the Intensive Care Unit (ICU). Guidelines for redeployment were developed recognising the challenge for staff moving into new areas particularly Covid wards. Staff had high levels of anxiety regarding personal safety. Media coverage from Italy was to the forefront of their minds. Through Doctors Hub and Medical Education a redeployment plan was drawn up identifying a movement of doctors across the system matching skills to areas of need. A full training programme was developed to skill doctors up and a programme of support from a network of clinical and educational supervisors for junior doctors alongside the Doctors Hub. Nurses had similar training programmes. The Regional Clinical Education Centre developed programmes to assist nurses who were in non-clinical roles to upskill. Specific competency based trainings were developed for staff moving into Intensive Care Unit (ICU) with nurse buddying to support and grow confidence.

18. Staff were redeployed outside the hospital through the pandemic. 3 Altnagelvin nurses worked in the Regional Nightingale Unit in Belfast.

19. Long Covid had an impact on staffing with a number of staff identified as having extended absence following Covid. A proportion of staff had a phased return whilst others had restrictions placed on their roles. Numbers changed through the pandemic. A snapshot from 8th March 2021 – 31st September 2021, reports 84 staff across the Trust attended Occupational Health reporting symptoms of Long Covid, with 35 of these attending for review appointments.

20. There were no occupationally acquired Covid deaths in Altnagelvin hospital nor any Trust facility. 4 staff however were cared for in ICU. The breakdown of staff groups was 1 porter, 1 cleaner, 1 junior doctor and 1 student nurse highlighting vulnerability across all staff groups. Regional daily Covid returns included staff numbers. The Trust lost one staff member to Covid, Nuala McLaughlin, a 50 year old, previously healthy, Social worker who died in South West Acute Hospital in December 2020. This was distressing for the whole Trust community. Psychological services had a 7 day a week helpline and provided specific interventions and support for team bereavement. She is remembered by the Trust through an annual Social Work staff award in her name.

21. Covid vaccination as a condition of employment for healthcare workers was not introduced in NI.

22. The Trust had continuous focus on workforce management and improving workforce capacity which was critical to service delivery for patients and their families. It focused on both stabilising the workforce through longer term recruitment and maximising benefit from temporary staff who made themselves available via the Appeal. It made emergency call outs through use of social media when the hospital was in crisis with such critical shortfalls of staff safety of patients would have been compromised. It made use of Regional financial incentives when appropriate. The HR team worked with frontline teams to develop a raft of interventions to support teams and to allow nurses to focus on nursing tasks. These included protecting Ward mangers and nurses from excessive

administrative work by increasing administrative staff. There was development of new roles for more generic tasks such as Ward housekeeper and Medical technicians. There were both Medical and Nursing workforce stabilisation programmes which included more long term strategies.

23. Altnagelvin is a training hospital for Medical students, Nursing students and Allied Health professionals. All professional groups were challenged to ensure students had experiences to allow them to progress. This included new challenges of ensuring they were all trained in Infection Prevention and Control (IPC), in wearing PPE, had access to PPE and were able to access training opportunities with patients balancing this need against reducing footfall both through and across clinical areas. Many junior doctors whilst providing services are also in training. Any cessation or delay in their training would adversely affect the supply chain of doctors going forward. This was an area which required focus and attention as the pandemic progressed. The Trust educational team worked closely with Northern Ireland Medical and Dental Training Association (NIMDTA) throughout to continue to meet training requirements within the rapidly changing clinical environment. Many innovations emerged with increasing use of Virtual teaching and development of Simulation trainings. It should be noted that Altnagelvin Hospital contributed to a number of National Covid Research Projects co-ordinated through the site based Clinical Translational Research and Innovation Centre (CTRIC).

Bed capacity

24. Bed capacity was challenging both in terms of number of physical beds available and the availability of staff to operationalise them. Bed capacity is also dependent on flow through the system and effective discharge processes. There were challenges to patient flow in Altnagelvin Hospital pre pandemic. A project team was established in January 2020 pre-pandemic to improve flow including streamlining discharge processes and focusing attention on complex discharges. Delayed discharges were reduced by 50%. In preparation for the pandemic, and

a possible escalation in need for beds the hospital took additional steps prior to 17 March 2020. A number of temporary placements were identified in community facilities for patients who were medically fit for discharge but for whom an appropriate package of care had not been sourced. Discharge planning continued in these step down facilities outside hospital. The Trust stepped down in patient Elective surgery in line with the Region. The Trust made no changes to its discharge policy.

25. Altnagelvin ICU beds formed part of Regional surge planning which was coordinated through the existing Critical Care Network Northern Ireland. (CANNI) Altnagelvin was funded for 8.5 Level 3 beds which translated into 10 bed spaces, usually 7 level 3 patients and 3 level 2 patients. The Unit developed ambitious surge plans in first surge for escalation to 24 beds. This was to be achieved by ICU by absorbing HDU beds, extending its footprint into Surgical Recovery area and then Theatre space. This physical space had to be adjusted to accommodate both Covid and non Covid pathways. This was achieved by an arrangement of pods of single rooms and small multi-bays. The physical reconfiguration posed challenges for nurse staffing making it difficult to work within the recommended nursing ratio. The lack of flexibility of the pods demanded higher patient nurse ratio to ensure safe nursing of all patients. CANNI took responsibility for purchasing additional ventilators. The Trust activated procurement of additional equipment promptly. Rapid procurement alongside existing emergency Trust resources ensured there was availability of all necessary equipment, Ventilators, CPAP machines, renal replacement machines and, Pumps. Early learning from Italy highlighted not just need for high volumes of oxygen but for high flow capacity to clinical areas delivering Covid care. Oxygen supply was enhanced through work of Trust Estates with support from regional Business Services Organisation (BSO). The Estates team in conjunction with ICU technicians did extraordinary work to re-purpose and modify care spaces and expand capacity in the areas where patient demand was expected to surge.

26. During First and Second Surge Altnagelvin ICU functioned as an independent unit within the usual Regional arrangement. Patients could be transferred across Trusts when necessary. In third surge of December 2020 / January 2021 a regionalised Critical Care Network model was developed. This changed practice with a regional ownership of all ICU beds, directing placement of patients and movement between Trusts. Altnagelvin ICU received 83 out- of area patients from 1 March 2020 through 30 June 2022. 65 of transfers in to the unit were due to regional bed pressures with 7 patients being transferred out of the unit due to bed pressures in the same timeframe. This brought its own difficulties for patients who were often far from family. ICU stays through Covid were often extended to 6/8 weeks compared to pre pandemic admissions which averaged 2 weeks. Within the regional arrangement Altnagelvin was identified as providing 16 beds but in practice maximum staffed beds were 14. The constraining factor was nursing staff numbers. This was despite proactive recruitment, redeployment from theatres, training, support, buddying, and attention to staff morale. The stress of redeployment to ICU through Covid has been highlighted in exit interviews as a contributor to resignations, early retirements and choices to move into other areas of nursing.

27. Altnagelvin transferred out a small number of patients. The ability of the unit to maintain capacity was attributed to patterns of working and the tight collaboration between the respiratory team, the general anaesthetic team and the ICU team. Within first surge with the down turn of theatres Anaesthetic consultant staff worked in respiratory wards skilling teams up on assisted ventilation. This meant high levels of support could be offered in the Respiratory and Medical wards protecting ICU capacity for those in most need. There were daily discussions between the teams of the needs of patients, capacity and forward planning to ensure appropriate treatments and interventions were available when required.

28. Ensuring expansion of ICU beds was much more than physical space, ventilators, equipment, Oxygen and nursing staff. The staff required a reliable source of PPE with confidence in its effectiveness and their ability to keep themselves safe.

Senior and Junior Medical Anaesthetic Staff were deployed from General anaesthetics to ICU. Nursing staff redeployment was largely from theatres where there had been down turned activity. There was also requirement for additional ancillary staff, technicians, cleaners and pharmacy support. The IT team provided additional technology including hand held phones to support communication between staff and video linked devices to support communication between patients and families and chaplains. Arrangements were made with catering team to provide food and refreshments for staff in the Unit. Psychological needs were acknowledged with creation of staff needed "wobble spaces". This was needed in larger surges when ICUs experienced higher rates of death than usual for ICUs. Longer lengths of stays also deepened relationships between staff, patients and families heightening staff loss. Psychological therapies provided critical incident debriefs for particularly difficult losses, a young mother, a 19 year old. Individual staff members could also access the individual counselling helpline.

29. Limited access to PCR tests created problems in ensuring appropriate patient placement. Patients were required to be managed as positive until confirmatory results of their Covid status became available. This required staff wearing full PPE. Rapid testing (Cepheid test kits) became available in July 2020. This allowed Covid test samples to be processed in the Altnagelvin laboratory and results provided within hours. The test kits were procured nationally and distributed through UKHSA UK Health Security Agency with Northern Ireland receiving a quota. The regional NI Pathology Network determined allocation to Trusts taking into account clinical need, testing provision and geography. The Trust received 28 kits per fortnight which equated to 280 tests per fortnight, 20 per day. Prioritisation for use of these tests were return of a critical staff member, discharge of a patient, cancer patient placement and emergency surgical patients. Rapid testing capacity increased with the introduction of new technologies in 2021. The Trust introduced the Samba II platform in January 2021 and LumiraDx testing in February 2021. Both platforms increased capacity for on-site rapid turnaround testing. This decreased reliance on Cepheid test kits and boosted the robustness of the local and regional testing system. Additional Cepheid test kits were made available to Northern Ireland in May 2021. There were a small number of individual drug

therapies shortages but substitutes were available minimising impact on patient care.

30. A BBC request to visit the Altnagelvin site was put forward to the Trust. Following consultation with the Department of Health, the visit was agreed and a date arranged for October 2020. The purpose of the visit was to highlight the pressures caused by the pandemic on all aspects of care, to outline the work and commitment of a wide range of Western Trust Staff in the frontline battle against Covid 19 and to help with carrying out important public messaging. The risk associated with lack of Oxygen, was robustly mitigated against throughout the Covid pandemic by a Multi-disciplinary team consisting of Clinicians, Pharmacy and Estate Engineering Staff. The introduction of these mitigations combined with the plateauing out and eventual reduction in Covid 19 admissions, ensured that the oxygen delivery system was not compromised throughout the pandemic. At no stage was oxygen supply an issue that affected clinical care. This was achieved by a number of actions. Modelling and stress testing of the Medical Gas infrastructure was undertaken to understand capability. Clinicians, Pharmacy and Estate Engineering Staff collaborated to understand the capacity of the piped medical gas infrastructure and to agree the safest physical location to treat multiple patients using high flow oxygen. Learning was garnered from Italy which highlighted the importance of oxygen flow capacity alongside oxygen volume. To support improved flow a number of Medical Gas Infrastructure pipework upgrades were carried out to improve the capacity of Oxygen delivery. Altnagelvin site capacity was increased by installation of a third Vaporised Insulated Evaporator (VIE) tank provided through British Oxygen Company (BOC). Altnagelvin was one of 3 hospitals in NI that had their oxygen capacity enhanced at the outset of the pandemic. The others were the Royal Victoria Hospital, Belfast and the Nightingale Hospital at Belfast City Hospital. The VIE storage tank was decommissioned by BOC in a commercial unit and installed at Altnagelvin hospital Oxygen pipe infrastructure within the hospital was enhanced in the areas expected to be under most pressure with respiratory patients. Oxygen Action Cards were developed to allow clinicians to understand the capacity of the Medical Gas

Infrastructure assisting with patient placement. Oxygen monitoring was put in place and its status was reported daily to Trust Silver.

31. A head of terms was signed by the Region on behalf of all Trusts with the Independent sector on 16 April 2020 to support delivery of non Covid services in particular Surgery. The Trust diverted General Surgery, ENT, Ophthalmology Gynaecology, Trauma and Orthopaedic work to the neighbouring North West Independent Clinic (NWIC). In total from 1 March 2020 through to 31 December 2021 there were 342 Admissions, 503 Day Cases 183 New Outpatients and 593 Review Outpatients. There were challenges to relocating services requiring an over-arching governance arrangement. Patients had to be selected recognising the limitations in post-operative care including the lack of an on-site ICU facility. Only substantive consultants were able to work in the NWIC as the clinic did not provide indemnity for non- Consultant doctors in training. 4 Orthopaedic day cases were diverted to South West Acute Hospital under NHS Core activity and Orthopaedic Day Case Project.

Infection Prevention Control

32. A Covid safe environment was the foundation for ensuring that services could be delivered safely to patients and their families. Please see attached Reference Report of Visit to WHSCT Facilities by the Visiting Sub Group of the Nosocomial Support Cell April and May 2021 document exhibited to this statement as Reference CMcD/5 – INQ000416864. If Covid 19 virus was being actively transmitted in the hospital then patients, most of whom would fall into the category of Clinically Extremely Vulnerable, would be at high risk of nosocomial (acquired in hospital) infection and death. Staff would be at similar risk of contracting Covid which would have both risks to their individual well-being and collectively to staff absenteeism and service provision. All measures possible were put in place to create a Covid safe environment for patients and staff. Early Trust Silver agendas include all the work streams that contributed to that safety. Covid and non Covid pathways (referred to "Red", "Green" pathways) and areas were created. This

included re defining wards and theatres, changes to the flow of patients through Emergency Department and creation of a Primary Care Covid Centre in the Outpatient Department. Isolation rooms were identified at onset of Covid for care of Covid patients. Demand increased prompting allocation of a ward to cohort Covid positive patients. As surges grew and admission numbers escalated additional wards were re assigned to Covid The IPC team lead the behavioural changes necessary to maintain Covid safety through leading training, sharing guidance, advising, monitoring, managing outbreaks, reporting and creating a culture of learning and continuous improvement. Support teams maintained a Covid free environment. The Trust increased cleaning staff by 50%, intensifying cleaning rotas in high risk areas. Laundry staff shifted to 7 day working and absorbed the laundering of scrubs which were being worn by all hospital staff. Porters took on new roles and were stationed at hospital entrances to implement visiting restrictions, to ensure compliance with mask wearing and hand sanitisation. Waste disposal increased by 60% over first surge as a consequence of PPE use. The Trust set up a Care Home Support team which liaised with Care Homes on a daily basis. The team provided support and interventions as required including movement of a cohort of patients to Ward 5 in the Waterside hospital when relocation of residents from a collapsed local residential care facility was stalled following a Covid outbreak. The Waterside Hospital is an Older Peoples Hospital providing Older Peoples Mental Health, Dementia and Physical Rehabilitation services. Ward 5 bed capacity was temporarily increased by the movement of residential home staff into the unit and procurement of additional beds. Ward management, infection prevention control supervision and training were provided by Trust staff. The influx of 13 patients did not have an impact on Altnagelvin bed capacity. All patients were safely transferred to appropriate community placements within 5 weeks.

33. Altnagelvin followed national Public Health England (PHE) guidance and subsequent regional Department of Health NI/ Public Health Agency (PHA) guidance. In certain instances the hospital modified the guidance making dynamic risk based decisions based on local data and trends. An example was delaying implementation of a downgrading of PPE and infection prevention control

measures in December 2021 as local figures indicated another pending surge linked to emergence of the Omicron variant. This assessment was based on local intelligence regarding high community prevalence rates, rising number of outbreaks in Community settings, increasing Staff Covid absence, integration of learning from incidents/outbreaks and environmental constraints. These decisions were approved by the Corporate Management Team and kept under regular review until data indicated a decline in Covid transmission prompting appropriate de-escalation. Altnagelvin Hospital had the lowest number of nosocomial (hospital acquired Covid) infections in the region and the lowest number of nosocomial deaths There were 51 confirmed Altnagelvin hospital acquired Covid infections with 6 associated nosocomial deaths during the period 1 March 2020 through to 30 June 2022. Regional interrogation of this data and pattern showed there was a limited increase in nosocomial infections through surge contrary to what was usually expected. This anomaly would suggest that the measures taken to keep the hospital as Covid safe as possible were robust even in the most challenging times.

34. The IPC team is a small team which was already experiencing staff shortage as a consequence of unfilled sickness vacancy. The Microbiology team was fragile consisting of two substantive consultants and were supported by locums who provided on call shifts to cover sick leave. An additional locum consultant was recruited bringing the team to three through the pandemic. Whilst additional funding was made for available for IPC workforce to support response to Covid including the extended reach into the Private Nursing Home (PNH) sector it was difficult to translate this money into staff. IPC is a specialised area with a small pool of skills across the region. Monies were non-recurring so temporary contracts only could be offered which were not attractive. Through the Regional recruitment programme the team did secure return of a recently retired nurse for 2 days per week.

35. The team had additional challenges as two senior staff were identified as CEV and could only work from home. ICT department responded quickly to this facilitating

remote working and allowing service to continue seamlessly. The team adapted quickly to this new way of working, developed on line daily meeting and huddles to support each other and prioritise work. IPC staff shielding who were working from home responded to calls, outbreak management, attended meetings and provided virtual training to allow other staff to provide IPC advice/support on site.

36. Any additional funding was utilised within the existing staffing resource for acting up posts to support the independent care homes and provide leadership to new staff who had joined the team during the timeframe. Some IPC staff moved to other posts and new staff were recruited who required a considerable induction programme.

37. The IPC team developed innovative ways of extending their reach and did this through development of PPE champions across the Trust who supported introduction of PPE and implementation of IPC measures across facilities and teams. It helped to disseminate the message that infection prevention control was everyone's business. The team felt supported by working groups that were set up focusing on PPE, the anxieties and concerns of staff. Staff were concerned for their own safety but also the negative impact of wearing PPE on their relationship and communication with patients. The PPE working group benefited from psychological input that helped cascade information in a manner that provided opportunity to listen and reassure. A separate Staff Safety group looked at introduction of testing in staff with early focus on clustering of positive cases, clarifying processes, prevention of transmission and supporting individual staff well-being. This process quickly indicated that the case definition of symptoms prompting testing was limiting and that staff were testing positive with a range of symptoms or none. This high-lighted a risk which was integrated in further risk assessments.

38. Rapid dissemination of information was critical throughout the pandemic but particularly in the first few months. Everyone was on a rapid learning curve about

the new virus and how to keep patients and staff as safe as possible. IPC guidance was disseminated and implemented via a range of channels.

39. These channels included Silver and Bronze arrangements which were designed as a cascade mechanism across the whole Trust and through all departments, to all clinical and non-clinical staff. It was fully functional 7 days/week so all guidance could be shared promptly even when new guidance came to the Trust on a Friday evening. The Trust Communication team attended Silver daily and developed a communication plan around all changes to guidance. They used various platforms such as Facebook and Twitter to communicate with all staff and with the public. They worked with the IPC team to produce videos, posters, podcasts, IPC/ COVID share point sites, discussion boards. The IPC team set up training programmes both virtual and face to face prioritising high risk areas.

40. The IPC team was integrated into all work-streams, attending Altnagelvin hospital planning group where plans for service delivery were made through Covid and Reset and Rebuild of services. They were an integral part of the Working Safely together group. The Working Safely Together group was established in December 2020 and I chaired it jointly with the Director of HR Membership included managers from across the Trust and Trade Union representatives. Its purpose was to ensure vigilance around Covid safety during rebuilding of services. A work stream within group was the nationally award winning "Working Safely Together" ECHO project. This project linked staff from approximately 100 facilities to a learning platform which hosted virtual meetings. A full programme of events with speakers was developed by HR and Facilities management departments through the pandemic. Subject matter linked directly to emerging needs of staff. Other work streams attended to updating of IPC guidance with communication planning, the development of Environmental Risk assessments and monitoring of Psychological Support needs of staff.

41. The biggest challenge to implementing IPC guidance was concern in the early stages of the pandemic that guidance was developed around supply issues rather than safety and that safety measures being advised were inadequate. PPE was initially restricted to staff working in areas where patients had tested positive for Covid or where there were high levels of suspicion based on the symptom definition. All staff felt vulnerable and those who did not meet criteria for provision of PPE felt de- valued and unsafe. This was reinforced by media reporting which used language of "shortage" and "saving PPE for". Social media shared comparisons of PPE guidance in other countries which was more robust. The general public also shared this narrative of PPE scarcity responding with donations of PPE. Royal Colleges were conflicted, advising that all patients should be considered potentially Covid positive at the same time advising adherence to national guidance which had a narrower case definition. Clinical staff had their own understanding of risk and some were compelled to source their own PPE. There was an early loss of trust and confidence in national directives. There was a moral dilemma for those charged with implementing such guidance. Within Trust governance arrangements, risk assessment is a cornerstone to ensuring safe services. This was the vehicle used to resolve dilemmas, to engage with staff, to consider the evidence available to make best decisions to keep all safe. Relationships with Trade Unions and inclusion of Union representatives in our Working groups helped build staff confidence. This was critical in allaying fear and anxiety and supporting staff to attend for work daily. Guidance issued on 2 April 2020 was welcome where there was recognition of the need for wide use of PPE and recognition of high risk areas and activities such as Aerosol Generating Procedures (AGPs) which required higher levels of protection. The enhancement of PPE provision in the amended guidance highlighted the inadequacy of previous provision and risk to staff.

42. New guidance was not accompanied by any resources such as posters, videos. This required creative skills of the IPC and communication teams. There was challenge to keep staff interested because of such frequent change in guidance and general staff weariness. The team had to remain creative including themed campaigns such as Twelve days of Christmas.

43. Guidance was open to differing interpretations - for example what constituted an Aerosol Generating Procedure (AGP). This was contentious as an AGP merited a higher level of protection and access to FFP3 masks. Examples of procedures that were debated as to whether they met the definition of an AGP were nebulisation and CPR. Neither were included in UK guidance but were included in other countries AGP lists. The Regional IPC cell offered a space for discussion and helped decision making alongside Trusts own risk assessment processes.

44. Altnagelvin Hospital has a mixed estate with older wards that are part of the original 1960s build ranging through to a new build, the North wing, partially opened before Covid and fully operationalised by April 2020. The ED is on the original hospital site with a limited footprint. A business case for a new build ED sits with Department of Health. The time frames and the limited footprint, created challenges to accommodate Covid and non Covid pathways. Estates team worked tirelessly with the ED team and IPC team to establish separate pathways. There were additional pressures when EDs were identified as sites for testing. The Trust managed this by purchase of a drop in Unit which was positioned adjacent to ED as a temporary measure. A more appropriate location was found for testing in the Clinical Translational Research and Innovation Centre (CTRIC), the research centre, diverting this activity and associated risks from ED. Minor injuries activity was diverted to Outpatients which was closed during the Emergency period. Covid and non Covid pathways were developed for all patient groups from waiting areas right through the hospital from ED to admission wards to labour ward to theatres. Challenges were evident when ED and Outpatient department returned to business as usual with congestion for patients, families and staff. The footprint was extended through the addition of a new multimodular build extension which was operationalised by early January 2021. It included an ambulance handover area which was operationalised by March 2021.

45. Altnagelvin in-patient facilities are a mix of accommodation with old and new buildings with varying access to isolation rooms, on-suite single rooms, single

rooms and multi-bedded bays. Wards had varying degrees of compliance with ventilation requirements. The Covid ward was initially located in Wards 31 & 32 (displacing Surgery) because of the availability of both isolation rooms and oxygen. This was a temporary measure and the Covid wards quickly moved to Ward 26, located in the new North Wing. The North Wing was a new build which opened fully in April 2020 increasing physical bed capacity and was risk assessed through a multi-disciplinary risk assessment. Ward 26 provided on-suite single rooms, a number of isolation rooms and ventilation was compliant. The layout of the new specialist Respiratory ward facilitated separation into Covid and non Covid areas. There were separate access arrangements to the two areas and care was delivered by separate teams to minimise Covid transmission. The layout also facilitated agile switching of beds from Covid to non Covid in response to ever changing pattern of demand.

46. Covid care expanded into additional wards as numbers of patients with Covid escalated. Ward 42 which was a Care of the Elderly ward switched to accommodate Covid end of life care. At peak surge wards 31 and 32 were re-designated Covid wards. The environments were risk assessed through a multi-disciplinary process, considering the layout of mixed single rooms and multi-bedded bays, toilet facilities and ventilation. Multi-bedded bays and shared toilet/bathroom facilities were a challenge contributing to higher rates of transmission. The hospital in as far as possible identified Covid pathways in areas that could facilitate single rooms or cohort nursing of patients with the same Covid status.

47. The Altnagelvin Estates team recognised risks linked to ventilation in the very early stages of the pandemic. This was highlighted for them as they re-purposed theatre spaces as part of the first ICU surge plan in March 2020. Positive pressure in theatres controls transfer of air contamination into the theatre but could have been counterproductive pushing potentially Covid contaminated air out. Ventilation adjustments were made to mitigate against this. Focus intensified on quality of ventilation as the evidence base grew and scientists debated the possibility of

airborne transmission. In October 2020 a neighbouring Trust carried out a review of a Covid outbreak in a haematology ward, which confirmed the importance of air-borne Covid as a factor. These developments continually informed the Estates team programme of risk assessment of ventilation across the hospital estate working with Clinical and IPC colleagues. Where possible ventilation was enhanced and where ventilation remained inadequate mitigations were introduced. Respiratory protection was increased from FRSM masks to use of FFP3 masks. Air cleaning devices were introduced whilst also improving the mechanical ventilation. Generic IPC messages were adapted to remind staff of the importance of ventilation and opening windows. Seating areas were created outside to allow staff to take breaks and lunch outside weather permitting.

48. Testing of staff and patients was essential to ensuring Covid safe environments and Covid free environments critical to care of patients and staff. Guidance around testing of staff changed through the pandemic which reflected both growing knowledge and improved access to testing. Testing for staff commenced on the Altnagelvin site on 26 March 2020. Staff also had access to the local independent testing site which was established on the 16 April 2020 though there were problems with transfer of test results to the NIECR system which were never resolved.

49. The Trust promptly followed NI guidance on testing. This was communicated through PHA communications and HSC Silver arrangements in early January 2020. There were a small number of exceptions were the Trust made decisions to carry out additional testing measures built upon local knowledge and risk assessment to protect patients from nosocomial infection.

50. The Trust focused on asymptomatic staff testing early in the pandemic when the IPC and Occupational Health teams identified Covid positive staff clusters. This prompted further testing of staff who were close contacts. Additional staff members were identified as Covid positive who fell outside the regional definition

for testing. Some staff had different symptoms and others no symptoms. A Staff Support group was set up and met to consider how to risk manage clusters of Covid positive staff on 22 April 2020. The group was supported by a retired Public Health Consultant. It included IPC team, Occupational Health, Psychology, Laboratory's and I chaired it.

51. Processes were set up to help identify clusters, manage risk, support staff and ensure Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting. This group was stepped down in June 2020 and more traditional outbreak management approaches were introduced in the second surge in October 2020.

52. First testing for patients based on travel history was introduced on 14th January with further reinforcement of assessment, management and testing of suspect cases on 24th January. First asymptomatic patient testing followed issue of May 2020 guidance Version 4. This was highly beneficial in supporting effective flow of patients and appropriate patient placement. Prior to this Covid precautions were taken with all patients until proven otherwise to protect other patients, staff and to minimise risk of Covid transmission.

53. There are a small number of references to shortfalls in testing kits. There were larger constraints from staff availability to carry out the laboratory work and availability of appropriate equipment. A certain number of tests were carried out on the Altnagelvin site and this increased over time. The laboratory staff were required to prepare specimens prior to transporting to the Regional virology lab in Belfast. The Regional facility was also challenged by sheer volume of demand. Altnagelvin is 70 miles from Belfast. The connecting road was being upgraded through the pandemic and journey time was 90 minutes. Specimens were taxied to Belfast with twice daily scheduled pick-ups. Laboratory staff across the Trust rose to the challenge, changing work patterns to ensure a consistent 7 day service. The Trust had access to a limited number of Rapid Tests which held for

emergencies such as emergency surgery, cancer patients, to support discharge and patient flow. The lag-time in getting a result varied from 20 minutes with a rapid test to up to 72 hours at peak surge. These delays did contribute to late diagnosis of COVID 19 increasing risk of nosocomial infection. It also caused delays in staff return to work creating additional workforce pressures.

54. Asymptomatic Staff testing was introduced on 23 September 2020 in the North West Cancer Centre (NWCC) in Oncology and Haematology wards. This followed events in a neighbouring Trust where Covid transmission in Cancer facilities resulted in multiple patient deaths. This highlighted the risk Covid posed for this vulnerable group of patients. Previous staff cluster testing in the Trust confirmed that Covid symptom definition was unreliable in identifying staff who may be Covid positive with many presenting with symptoms outside the definition. Community rates were beginning to rise and a decision was taken by the Corporate Management Team (CMT) to commence an asymptomatic testing programme in the Cancer unit. Staff were tested twice weekly. A pathway had been established in first surge to ensure all patients were confirmed Covid negative before entering the Cancer unit. The hospital also made a decision to increase the frequency of testing for patients in multi bedded bays with poor ventilation, shared toilet facilities across the hospital as a result of local learning from incidents/outbreaks and risk assessment.

55. Except for these identified high risk areas frequency of patient and staff testing was implemented as per Regional guidance.

56. The hospital initiated outbreak management processes following the Trust Outbreak Control Plan in March 2020. Please see attached Infectious Incident / Outbreak Control Plan dated March 2020, document exhibited to this statement as CMcD/12 – INQ000474038. The plan was updated in January 2022. Please see attached Infectious Incident / Outbreak Control Plan updated January 2022, document exhibited to this statement as CMcD/13 – INQ000474037. Post-

infection reviews were undertaken for any nosocomial case of Covid 19. Limited guidance existed. Altnagelvin Hospital utilised testing guidance and limited case definition within Public Health England (PHE) and Regional Public Health Agency (PHA) guidance. An outbreak was declared where there were two environmentally linked cases. This became more difficult when COVID 19 became endemic and it was unclear as to whether staff had contracted Covid in the community or through their work. Outbreaks were particularly common in settings where patient groups had difficulty complying with restriction of movement such as confused elderly and patients with mental health or learning disabilities.

57. Balancing the need for staff isolation in outbreak management to ensure Covid safety against the need for staff to be available for work to deliver service was challenging. This was particularly difficult in December 2021 / January 2022 surge. A template was developed to assist managerial staff in considering a balance of risk with escalation and decision making processes in place.

PPE

58. PPE was critical to keeping staff, patients and visitors to the hospital site safe. PPE was part of early planning for Covid with the Trust drawing up a plan for procurement prior to 17 March 2020. At the start of the pandemic, the Director of Finance had oversight of PPE management. The role of PPE Lead was then delegated to the Head of Pharmacy and Medicines Management who was supported by a wider team of staff from Finance, Planning & Performance, Pharmacy and Infection Prevention and Control. The Trust created a single point of contact system which was critical in creating reliable flow of PPE through the hospital and an ease of access that reassured staff. This essential role was formalised through the appointment of a permanent PPE Manager in February 2021. Challenges were greatest in the early months of the pandemic when demand outstripped supply. There was a short period when the Trust understood that it would be sourcing their own PPE but that quickly shifted to Regional Procurement and Logistics Services (PaLS) within BSO. At the outset of the pandemic PPE distribution had to scale up exponentially in the Trust, moving away from a small

number of "cold" stores which were rarely accessed to multiple distributed stores as central stock was pushed out across the Trust. The volume and bulk of goods to be stored required the Trust to secure a storage unit at Maydown, an industrial estate close to the hospital, and to set up a stock management system to control the receipt and issuing of stock. The store was managed by staff from PaLS through a service level agreement with the Trust. Drivers were employed by the Trust to deliver PPE. A small back-up stock of PPE was kept on site in Altnagelvin as contingency.

59. A Trust procurement group was set up to identify new supply channels to help stabilise supply and build up a contingency. There were robust governance arrangements for procurement, logistics, product specifications and value for money. A local company Seagate was approached for PPE in March 2020 but this was not fruitful. Other local companies diversified into the production of assorted PPE items and made offers to the Trust. The offers were managed through regional processes and forwarded to BSO PaLs for further exploration. PPE and PPE procurement were a critical part of daily Regional Silver meetings that directly linked to Gold Command. PPE updates were shared at Trust Silver meetings daily.

60. A small number of re-useable FFP3 masks were purchased by the Trust for essential staff at most risk of contracting Covid should the supply chain break down. These provided a small degree of comfort as a safety net during the first precarious weeks. They were never required.

61. A number of working groups were set up within the Trust to support flow of PPE in appropriate quantity and quality across Altnagelvin Hospital. The Trust set up a PPE Local Modelling group to determine the quantities and types of PPE that would be needed. This work was later led regionally by a regional PPE modelling group established by the PHA. A PPE Advisory group did a daily stock take of PPE, ensuring distribution and timely communication through Silver of arising issues.

62. Requests for stock lines were managed by the Regional PPE supply chain, chaired by the BSO logistics lead, initially through daily 'push arrangements', based on stock availability and the percentage apportioned to the Trust. Mutual aid arrangements were facilitated through the daily Regional supply chain meeting. It was activated on a small number of occasions. Altnagelvin Hospital required mutual aid assistance to maintain a week's supply of FFP3 masks in November 2020 The lowest level stock fell to in Altnagelvin was 3-days' supply. Regional stock holdings improved, in June 2020, and a 'pull system' was introduced, whereby Trusts submitted a re-order form, twice weekly. The DoH instructed the Trust to provide PPE to the Private Nursing Home sector. The Trust also provided PPE to the Primary Care Covid Centre on the Altnagelvin site. Delivery times from when an order was placed ranged from 2 hours to 2 days. On rare occasions Trust transport picked up deliveries.

63. BSO delegated their responsibility to the Trust to coordinate, manage and supply high demand items including PPE and cleaning products on the 23 March 2020. Please see attached (letter from Mrs Cathy Harrison, Chief Pharmaceutical Officer, DOH, and dated 23/3/20 document exhibited to this statement as CMcD/6 – INQ000120711.

64. A PPE Quality Assurance group managed the quality of the supply of PPE. They reviewed all PPE delivered to the Trust to ensure it was fit for purpose before distribution to the wards. This group included senior staff from Infection Prevention & Control, PPE manager, Critical Care Technician and Decontamination Manager. Product lines for consideration were fed into the group form a range of sources. This included what was sourced locally and what came through regionally. There were also small numbers of donations in early stages of the pandemic, which were held separately. Clinical staff could also highlight concern to this group. Problems were identified with quality of products such as aprons that tore readily, goggles that were poor fitting, FRSM masks with faulty ties. When products were identified as substandard they were immediately recalled.

65. A Regional quality assurance process was set up through the Medicines Optimisation Innovation Centre (MOIC). All items to be procured by Trusts or BSO PaLS were vetted by MOIC to assure appropriate certification and standard before procurement. The Regional Infection Prevention & Control Cell contributed to this process. MOIC built up expertise which supported the procurement of quality assured products in a volatile, pandemic market.

66. Face fit testing was necessary to ensure that staff exposed to Covid had access to well-fitting FFP3 masks. The Trust had a Face-fit testing service in place prior to the pandemic which engaged in pandemic preparation face fit testing for high risk groups of staff from 07 February 2020. The capacity of the team was enhanced by increasing the number of internally trained staff and sourcing external company support. There were multiple different FFP3 mask models and each had to be face fit tested as there was variation in fit. Supply issue challenges meant that the model delivered to the Trust changed frequently prompting new rounds of face fit testing on a new model. Efforts were made to direct supply of a particular model to a certain clinical area to minimise the number of face fit tests staff members had to undergo. The quality of performance of external companies was brought into question. This resulted in a regional review of FFT process, standard setting and recommendations. The Trust Occupational Health department sought funding and recruited a team including a Face fit Testing Manager who brought rigour to the scheduling and worked closely with the PPE Manager.

67. The Trust had concerns that there would be insufficient FFP3 masks that would fit a range of different face sizes, especially smaller faces. Face fit testing slots were increased with prioritisation of staff who were working in high risk clinical areas. Respiratory hoods were purchased for a small number of surgeons and staff in Critical Care who had failed face fit testing. Reusable FFP3 (Pureflo) masks were purchased and these were also a resource for staff with face fit testing fails. When National PPE guidance supported use of FFP2 masks, these were purchased. Since then the region led on work to design a locally manufactured mask (Denroy) that fitted a wider proportion of staff in particular smaller faces. It is hoped that local manufacturing will minimise supply chain problems and any delays in delivery.

68. PPE and Human Factors group was established to specifically address staff anxieties about PPE. There was a pervasive anxiety about the availability of PPE. One staff nurse on the COVID ward described her anxiety as she saw the stocks of FFP3 on her ward decrease through the day and not being sure whether they would be restocked on time. The PPE Lead met with her and the process changed so that PPE was proactively topped up each day. There was learning about the importance of a visible PPE supply on the ward to provide reassurance. Whilst there was fear of shortage supply chains were maintained for critical staff to ensure safe care of patients. Anxieties however could not be fully allayed because the supply chain at times was tenuous.

Visiting Restrictions

69. Visiting restrictions were introduced on 26 March 2020 for the first time with full hospital lockdown on 31 March 2020. To facilitate operationalisation of both restricted visiting and hospital lockdown porters managed entrances. The hospital quickly set up a Visiting group chaired by the Director of Nursing. Visiting guidance was regularly reviewed and risk assessed to ensure benefit of ensuring a Covid safe environment out-weighed the emotional cost to patients and families of being unable to visit. Visiting guidance required modifications in particular circumstances such as increased restrictions on a ward where an outbreak was declared or decreased restrictions for individual patient circumstances such as end of life or where age or disability created communication difficulties.

70. In first surge there was an exceptional circumstance where a request to visit in ICU was escalated agreed and facilitated by the team. It required rigorous planning between staff and the family member. The family member was met at the hospital entrance to ensure adherence to the safe routes through the hospital. They were supported with donning and doffing PPE recognising the risks of transmission. There was additional nurse staffing arranged to provide emotional support through

a very distressing visit. This experience provided learning that was incorporated into a risk assessment tool that provided a framework for equitable decision making around visiting. It considered levels of community transmission, patient circumstances, availability of PPE, capacity within unit, capacity within staff. Patients and their families appreciated the efforts that were made to accommodate visits and the rigour of the process which was applied uniformly balancing risks. This tool was discussed and supported by the Ethics committee. Of note the only request for an Emergency Ethics committee meeting related to a visiting request highlighting the level of dilemma experienced by frontline staff.

71. All wards were provided with IT equipment to facilitate virtual visiting. Training on communication and difficult conversations was provided by Palliative Care Consultants across Altnagelvin Hospital for nurses and doctors. This included consideration of how best to communicate with families when face to face meetings were not possible. Covid wards and ICU developed family communication plans early in Covid preparations learning from colleagues on the mainland who were two/three weeks ahead in Surge. The models were proactive reaching out to families. The respiratory ward ensured twice daily calls morning and evening to families. ICU ring-fenced medical time so that families received a daily medical update mid-afternoon. This was in addition to usual response to inquiries.

72. The visiting group which was set up in September 2020 oversaw visiting both in hospital and in community. The hospital followed Regional guidance as issued by the DoH keeping eye to local community transmission rates. As previously referenced the local pattern of community transmission did not always align with region prompting a 2 week early community lockdown in October 2020 during second surge. This was accompanied by Altnagelvin Hospital imposing visiting restrictions earlier than the rest of the region. A similar incongruence prompted earlier visiting restrictions in the fifth surge. A decision was taken as a raft of indicators, community transmission rates, increasing numbers of community out

breaks, rising staff Covid absence, hospital outbreaks linked to visiting signalled escalating risk.

73. The public were kept informed and updated of all changes to visiting through the Trusts website and social media channels. Restrictions took cognisance of vulnerable groups and exceptions were made in keeping with Region. Communication difficulties were recognised as an exceptional circumstance in all policies with recognition of need for accompanying person for children, elderly, deaf, non-English speakers. The Visiting group reviewed restrictions weekly, lifting them gradually as it became safe to do so.

74. The limits on visiting were harrowing for all. Patients admitted to hospital did not know if they would see loved ones again and equally for families, not knowing if they would see the patient again. Families were asked to make tremendous sacrifices for the benefit of the unknown other. It was difficult for anyone to accept the loss of visiting a loved one as essential to keeping all patients in hospital safe. Staff did their best to care for dying patients and their families at this time. One family took great comfort when they lost both parents to Covid in the first surge to learn that their father had been moved from the general ward to the ICU to be alongside his wife when she died. He died shortly later. Staff placed small wooden hearts in pockets of all patients approaching death as a symbol of connection with loved ones who could not be physically present.

75. Death from hospital acquired Covid infection was particularly difficult. A Bereavement Support team was set up, staffed by re deployed nurses to provide bereavement follow up calls to relatives of all deceased patients. Bereavement support packs containing support literature were distributed through the mortuary and posted if requested through the Bereavement support team. The team also provided a Bereavement support helpline. Healthcare teams were provided with support from Psychological therapies service.

76. Limiting visiting was a very difficult decision but was less difficult for those who understood that failure to keep hospitals safe from Covid would have resulted in multiple deaths of the sick and vulnerable as well as staff. Patients and staff alike contracted Covid in hospital and without the restriction there would have been more deaths.

Patient treatment and care

77. All services continued to be delivered albeit it in an adapted form through the pandemic. The hospital was divided into Covid and Non Covid zones to ensure that care and treatment was delivered safely. Regional guidance was issued in April 2020 providing guidance to specialties on prioritisation. A Hospital Planning Group was established and chaired by the Director of Acute Services. This group included senior managers and lead professionals and was responsible for decisions regarding bed capacity and operational service issues. The group reported through to Trust Silver. Please see attached Protecting Critical Secondary Care Services in Health and Social Care Trusts within Northern Ireland during the Covid-19 pandemic document exhibited to this statement as CMcD/7 – INQ000416866

78. The Trust followed regional guidance on down turning of elective Surgery which was required to ensure capacity within ICU. Through First surge and the state of Emergency elective surgery was delivered through Day case theatres. During Second surge the Trust managed to deliver 50% of surgical services as compared to previous year despite staff shortages and limited access to Theatre space. By third surge a regional prioritisation operational group was set up which risk stratified elective surgical procedures. Red flag surgery which was cancer surgery was highest priority. Additional time critical conditions were added to the priority list such as renal stones which could precipitate life threatening complications. The aim of the Regional group was to ensure equity of access to services across the region but implementation in the delivery system which existed was difficult.

79. Limited access to theatres was frustrating for surgeons and distressing to their patients. Other challenges to delivery of surgical services was the disassembling of specialist surgical wards into pan surgical wards diluting specialist nurse teams. This was most acutely felt by Ear Nose and Throat and Oral Maxillofacial Surgery where technical airways skills and competence are important and the nursing team was fragmented. These teams were particularly impacted by the Infection transmission concerns around Aerosol Generating Procedures which carried high risk of Covid. Many elements of their assessment and treatment procedure fell into that category. To carry out these procedures safely out-patient clinic environments required lag times and between-patient cleans. This required additional ancillary support to run a clinic and slowed flow of patients. Surgical Laparoscopic procedures were suspended for similar reasons and were restarted following guidance from Royal College of Surgeons. Specialties looked to Royal Colleges for guidance on all these issues.

80. All out-patient clinics were suspended in First Surge. All specialities had emergency assessment arrangements in place which included Triage calls and Covid screening. Patients where Covid was suspected were directed to ED Covid pathway. Some specialties such as Obstetrics and Cancer services by-passed ED creating their own Covid and Non Covid pathways. During first surge the Altnagelvin Out-Patients Department (OPD) provided space for the Primary Care Covid service and provided space for ED minor injuries service. Restarting OPD services required relocation of both. The OPD environment was modified by need for social distancing with waiting area seating essentially halved. Patients were advised to attend alone except for vulnerable patient groups where one person could attend to support. Patients required Covid screening. Mask wearing and hand sanitisation were compulsory.

81. The Trust set up Phlebotomy services to support clinical assessment at out – patients, for those patients who were suitable for "virtual" clinics, as part of the move to minimise footfall on the hospital site and to risk manage Face to Face

assessment. This also served to support Primary Care, where Treatment room services no longer carried out bloods for outpatient assessments. Patients attended the Phlebotomy centre which was located on Trust facilities at a neighbouring site. All patients were required to comply with Covid safety measures.

82. To ensure that all clinicians were kept up to date with Covid care, treatment and implications for clinical practice a Clinical Advisory Group was set up. I chaired the group which was led by Pharmacists and Clinical leads. The group developed a Clinical Guidelines for Treatment of Covid document, to keep clinicians up to date with new drug treatments as they became available. The group also identified best practice in relation to management of Diabetes in Covid and management of Covid in pregnancy. The Guidelines were disseminated to all clinicians and were shared on the Trust intranet so easily accessible to treating clinicians. Please see attached Clinical Advisory Group Terms of Reference document exhibited to this statement as Reference CMcD/8 – INQ000416867.

83. The Orthopaedic team was innovative in the absence of access to usual theatre and outpatient space. The Saturday mega foot and ankle clinics were set up in Omagh Hospital and Primary Care Complex, where a multidisciplinary team carried out new assessments on 100 patients in a day. Foot surgery shifted from in-patient delivered to day-case delivered hence no longer reliant on bed availability. The team also worked to increase volumes of total hip replacement surgeries undertaken in their operating sessions at Altnagelvin. They co-ordinated people and processes so that operations ran smoothly and to time increasing output.

84. There was a significant shift to use of phone and virtual clinics which had an initial impact of reducing the growth in Out-patient waiting lists. 200 Virtual clinics were set up across the Trust with system integration with existing Trust systems hence minimising duplication of work. These clinics however have shortfalls with some patients having an ongoing requirement for face to face assessments and reviews.

85. Maternity services were adapted to ensure continued delivery of safe treatment and care taking cognisance of risk of Covid transmission. Pregnant women were identified early as a high risk group. Ante natal outpatient care by its nature, requiring physical examination could not be delivered virtually. Clinics continued to run face to face but moved out of community settings and onto three central hospital settings including Altnagelvin. Flow of women through clinics was slowed by need for changes in PPE and cleaning between appointments. Clinic times were extended. Women were asked to attend the clinic on their own with partners remaining outside. Partners were invited in as supports if there was bad news.

86. Booking appointments were carried out by phone and a Covid screening was carried out prior to a face to face appointment where booking physical and bloods were completed. Covid was a risk to pregnant women. Following clinical guidelines all women diagnosed as Covid positive were risk assessed via telephone for Venous Thromboembolism (Clot). If risks were identified the woman attended hospital for a face to face appointment with an Obstetrician. Medication if required was prescribed, dispensed and education provided.

87. The Maternal and Foetal assessment Triage service which provides emergency assessments for pregnant women continued to operate as normal if the woman screened negative for Covid. If the woman screened potentially Covid positive and needed obstetric assessment she was directed to the designated Red Covid pathway part of ward.

88. All women being admitted to hospital for planned surgery were tested for Covid. This was initially PCR changing to LFT per guidance and moving more laterally to Lumira (a Covid antigen test). The Midwifery Lead Unit (MLU) space was identified as a Red zone where Covid positive women in labour were cared for. The MLU activity was relocated to the main Obstetric unit. Use of birthing pools was stopped

in the early months of the pandemic. More information became available on the safety and access to birthing pools was re-established.

89. In the very early months of the pandemic all COVID positive obstetric theatre cases where taken to main theatre at Altnagelvin. (Very minimal numbers).This increased the transfer time to theatre and delayed procedures. This changed within 1-2 months and surgery was relocated to the Delivery Suite theatre as occurred pre-pandemic. Theatre time for COVID positive women was extended by donning and doffing, entry and exit of theatre area. These delays did increase risk to mothers and baby's as time critical hence was factored into clinical decision making. Cleaning created a lag time of 20 minutes before the theatre could be used. On one occasion this delay prompted transfer of a woman to the general theatre facility.

90. Postnatal follow up was delivered by a mix of virtual and face to face contact with requests that only mother and baby be present during face to face appointments.

91. The Paediatric ward also created Covid and Non Covid pathways with a separate unit/ward designated for Covid patients. This did cause some challenges in providing adequate staffing for both units. A parent was allowed to accompany a child throughout lockdowns and visiting restrictions. Whilst Paediatrics did not experience surge numbers as compared to adults they noted delays in children being brought for medical attention with an increase in first presentations of diabetes with diabetic ketoacidosis, a diabetic crisis and life threatening. The service has also noted a surge in mental illness presentations in children in the aftermath of the pandemic.

92. Ambulance handover times showed little variation through this period in Altnagelvin Hospital. The DoH published a Covid 19 Urgent and Emergency Care Action Plan "No more Silos" on 16 October 2020. Its purpose was to rapidly

implement 10 Key Actions to ensure urgent and emergency services across primary and secondary care could be maintained and improved upon. This included an Action specific to Ambulance arrival and Handover time. Altnagelvin Hospital had lower than average handover times which were essentially maintained through pandemic with 90-95% of patients being handed over within 60 minutes. The expansion of the ED footprint by addition of a modular build in December 2020 included a dedicated Ambulance Handover which became operational in March 2021. This helped maintain this performance through both Covid and non Covid surges of activity and demand.

93. An Ethics committee was set up in the Trust on 27 March 2020 which I chaired. Please see attached Terms of Reference for The Ethics Committee document exhibited to this statement as Reference CMcD/9 – INQ000416868. This was in recognition of the challenging decisions ahead for clinicians should demand for care and treatment outstrip resource. The committee included Consultants from all specialities, Senior Nurses, Psychologist, Bereavement Counsellor, Chaplains, Non-Executive Director and Members of the Public. The purpose of the committee was to provide practical tools and processes to support decision making, to share best practice, to recognise moral distress and to ensure fairness and equity. The committee met weekly. Clinicians in particular welcomed this support in the absence of a national decision-making tool for rationing care. Members of the Trust Ethics committee joined the Regional Ethics committee which formed on the 15 April 2020 and which provided additional support.

94. The Trust developed a Hospital Treatment and Escalation Plan (HTEP) which was based on the principles of anticipatory care planning. It was completed at point of admission where a patient was seriously ill or had expressed preferences regarding interventions. It recorded both the patient's preferences and the clinicians care goals including ceiling of treatment. This was discussed with relatives where they were also informed of the fluid nature of the plan. The plan could be changed and would apply to the specific hospital admission only. Decision making regarding patient placement was built around a pre-pandemic

triage model designed to prioritise patients for specialised respiratory care recognising it was a limited service provided by a small team of Consultants. Patients with severe respiratory conditions who might require ICU were prioritised. Less unwell patients were cared for in Adult Medical and Care of the Elderly wards. This model was adapted to accommodate Covid and Non Covid split on the respiratory ward ensuring patients with non Covid severe respiratory needs continued to have access to Respiratory specialist care. The Respiratory team received additional support from the General Anaesthetic team who worked into the ward providing early assessment and discussion of deteriorating patients. The nursing team was enhanced by redeployment of nurses skilled in respiratory support and the use of Non-invasive Positive Pressure Ventilation (NIPPY) and Continuous Positive Airway Pressure (CPAP. All Covid teams participated in a daily virtual ward round creating a forum for Consultant discussion of all patients. Patients with lower need for respiratory support were cared for in Medical and Care of Elderly wards. Those who were identified as terminally ill in the community were cared for by Care of Elderly where there were most appropriate nursing skills. When patients were identified as approaching end of life Palliative care support and if appropriate chaplain support were sought. There were guidelines for ED staff to help with triage. Patients were transferred across wards during their hospital stay if their condition deteriorated or stabilised.

95. These systems and collaborative working relationships were the basis for decision making. The process in relation to admission to ICU remained unchanged. The medical team, respiratory team and ICU team worked collaboratively throughout with daily clinical discussions. The cross working of General Anaesthetists into the Covid wards enhanced the level of respiratory support that could be given in that setting hence shifting the threshold at which an ICU bed would be required, decreasing pressure on the finite resource. By April 2021 it was identified that 29 High Dependency Unit level beds were being managed outside the ICU setting. This was possible because of the availability of the appropriate equipment, the provision of specialised skills and an Oxygen infrastructure to support.

96. Through the pandemic clinicians worked in a pervasive climate of fear of scarcity. It was agreed should a decision be influenced by a need to ration the decision makers needed additional support. This lead to the development of a decision making tool that would be applied to the situation by an Emergency Decision making Support Group. The group was made up of three, an ICU consultant, a Medical Consultant and a Senior Nurse. A team was trained up and a tool developed but their services were never required. The decision making tool was built around best practice pre-pandemic recognising the limited understanding of Covid specifically. Changes were made to the decision tool in August 2020 as new evidence emerged. All documentation was brought through the Ethics committee.

97. Northern Ireland did not have an Advance Care Planning policy until October 2022. "Do not attempt cardiopulmonary resuscitation" (DNACPR) was a topic regularly discussed at Ethics group. The Trust policy remained unchanged. Discussion was enabled within the Hospital Treatment and Escalation Plan which has been referred to. Palliative Care Consultant led trainings on communication, addressed the challenges and sensitivities in carrying out these conversations with patients and their families. There were no issues raised through incident reporting, complaints, and raising concerns channels in relation to changes to practice in applying DNACPR. DNACPR forms are not available on the NI Electronic Care Record. They may be shared as part of community documentation at time of admission or similarly with primary care when discharged from secondary care.

98. Wearing of masks as part of PPE requirements hindered communication with people who were deaf. This was addressed nationally, regionally and locally by development of transparent face masks. This process took time as masks had to comply with standards. Meantime alternative arrangements were made on a risk assessed basis. Staff and patient wore clear see through visors and applied social distancing where possible. All visiting guidance made provision for situations where patients had communication difficulties. This could be related to disability,

age or where English was not the patient's primary language. This was accommodated within Trust risk assessments.

Impact on hospital staff

99. Staff working in hospitals had a unique experience during the pandemic. Whilst most of society struggled with restrictions placed on their lives to keep safe, hospital staff were required to expose themselves to Covid or possible Covid every day in the workplace. Covid was a life threatening virus and, for the first nine months of the pandemic, there were no vaccinations and for first twelve months no treatment. The media reported high deaths rate in hospital staff groups across Europe and there was an expectation at that time there would be similar deaths within the Altnagelvin hospital workforce. Despite this within the first year of pandemic staff morale was maintained. In a Regional survey of staff well-being in autumn 2020 the Trust scored highly on Compassionate Culture and Team work. In the National Training Survey of Junior doctors in 2020/2021, 25% of Trust scores across all areas of training and support were in the green flag category. This means they fell within in the top 5% in the UK. No concerns were raised by doctors through the British Medical Association (BMA) in First Surge in contrast to other Trusts.

100. 887 staff across the Trust were identified as contracting Covid in the workplace, 342 in 2020, 195 in 2021 and 287 in 2022. These figures reflect the persistence of Covid and the ongoing impact on staff. Altnagelvin Hospital faced particular challenges in the fifth surge which took place over December 2021- February 2022. It was the second Christmas where the hospital was overwhelmed with admissions of patients with Covid. There was no downturn in other services and there was the post pandemic surge in non Covid illness presentations. There were high levels of Covid in staff and critical workforce shortages in the workplace. Covid safety within the hospital was particularly challenged by the dissonance between the ongoing need for Covid safety in hospitals compared to the

community, where restrictions were lifted and the public were returning to life as normal. Staff were negotiating two worlds, unable to gather in a tearoom within the hospital but could socially gather outside work. It was confusing for the public and the hospital experienced its first incidents of visitor non-compliance with IPC measures and visitor linked hospital outbreaks. Staff were exposed to more verbal abuse prompting a Trust public messaging campaign. Staff were weary. They had experienced a surge through Christmas 2020, Summer 2021 followed by Christmas 2021, Holiday times when they expected to rest and spend time with family were interrupted by Emergency callouts for staff as workforce dropped and demand for services increased. This final surge was the most challenging for staff. Nurses and doctors expressed concern about individual professional liability as they delivered care within suboptimal staffing arrangements. Both GMC and NMC were approached for guidance as to how to protect staff from individual blame when the system was failing. The hospital actively risk managed the workforce challenges in particular looking at balance of following IPC guidance with need to maintain the workforce. The tension and mismatch of workforce capacity, clinical demand and public expectation was the ultimate challenge to staff morale.

101. Staff well-being and safety was central in all pandemic planning. The foundation was ensuring a safe environment for staff to work in. All efforts to keep Altnagelvin Hospital as Covid free as possible was to ensure a safe working environment for staff and a safe space in which patients could be cared for. Please see attached WHSCT Working Safety Alongside Covid Practical Guidance for Staff in relation to the Working Environment dated 13 December 2021 document exhibited to this statement as Reference CMcD/10 – INQ000416859. This meant ensuring access to PPE and to infection prevention control training. It was reinforcing of Covid safe behaviours, hand washing, hand sanitising, wearing of scrubs and face masks, social distancing, wiping of surfaces, ventilation of shared areas, respecting safe numbers in tearooms, remote working and virtual meetings. The impacts of "distancing" brought its own challenges, impacting on interpersonal interactions, team cohesion and camaraderie. Staff were encouraged to set up virtual gatherings as substitutes, Zoom Christmas quizzes, and Coffee mornings.

102. The Doctors Hub focused on very practical supports for doctors, particularly junior doctors in training, who rotate through hospitals and were disconnected from their usual social supports. Supports included daily Covid check in calls for doctors who were isolating with Covid, food deliveries and creation of a well-being space in the main hospital block. The Covid check in call was life saving for one young doctor when it prompted immediate medical assessment following which he was transferred to ICU. He recovered.

103. The pandemic shone a spotlight on the psychological needs of staff. The Trust responded by identifying two senior Psychologists to lead on development of a programme of support. The Psychologists wove their way across a range of working groups to ensure high visibility for staff wellbeing in all decision making. They provided critical expertise in the early stages of the pandemic, supporting the PPE group to use Human Factors to help guide the behavioural change necessary for staff to embrace and feel confident working in PPE. They contributed to discussion and reflection on staff moral distress within the Ethics Group. They taught and shared their expertise through the ECHO platform. They developed a raft of interventions harnessing skills of other psychologists and mental health professionals. This included setting up of a 7 day/week Psychological Support Helpline as part of Regional initiative. Psychological services also provided Critical Incident Stress Management (CISM) – a specific debrief process lasting approximately 3 hours which is used to help process specific traumatic events.

104. The HR and Health Improvement departments within the Trust co-ordinated "We Are With You" Programme to support staff during and post Covid. It included enhancement of the existing staff well-being initiative TWIST West. TWIST West focused on delivery of a range of information, services and opportunities for staff to enhance well -being. In addition to their regular newsletter they developed a weekly Tranquil Tuesday message which proved very popular. There were practical resources, Anxiety Management Resources for staff and Guidance on Risk Management. Occupational Health also established a COVID-19 Helpline and dealt with over 800 calls in one month at the peak of demand.

105. As an extension to the Health and Wellbeing Work Programme, messages and resources to the wider public were made available through Social Media and the Internet. The Trust also launched the 'Let's Talk it Through' Service using the Trust Coaching Network. This was a space to talk privately and confidentially to a trained Coach about COVID experiences and learning. Please see attached Safety Update to the People Committee dated February 2021 document exhibited to this statement as Reference CMcD/11 – INQ000416860.

106. A Managers Guide to supporting and Caring for Staff with Covid was developed to ensure best care and support for staff who developed Covid. This included ensuring staff accessed help as required from the Occupational Health Team, the Psychological Support Team, Chaplaincy services and the Health Improvement Team including resources from Twist West.

107. The Health Improvement team developed, "Your Post Covid Recovery Plan" booklet to support staff with physical and psychological sequelae of Covid. Occupational Health clinicians carried out a work assessment on all staff absent from work with Long Covid and advised on symptom management. They provided the staff member with the Trusts Post COVID - 19 Recovery Plan Booklet and signposted staff to further supports to help with their recovery such as Chest Heart and Stroke NI, NHS- Your Covid Recovery webinars. Staff would be advised to consult with their GP for onward referral to specialities and/or referral to the Post Covid service for tailored rehabilitation support and guidance. The Occupational Health team kept staff with Long Covid under regular review to gauge their progress. The team advised on fitness to return to their post, on possible restrictions of duties, adjustments or medical redeployments and in some cases would have advised on ill health retirement.

108. The Trust adopted and implemented Regional IPC guidance with the expectation that Equality Impact assessments had been carried out at a regional level. All working documents in relation to Covid Emergency planning, Reset and Rebuild

were equality screened. There were fewer Equality Impact assessments through the pandemic. This was most likely the impact of the unstable system where priorities changed weekly on the normal programme of service development. There were fewer substantial service developments of a nature requiring an Equality Impact Assessment. The Trust made no decision to downturn this work during the pandemic.

109. It was noted that face fit testing failure was more frequent for smaller faces, often women. A short term response was to ring fence supplies for an individual when a suitable FFP3 mask model was sourced. An opportunity arose within the Regional project lead by MOIC who are working with a local NI company to develop a sustainable supply chain of PPE. A new FFP3 mask model has been designed to fit smaller faces and will be produced locally. Altnagelvin hospital has a disproportionately ethnically diverse workforce as compared to the community it serves. The hospital has been successful and benefited greatly from international recruitment. The vulnerability of Black, Asian, Minority, Ethnic staff (BAME) was recognised and acknowledged by the Chief Executive. She set up meetings (via zoom) with BAME staff. This prompted the creation of a Trust BAME network which was re named the Ethnically Diverse Staff network. This network provided a platform for ethnically diverse staff to raise concerns and receive support and advice. The network is a key point of contact for staff in order to create a safe, shared, welcoming working environment. This group is supported by HR and has been a catalyst for increasing visibility, integration and celebration of diversity within the Trust community.

110. The pandemic was a rapidly changing environment with high levels of fear and uncertainty for all hospital staff. It took courage to come to work every day. Communication was essential to allay unnecessary fears but recognising some fears were real. It was critical to provide facts and information as they became available acknowledging that a lot was unknown. It was important to listen for the purpose of understanding, empathising, learning and problem solving. A hospital is a complex organisation with multiple moving parts interconnected,

interdependent and influencing each other. Clarity of purpose and understanding of individual roles in contributing to an effective response to Covid was essential. Communication was key to ensure the collaboration and coordination so the organisation ran like a "well-oiled machine" as Altnagelvin Hospital was described in BBC Report October 2020.

111. Trust Silver arrangements were designed to open communication channels up and down and across the organisation. Bronze teams were designed to be inclusive of Service managers, professional leads who had their own cascade arrangements. Alongside this there was an open meeting weekly with senior doctors, a critical touchstone to ensure strategic thinking at CMT level was aligned with experience at ground level. This was mirrored by a similar meeting for junior doctors chaired by the Director of Medical Education. There were weekly meetings with Unions and Trade union representation on the Trusts Working Safely Together Group and TWIST West, the staff well-being committee.

112. Easy access to information at times of crisis was critical hence creation of Single Point of Contacts (SPOCs). These included a Covid SPOC for the public so they could access Covid information. The Doctors Hub provided SPOC for doctors and the PPE SPOC for all matters PPE across the Trust. Medical Education and the Doctors Hub provided a digital weekly newsletter and a dedicated on line 'Page-Tiger' resource that facilitated a SPOC for teaching, training, doctor redeployment and updated clinical guidelines for Covid. These initiatives minimised confusion and eased anxiety.

113. Trust business continuity arrangements were aligned with Regional cells ensuring communication up and down and across the Regional system. There were daily meetings with Regional Silver and Trust staff were part of supporting Regional cells including HR, IPC and PPE. The cells were a source of guidance and support. The HR cell compiled a list of Frequently Asked Questions with responses helping to allay staff fears. There was daily communication with the PPE cell which was

essential to allay anxieties around PPE scarcity. The IPC cell was a robust forum for sharing challenges and receiving guidance. The Chief Medical Officer (CMO) met with Medical Leaders to provide updates. The Chief Executive attended weekly meetings with the DoH and regional decision makers who were connecting directly into national decision making.

114. There appeared to be a time lag between urgency on the ground translating into urgency and decision making at national level. There was a tension between ensuring regional/national uniformity which required conformity and responding to local realities which required more individual approaches. Doubling times were used to indicate pattern of Covid transmission, the higher the doubling time the more rapid the spread. There was a lag time between increased doubling time and increased hospital admission numbers by about two weeks. Local doubling time data allowed the Trust to predict the increase demand on hospital beds and the ability of the hospital to respond. Interventions needed to be triggered by doubling times to decrease transmission and flatten the curve rather than hospital admission numbers. In early October 2020 Derry/Strabane had the highest doubling rates in the UK. Hospital admissions were beginning to rise slowly but were clearly going to escalate exponentially in the following weeks beyond Altnagelvin hospital's capacity to manage. Discussions took place between the Trust and the DoH which contributed to an early localised lockdown in Derry/Strabane area which had the desired impact, curbing an exponential rise in cases. This effectively decreased case numbers and associated deaths.

115. National guidance varied, at times formulated around what was feasible at others around what was a desirable gold standard. Early PPE guidance seemed formulated around what was feasible as compared to what was gold standard and desirable. The introduction of NMABS service was desirable but challenging to deliver in the absence of additional workforce. These on-going tensions were the out workings of demand and supply mismatches.

116. The Trust worked collaboratively with the DoH and the PHA throughout the pandemic. The Royal Colleges were a source of expertise and support for clinicians. Guidance from Colleges did conflict at times with national guidance. As a Trust we used Risk assessment tools in collaboration with clinicians to support decision making.

117. IPC training is mandatory within WHSCT but is not a Regional mandatory training. The IPC team focused on trainings pertinent to Covid at onset of pandemic, in particular training all staff in the skills of donning and doffing PPE. In September 2020 specific Covid IPC training was introduced which expanded on previous IPC trainings to include Covid specific information. The systems were not in place to capture the uptake of this training so no comment can be made on how many ED nursing staff completed it. Releasing staff for on line training from ED was challenging because of high turnover of staff in the department and chronic staff shortages. Altnagelvin Hospital had the lowest rate of nosocomial infections in the region. There was no evidence through incident reporting or learning from outbreak reviews that identified ED as a High risk area for Covid transmission.

118. All specialties immediately moved to a form of virtual clinic when Emergency lockdown declared. This varied from simple telephone calls to video- linked consultations depending on confidence and digital literacy of individual professionals. As the hospital moved through surges with periods of increased face to face consultations most services continued with a blended approach. These changes had potential to disadvantage people with deafness. The Trust worked in collaboration with a Regional project which developed a Regional Remote Interpreting service, Interpreter Now. This service provided a deaf person with access to support when contacting a service or support with a one to one consultation with a healthcare professional. Patients where English was not their first language could also find virtual consultations difficult. Foreign language interpreting services continued to be provided with a decrease in requests for face to face support but increased demand for phone call support through 2020-2021. The pattern of request returned to pre pandemic rates through 2021-2022. The

Hospital accesses this service from The Big Word and Northern Ireland Interpreting Services. The Trust continues to me mindful of limited or poor broadband and telephone connections in rural areas and makes alternative arrangements for these patient groups.

119. The chaplaincy service was never withdrawn from Altnagelvin Hospital. Chaplains are considered a critical part of the care and support team for patients. Preparation to ensure chaplaincy services could be delivered consistently through the pandemic began before 17 March 2020 within Emergency planning arrangements. The IT department provided all chaplains with devices to allow them to maintain communications with patients and families. The new contact arrangements were communicated to all Wards directly. The information was also available under the Trust Intranet Covid tile. Chaplains were provided with PPE and received PPE training and IPC Covid safety training. In the absence of chaplains on wards additional spiritual support was provided with individualised packs of multi-denominational prayers. Boxes with these packs remain on the wards post Covid. Chaplains were an integral part of the Ethics committee. The chaplaincy team returned to face to face service when it was risk assessed as safe both for the chaplain and the wards.

Recommendations

120. It is easy to become complacent about the level of threat Covid posed to health and well-being of everyone at the start of the pandemic in March 2020. Vaccinations, herd immunity and effective treatments over the last four years have moderated the impact of the virus. It is also easy to forget how the pandemic disrupted the system, how difficult it has been to reassemble it and the impact on patient care today. Waiting lists grow, staff morale is low even as Covid activity recedes.

121. The health and social care system will only have capacity to flex in the future if it is adequately staffed. There is urgent need for active recruitment and retention of

health care workers, nurses, doctors and other disciplines to deliver service. There should also be a focus on health and well-being of all current staff who have lived and worked through the pandemic and who will be carrying trauma. Within future planning thought should be given to development of a "reserve healthcare workforce" who have levels of skill and training that can be mobilised at time of emergency much like the military.

122. Service delivery structures were modified through the pandemic with a shift to regional approaches around elective surgery. There would be merit in exploring further opportunities to future proof elective services at times of emergency to prevent an accrued backlog and delays for patients.

123. Pandemic planning is critical in "peace times". Modelling for anticipated PPE demand should be taking place to create stocks and supply chains that ensure safety of staff and patients in the future. The testing infrastructure needs reviewed to build capability, capacity and responsiveness. Constraints in testing and delays in accessing results impacted both patient care and staff capacity. Facilitation of visiting through a pandemic requires study to inform guidelines for the future.

124. The pandemic response required us all to do things differently and within that there were some remarkable achievements. This provides a great learning opportunity to better understand how to promote success within health care. Rapid learning, agile decision making, collaborative working, communication networks, compassionate culture may all be elements and merit further research.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 8/5/24