Witness Name: Christopher Hagan

Statement No.:

Exhibits:

Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Mr. Christopher Hagan

I, Chris Hagan, Consultant Urologist and former Medical Director of the Belfast Health and Social Care Trust (Belfast Trust), will say as follows:

1. This is my first witness statement to the UK Covid-19 Public Inquiry.

2. The documents that I refer to in this witness statement can be found in the exhibit bundle marked "CH1".

3. I have been asked by the UK Covid-19 Public Inquiry to address a number of questions set out in a rule 9 notice dated 6 December 2023. I endeavour to address those questions in this witness statement.

4. I am happy to try and assist the UK Covid-19 Public Inquiry in any way I can. I have set out my recollections below to the best of my present ability. The impact of the Covid-19 pandemic was deeply traumatic to all staff working in Health and Social care. The Covid-19 pandemic occurred at a time when the health service in Northern Ireland was already under extreme pressure due to a lack of long-term

budgetary planning, excessive waiting times for treatment and industrial action at the end of 2019. Like all staff working in Health and Social care, I did my best to manage a complex evolving situation to the upmost of my ability. I have done my best to set out what I recall of the events, but due to the pace of change especially in February to June 2020, it is not possible to recall every event in detail.

5. Looking back at that time, it is impossible not to be deeply moved and affected by the commitment, willingness and compassion shown by all those working in health and social care in Northern Ireland to unite in a common cause to keep the people of Northern Ireland safe and provide the highest quality of care possible. As I will describe later in my statement, the outcomes for patients who required treatment for Covid-19 in Belfast Trust were excellent, and the contribution to research into Covid-19 was outstanding. I also cannot forget the care and support that Belfast Trust staff provided to those patients and service users in community settings in both care homes, and with primary care colleagues in the Covid-19 GP centre.

6. I also have to accept, having reflected on that extraordinary period with the benefit of hindsight, that I did not get every decision right. I did, with colleagues, try to make the best decisions possible with the information I had available at that time. I often think of the words of Dr Mike Ryan, of the World Health Organisation, who stated:

"Be fast
Have no regrets
You must be the first mover
The virus will always get you if you don't move quickly
If you need to be right before you move, you will never win
Perfection is the enemy of the good
Speed trumps perfection

The problem is people are afraid of making a mistake
Everyone is afraid of the consequence of error
The greatest error is not to move
The greatest error is to be paralysed by the fear of failure"

Dr Mike Ryan, Health Emergencies Programme, World Health Organisation

The words of Anthony Hidden (1989) following the Clapham Junction Railway incident are also important to me:

"There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight"

7. The statement has been compiled drawing on extensive documentation from within the Belfast Trust, and also by talking to staff who were involved in leading and delivering care at the front line. I am indebted to all those who have helped me compose this statement. I have been particularly helped by reports I and others provided to Trust Board and by communications from the Covid-19 Oversight Group, which I led.

8. At the outset I would also wish to record my condolences, and those of my colleagues, to the families of all those we tried to help, but who sadly lost their lives, directly or indirectly, due to the pandemic. This included two members of Belfast Trust staff who lost their lives to Covid-19 during the pandemic. Tony Doherty died on 3 November 2020 and Shirley Lucy died 11 December 2020. They were both highly valued and highly regarded members of staff of the Belfast Trust.

Belfast Trust Overview

9. The Belfast Health and Social Care Trust (Belfast Trust) is one of the largest integrated health and social care trusts in the United Kingdom and delivers a wide array of treatment and care to the citizens of Belfast, as well as providing most regional specialist services for Northern Ireland.

10. BHSCT operates 5 large hospitals: the Royal Victoria Hospital (or RVH), Belfast City Hospital (or BCH), Mater Infirmorium Hospital (or the Mater Hospital), Musgrave Park Hospital (or MPH) and Royal Belfast Hospital for Sick Children, (or RBHSC), as well as a series of other care establishments including 14 day centres, 5 residential homes, 5 supported living facilities, together with the provision and operation of 11 children's homes. It has a workforce of approximately 22,500 people (twice the size of the largest private employer in Northern Ireland, and larger than the entire Northern Ireland Civil Service combined).

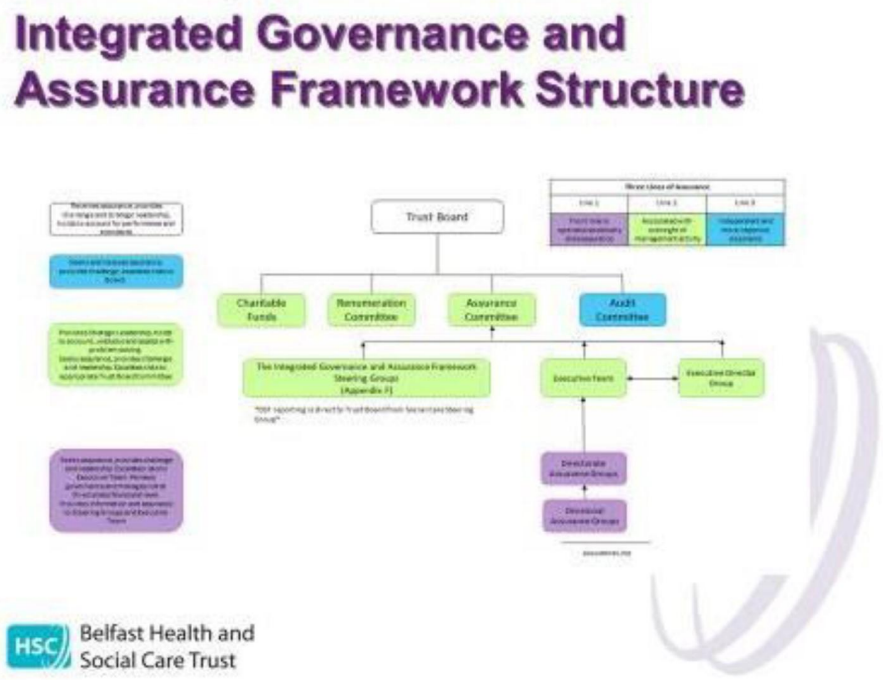
11. The Belfast Trust has an annual budget of approximately £1.9 billion. That is about one sixth of the entire core DEL funding provided to the Northern Ireland Executive by the United Kingdom Government (commonly referred to as the Block Grant). Almost half the Block Grant moves through the Northern Ireland Department of Health (NI DoH), at present approximately £6.5 billion. Just under one third of that health funding allocation is then utilised to fund the Belfast Trust and the care it provides.

12. The Belfast Trust was commissioned by NI DoH to host the only "Nightingale Hospital" in Northern Ireland. Due to its size, and the extent of the services it provides, the Belfast Trust has been and continues to be the effective health trust of last resort in Northern Ireland. During the pandemic the Belfast Trust

designated the Mater Infirmorum Hospital (Mater Hospital or MIH) site as a Covid-19 Regional Respiratory Centre.

13. The Belfast Trust is a large and complex organization with eight service directorates, each led by a service director. The directorates are further subdivided into divisions each led by a collective leadership team of a Chair (doctor), Co-Director (manager) and Divisional Nurse.

14. The Belfast Trust operates an integrated governance and assurance framework, which is hopefully helpfully illustrated by the diagram below.



My current role and experience

15. I am presently 57 years old. I am a Consultant Uro-oncology and renal transplant surgeon by profession. I commenced the role of Belfast Trust Medical Director in January 2020. I have temporarily stepped back from that role in January 2024 after 4 years in post. The Medical Director role in Belfast Trust is demanding and difficult.

16. I graduated from Manchester University Medical School in 1990 and following House Jobs in Manchester, began surgical training in Scotland in 1991. I decided to train in Urology and took a middle grade post in the Urology department of the Western General Hospital Glasgow from 1996 to 1998 where I was able to gain great experience in surgical urological oncology.

17. In August 1998, I returned to Northern Ireland as a higher surgical trainee on the Northern Ireland Urology training scheme. This was a 5-year rotational training program that led to me passing the Fellowship of the Royal College of Surgeon, Urology (FRCS (Urol)) examination, gaining a Certification of Specialist Training (CCST) in Urology, entry onto the General Medical Council (GMC) specialist register for Urology and the ability to apply for a consultant post in Urology.

18. In 2003 I was appointed a Consultant Urologist with special interest in Uro-oncology and Renal Transplantation in the Belfast Trust. Between 2005 and 2009 I was the Clinical Lead for Urology Surgery in the Belfast Trust. In 2009 I was appointed Clinical Director of Urology and Renal Services in the Belfast Trust. Following the Review of Urology in 2010, the role evolved to become Clinical Director for Urology in Belfast and South Eastern Trusts as part of "Team East". In 2015 I was appointed an Associate Medical Director within the Belfast Trust with responsibility for Children's, Maternity and Orthopaedic services. I undertook this

role into 2016. In 2016, I was appointed Chair of Division for Children's Services within the Belfast Trust. Between 2018 and 2020 I held the role of Deputy Medical Director for Risk and Governance within the Belfast Trust. I continued to perform complex surgery whilst undertaking this leadership role, but also had a senior management role with responsibility for risk and governance that included adverse incident reporting, complaints, coroners work and litigation, I was also responsible for standards and guidelines, emergency planning and Human Tissue Authority (HTA) licenses.

19. As indicated above, in January 2020, I was appointed Executive Medical Director of the Belfast Trust. This role has two main functions – a statutory role as Responsible Officer to around 1,400 doctors, and as the lead for patient safety in the Belfast Trust, which is also a statutory function. In addition, I was also the professional medical lead for the Belfast Trust and had overall lead responsibility for integrated clinical governance, risk management, management of concerns in respect of doctors, appraisal and revalidation, undergraduate and postgraduate medical education, job planning, research and development, quality improvement, implementation of standards and guidelines. I also contributed to corporate planning, policy and strategic decision making within the Belfast Trust. During the Covid-19 pandemic, I also became the lead of the Covid-19 Oversight Group, which led the Belfast Trust's response during the pandemic and reported to Trust Board and the Executive Team.

Overview of Belfast Trust Response to Covid-19 Pandemic

20. In the following paragraphs I will set out how the Belfast Trust responded to the challenges of the Covid-19 pandemic, with a particular focus on how we organised ourselves in 2020. Following this general overview, I will endeavour to specifically

answer the questions posed by the UK Covid-19 Inquiry that have not been addressed in this overview.

21. Covid-19 was declared a pandemic by the World Health Organisation on 11 March 2020. By this point, the NHS had already declared Covid-19 a Level 4 National Incident and the UK Government had published its coronavirus action plan. The first positive Covid-19 test in Northern Ireland occurred on 26 February 2020. This patient was due to be transferred, as per local PHA policy to an HCID unit in Newcastle-upon Tyne, England, but there was no suitable air transport available. The patient was therefore admitted to ward 7A Royal Victoria Hospital (RVH) and subsequently discharged uneventfully.

Covid-19 Oversight Group

22. The Belfast Trust sought to implement a robust command and control structure through the formal establishment of a Covid-19 Oversight Group. It was established on 6 March 2020. It led by me, and consisted of an Interim Operations Director, Co-Director for Older People's Services, and a Deputy Director of Nursing to oversee and lead on the Covid-19 plan. This group replaced the Pandemic Oversight Group that I had previously established on 27 January 2020 in my role as Lead Director for Emergency Planning. It had published the first Covid-19 Operational Plan on 14 February 2020. The Covid-19 Oversight Group was supported by a small number of senior managers and administrators and reported through to Executive Team. A copy of the terms of reference of the Covid-19 Oversight Group is included at CH/01 – **INQ000496094**

23. The Covid-19 Oversight Group operated in a similar fashion to an incident management team, coordinating information and updates from each Belfast Trust directorate and division on a daily basis to inform decision making at Trust level, and to inform a report to Silver Command (Health and Social Care Board

(or HSCB) and the Public Health Agency (or PHA) every day for onward submission to Gold Command (DoH NI). The Belfast Trust Executive Team had a daily meeting to review:

- Daily activity
- Assess capacity to deliver ongoing services,
- Staff availability and safety
- Provision of PPE stocks and usage
- Receive a report from COVID-19 Oversight team
- Decision making and identify issues for further escalation

24. We utilised the Charles Vincent Model based on the Measurement and Monitoring of Safety to inform how we prepared on a daily basis. This considered 5 basic parameters:
    - Past Harm
    - Reliability of Process
    - Sensitivity to operations – are we safe today
    - Anticipation and preparedness
    - Integration and Learning

The Charles Vincent framework now forms the core agenda of Belfast Trust Safety Huddles.

25. The key functions of the COVID-19 Oversight Group were:
    - Comprehensive surge plans to inform regional surge plans. These were reviewed and updated regularly.
    - Daily Sitrep report (an example is at **CH/02 - INQ000496085** which included information from each directorate on key issues across hospital and community settings, including the number of Covid-19 patients, numbers ventilated, number of deaths, available beds, staff absence, staff numbers tested, PPE fit testing, stocks and usage. The sitrep report was used to inform daily Silver and Gold discussions.
    - Input into a daily call with Silver Command to highlight key risks or concerns which were then fed into the Gold Command call.
    - Operational leadership of Trust hospital and community operations to manage the developing Covid-19 situation, including changes to

infrastructure, engagement of external accommodation or facilities, expansion and retraction of services, workforce planning and communications.

26. Decisions made by the Covid-19 Oversight Group were fully documented and endorsed by Executive team. Where necessary, appropriate risk assessments were carried out with the involvement of relevant staff including for example infection control, laboratory or estates professionals.

27. All meetings involving the Covid-19 Oversight Group were minuted in full to provide a clear and detailed audit trail of discussions held, decisions made and actions taken. This also could be used as a learning tool for future incident planning.

Community Planning & Preparedness

28. A community Covid-19 group within the Covid 19 Oversight Group was chaired by the Co-Director of Older People's Services and coordinated information pertaining to community services, including children's services, mental health and community learning disability

Adult Community Services

29. There were weekly meetings and daily contact with adult community divisional teams alongside weekly regional directors' meetings focusing on the specific issues in care homes and domiciliary care day services to ensure information sharing, learning and mutual support.

30. Intensive Covid-19 Adult Community preparation commenced in late February 2020, which included

- Assessment of readiness
- Preparation of Covid-19 business continuity plan
- Development of detailed action cards for staff teams covering care homes, supported living facilities, dementia ward, day centres and domiciliary care
- Communication plan developed targeting service users, carers, staff, trade unions and independent sector partners
- Twice weekly meetings bringing learning disability and mental health senior staff together to ensure good communication and common approaches
- Early meetings in 2020 held with Belfast City Council and community and voluntary sector to begin developing multi agency welfare Covid-19 response
- Hosting two well attended workshops in early March 2020 with independent sector care homes and domiciliary care agencies. These sessions were used to share the Covid-19 actions cards, summarise the emerging guidance from PHA/PHE at that time, reinforce the need for good infection prevention control, offer training which was taken up, establish baseline PPE supplies in the independent sector and agree models of support and communication during the pandemic
- Establishment of central supply point in Knockbracken Health Care Park to supplement and distribute PPE to the independent sector. All providers were provided with an initial emergency supply pack. This system was very effective was able to meet all requests in a timely way.

31. The Belfast Trust Chief Executive participated in a call with other Chief Executives and HSCB three times per week, and had a twice weekly call with the DoH NI Permanent Secretary and other policy leads in Gold Command at the beginning of the pandemic.

32. Within the Belfast Trust there was an Executive Team call every day to review the daily Sitrep, and to receive updates from the Covid-19 team, the Community subgroup and members of Executive Team. This became known as the Executive Team Charles Vincent Huddle and it has been continued post the pandemic. It still occurs every weekday at 11am. An action plan is maintained

and updated at each meeting.

Workforce group / Trade Union Engagement

33. A workforce group was established within the Belfast Trust and comprised senior managers/co-directors from each directorate as well as Trade Union representation. The group was chaired by the co-director for Human Resources. Within this workforce group were separate groups for medical, nursing and AHP staffing.

34. There was a weekly call between Trade Union representatives, the Chief Executive and the Director of HR and her senior team. This ensured early identification of any issues, and also sought a sense check across the organisation of staff morale and wellbeing.

PPE Group

35. A member of the Covid-19 Oversight Group participated in the regional PPE group which was established to deal specifically with challenges of adequate PPE and was key to staff safety. The Covid-19 Oversight Group ensured that the Belfast Trust's requirements were identified and communicated to the region and that PPE distribution and use was managed effectively across the Belfast Trust.

Service Changes to facilitate COVID-19 patients

36. The Belfast Trust had to adapt rapidly to meet the changing service needs of patients during the Covid-19 pandemic. Covid-19, as described previously, was a severe challenge to an already stretched workforce, particularly in areas such as respiratory services, ICU (where the most seriously ill Covid-19 patients required hospital treatment), and across older people's community services where the population was most vulnerable to the disease.

37. Clearly, there was a significant risk associated with the pandemic not only because of the associated potential for large numbers of critically patients presenting for treatment, but also to the many patients who could not receive planned assessment or treatment for other medical issues, thereby extending waiting times and risk of harm. The initial Covid-19 modeling predications, based on Imperial College and other groups, were for very large numbers of seriously ill patients, which in the worst case scenario would have overwhelmed the health service in Northern Ireland (see some early modelling data). Undoubtedly, the availability of the vaccine and early implementation of measures such as social distancing and mask wearing reduced the impact of the disease in Northern Ireland.

38. The Belfast Trust's plan to prepare the organisation in response to the Covid-19 pandemic had therefore to be multi-faceted. Some of the major issues were as follows:

Non-COVID-19 Services

39. On 16 March 2020, the Belfast Trust took the decision to stand down routine face to face outpatient and elective work to release staff in order that they could get training to manage Covid-19 patients and that they were FIT tested. Where

possible, clinicians moved to telephone outpatient appointments to reduce the numbers of patients attending Belfast Trust premises.

40. Safe and effective care remained the Belfast Trust's top priority and as such there was little impact on necessary emergency work, which was mainly delivered on the RVH site.

41. A reduced chemotherapy and radiotherapy service was provided in the Cancer Centre, based on individual patient presentation and risk/benefit balance of treatment at this time. This approach involved identifying those interventions within each cancer sub-speciality (tumour site) which had the highest impact on reducing mortality/morbidity, and conversely those interventions that could reasonably be delayed with an acceptable level of risk.

42. The Director of Surgery and Specialist Services led on regional work to ensure a robust and equitable approach to the delivery of cancer services during the pandemic. The regional HSC system secured the use of three Independent Sector hospitals across Northern Ireland from 6 April 2020, which supported the delivery of urgent cancer diagnostics, surgery and treatment.

43. Dialysis treatment continued, however, in keeping with other renal transplant programmes nationally, the renal transplant service was paused during the first wave, although Belfast Trust was one of the first units to re-establish the cadaveric transplant programme in the UK. As discussed later, it transplanted significant numbers of patients.

44. All elective orthopaedic services were suspended in March 2020 with relocation of much of the fracture service, when possible, to the Elective Orthopaedic

hospital at Musgrave Park. Elective Orthopaedic surgery was not fully re-established until the end of 2022.

45. A formal request was made by all Health and Social Care Trusts in early 2020 to DoH NI to suspend the implementation of aspects of the Mental Capacity Act (Northern Ireland) 2016 (the MCA), which was not accepted. However, the requirements of the MCA were relaxed. Short term detention authorisers were redeployed into social work roles across community mental health, hospital mental health, hospital social work and community social work for adults.

46. The ENT and Dental services moved to emergency services only, and teaching in the dental school was suspended. Both these services were considered high risk as their procedures are aerosol generating due to the use of high-speed drills.

47. Maternity services continued as 'normal'. The Midwifery Led Unit (MLU) in the Mater Hospital was absorbed into Royal Jubilee Maternity Services (RJMS) with obstetrics and gynaecology then operating only out of the RJMS. Gynaecology services had normally been based in the Mater Hospital or Belfast City Hospital (or BCH), but relocated. A temporary Early Termination of Pregnancy Service was established in the Belfast Trust in April 2020. Regional fertility services were suspended in March 2020. Genito Urinary Medicine moved to a telephone and postal service.

48. Royal Belfast Hospital for Sick Children (RBHSC), adject to the Royal Victoria Hospital, suspended all elective services in March 2020. RHBSC worked closely with the other children's services in the region to provide emergency and urgent services to children. RBHSC also increased the age of attendance

at the hospital from 14 years to 16 years in order to try to reduce demands on adult services, bringing the age profile more in keeping with hospitals for children in Great Britain.

49. Mental health inpatient services continued as normal, however outpatient services (as with other service areas) were mainly delivered by teleconference and video, with face to face contact being minimised. Accelerated plans for a step-down unit for community rehabilitation were implemented as regional Covid-19 contingency planning meant that we could no longer transfer acute patients to other Health and Social Care Trusts in the region. Mental health professionals predicted that there would be a significant surge in demand for their service post lockdowns, given the impact isolation was expected to have on individuals and families. This was shown to be correct.

Hospital Covid-19 Services

50. Establishing specialist Covid-19 areas was identified as a priority by the Belfast Trust in February 2020. This was before the first Covid-19 patient presented. Initially, a dedicated ward (ward 7A) in the RVH was reconfigured and staffed to treat the first Covid-19 patients in Northern Ireland.

51. However, within a few weeks, the Mater Hospital (also operated by the Belfast Trust) was designated as the region's first Covid-19 hospital. This was to deal with the increasing number of Covid-19 patients. This required some services normally based at the Mater Hospital (for example Hepato-biliary surgery) and staff to move to other hospital sites, and an expansion of respiratory and ICU services at the Mater Hospital in order that initially 75 non ventilated patients with Covid-19 could be accommodated. The Mater Hospital Emergency Department was redesigned to separate Covid-19 patients from non-COVID-

19 patients and the Northern Ireland Ambulance Service (NIAS) was instructed to take suspected Covid-19 cases to the Mater Hospital.

52. Phase 3 of the Belfast Trust's surge plan was to use Belfast City Hospital for Covid-19 patients with additional capacity of at least 78 ICU beds and 48 Covid-19 recovery beds as per the initial Covid-19 summary plan **CH/03** **INQ000496081** This was achieved by vacating up to eight floors of the Belfast City Hospital by relocating services to other parts of the Belfast Trust, including cardiology, urology, gynaecology, respiratory medicine and care of the Elderly.

53. On 2 April 2020 the BCH was designated by DoH NI on as the regional HSC "Nightingale Hospital" for Covid-19 positive patients requiring Intensive Care Services. Significant estates work, including improvements to the electrical supply and the expansion of oxygen capacity, had been carried out prior to this to allow the Belfast Trust to accommodate up to 230 critically ill patients with Covid-19 requiring ventilation and ICU care. Additional ventilators were ordered so that up to 230 patients could be ventilated at any one time. Local and regional surge plans were agreed which determined how ICU and other beds would be used across the region to respond to increasing numbers of Covid-19 patients. This modelling work was supported by the Belfast Trust Deputy Chief Executive and me. The Mater Hospital continued to care and treat patients with Covid-19 who required hospital care, but if these patients required ICU care, they were transferred to the BCH "Nightingale" ICU.

54. The Belfast Trust adopted the Public Health England (or PHE) guidance for staffing ICU in line with other "Nightingale" hospitals in England. This meant a reduction in both intensive care nurses and consultant intensivists to patient ratios compared to normal ICU ratios. Other medical and nursing staff were upskilled to work alongside the ICU trained staff caring for the ventilated

patients. This staffing model ensured that the intensive care unit in BCH was resourced to meet demand. There was also a regional agreement that other Trusts in Northern Ireland would provide additional staff to support the regional "Nightingale" ICU. As a Trust leadership team, we were very aware that revised staffing levels, and new and unfamiliar roles for staff, had the potential to increase psychological and physical pressures for staff. Measures introduced to try and deal with this are discussed later.

55. As part of the Critical Care Response to the Covid 19 Pandemic, the Critical Care Educators in collaboration with medical colleagues developed, delivered and evaluated education sessions utilising the Critical Care Network for N. Ireland (CCANNI) nursing practise skills framework for non ICU nurses, to appropriately train staff to carry out their role safely in a critical care environment. Flash card safety checks were also developed for each bed space. Additional education resource, materials including an induction and orientation pack for the Nightingale Critical Care Unit was provided to every staff member redeployed to the ICU/ Nightingale. The education and awareness sessions were for staff being redeployed, and not an assessment of their competency. There was a registered nurse with every patient. All re-deployed staff worked under the close supervision of a fully trained and experienced ICU nurse. Intensive Care Clinicians and Allied Health Professionals also worked in the ICU ward, providing ongoing support to each other during this challenging time.
The training was developed and delivered with an extremely short turnaround time – the working group was convened on Friday 20th March 2020 and training commenced on Monday 23rd March. Training focused on the ABCDE approach as used by The Resuscitation Council, which was developed into a 2.5 hour teaching session which covered the nursing basics of critical care.

A – Airway: using a low fidelity manikin to demonstrate safe and effective care of the patient with an endotracheal tube, including mouth care, suctioning orally and using the closed suction system and safe balloon inflation pressure. Ensuring tube not pulling and enforced the importance of not to disconnect from ventilator.
B – Breathing: included site specific ventilators and provided staff with the opportunity to see how the ventilator works, the main modes of ventilation and the basics of alarm management. Non ICU staff were advised if required to adjust the setting this must be with guidance from ICU staff.
C – Circulation: using a low fidelity manikin or talked through equipment and demonstrated the care of a central line, the importance of the flush bag, the care of an arterial line, including correct transducing. Importance of observations and knowing the parameters set for that patient. This included

vasoactive drugs and the importance of ensuring that they did not run out, including relevant paperwork to be used.
D – Disability: this covered blood sugar management, drug administration and the fundamentals of pressure area care (with reference to both proned and supine patients) Pupils and drug allergies.
E – Exposure: this covered using a Nasogastric Tube demonstration manikin to show the correct placement of NG feeds and how to safely commence and discontinue NG feeding. It also covered drug administration via the NGT. Eye and mouth care, SRC +/- documentation of skin

Critical Care bedside safety checks were covered at the end of each session. There was the opportunity to ask questions at each session.
It was recognised that this was a mass training event for an incident that was unprecedented and we had to do the best with the time and resources available.

56. What was the effect of such redeployment on staff morale and well-being (including the increased risk of burnout)?

The effect of such redeployment on staff morale and well-being (including the increased risk of burnout) was always taken into account. When a staff member was struggling, upset and tired this was highlighted to the nurse in charge/lead nurse, and a meeting was quickly organised with the staff member to listen to their concerns and to check what support they required. There were weekly meetings organised for redeployed staff to meet their own line managers. This provided further support for the staff redeployed to ICU. The senior ICU nursing team supported staff working in ICU throughout the pandemic, providing reassurance to ICU staff and to redeployed staff upskilled to work in ICU. All redeployed staff worked under the close supervision of a fully trained and experienced ICU nurse. Intensive Care Clinicians and Allied Health Professionals also worked in the ICU ward, providing ongoing support to each other during this challenging time.
Drop in sessions and listening exercises were in place for staff to escalate and discuss concerns. Weekly meetings were established for staff to meet with the senior ICU team to discuss what was going well, suggestions to support what was not going well, and the implementation of proactive actions. There was regular psychology drop in clinics for staff, weekly HR meetings and meetings with OH colleagues who provided support for staff. Additional administration support was provided to enable staff to focus on patient care and provided further support during this challenging time.
The education team provided additional support and ongoing bedside teaching, additional resources were developed to support the redeployed nurses, including welcome packs with induction information, staff services resources for psychological support, and sign posting leaflets detailing how to look after yourself. Videos were developed to support redeployed staff on equipment and the layout of the ICU wards.

57. The RVH site, including the regional ICU at the RVH, was largely protected for non-Covid-19 patients during the first wave. The RVH ED was redesigned to segregate patients, and patients with Covid-19 were also transferred from the RVH to the Mater Hospital or BCH sites depending on their clinical condition.

Adult Community Covid-19 Services

58. A number of rapid service changes and developments were required in adult community services. This was to ensure that, as far as possible, the almost 7,000 vulnerable service users in older people and learning disability divisions already known to the Belfast Trust (as well as those not yet known, but who may become known to the Belfast Trust), and who might become symptomatic or ill with Covid-19, could receive safe, compassionate and effective care.

59. Key challenges in this area included:

- absence management of the workforce who were self-isolating or shielding
- stepping down key services and ensuring "keeping in touch" and other alternative measures were working, so as to ensure core service provision to the most vulnerable service users continued

- ensuring effective social distancing protocols were maintained in staff teams
- Supporting the residents and staff in the independent care home sector who were dealing with escalating levels of Covid-19 acuity and deaths amongst their residents, often presenting in atypical ways, alongside increasing staff absences.

The key changes implemented were:

- A seven-day community testing pod was set up in the Crumlin Road Health Centre in mid-March 2020 to increase testing capacity. This delivered over 1,000 tests in its first fortnight. As additional testing capacity became available through facilities set up at the MOT and SSE centres, the community pod increasingly focused on specific groups, such as in-reach into care homes, children with disabilities, and patients receiving chemotherapy.
- A seven-day primary care Covid-19 centre was established in Beech Hall Health and Wellbeing Centre within a period of four days of planning. This centre was run by senior community nurses and facilitated a team of GPs to consult with on average 40 to 50 patients a day with COVID-19 symptoms who had been referred by GP practices, and to decide on appropriate treatment and pathways including hospital. This reduced the number of patients attending ED.
- Following government social distancing guidance, all eighteen Belfast Trust day centres were closed over a period of days after risk assessments were completed and "keeping in touch" plans were put in place.
- The re-ablement team was stood down and refocused on the provision of skilled Covid-19 domiciliary care.
- A community multi-disciplinary response was operationalised to respond to Covid-19 symptomatic patients living in their own homes, consisting of district nursing, AHPs and dedicated Covid-19 home care staff.
- A community coordination centre was developed and operationalised on 23 March 2020 to centralise and coordinate the provision of social care and welfare supports to those affected by Covid-19. This centre was led by the Belfast Trust's Connected Communities manager and supported by staff from the community development team. This centre supplied

groceries, medications and emotional support, and coordinated responses from the community and voluntary sector. Six staff supported the community coordination unit and eight staff supported the joint co-ordination centre with the Belfast City Council, the PHA and community and voluntary sector. Other staff worked with Roma and BAME communities to offer support and advice.

Independent Sector Care Homes

60. The Covid-19 pandemic raised particular challenges for care home residents, their families and the staff who looked after them. The Adult Community Division built on already strong relationships and engaged productively with the sector. Given that the care home sector usually operated at a very high occupancy rate, efforts to increase capacity for interim care beds unfortunately had limited success. A lack of capacity in community interim care beds was assessed as being a significant surge risk.

61. A local independent care provider, Health Care Ireland, offered the use of a temporarily closed hotel in Belfast city centre. Subsequently, a partnership model was agreed to use the Ramada Hotel, St Anne's Square, Belfast as a step-down facility for patients. A significant amount of work was undertaken to convert the hotel and develop operational protocols. The Regulation and Quality and Improvement Authority (RQIA) and DoH NI were consulted on this development and RQIA inspectors subsequently visited the hotel and expressed their satisfaction with the environment. RQIA confirmed that it would be content for this service to be considered as an innovative model. The purpose of using the Ramada Hotel was to increase step down bed-based capacity to address Covid-19 contingency scenarios. The hotel had a capacity of up to 150 beds for a temporary period of three months. The facility was primarily used for patients discharging from hospital who had a Covid-19 positive diagnosis and were in the recovery phase of the illness. However, it also had the potential for use by community clients who might require step up

care. The service opened on 17 April 2020 and received its first admission from the RVH on 18 April 2020.

Covid-19 Risk Management in Care Homes

62. A number of care homes in the Belfast area were impacted by the Covid-19 pandemic in early 2020. This resulted in a number of care homes experiencing significant staff depletion and increased acuity of residents.

63. The testing of care home residents with suspected Covid-19 began on 19 March 2020. On 23 April 2020, the Belfast Trust commenced a pilot to test asymptomatic care home staff and residents in settings that were deemed to be Covid-19 free.

64. On 24 April 2020, testing commenced for all service users admitted to or returning to care homes as per guidance from the DoH NI Permanent Secretary. Prior to that, testing guidance had been to test symptomatic patients only (see the Trust Board papers for October 2020 at **CH/04 - INQ000471366**

65. By April 2020, it had become clear that care homes were coming under increasing pressure due to both the number of residents with Covid-19 (or displaying symptoms of Covid-19) and the level of staff absence due to Covid-19. On 28 April 2020, it was reported that approximately 37% of the care home population had or were confirmed or suspected of having Covid-19. By 5 May 2020:

- There were 62 residential/nursing homes in the Belfast Trust area caring for 2,376 residents.
- There had been 336 positive cases across 23 of the homes (13 homes had more than 20% of residents reported as positive cases, with the highest outbreak being 67% in one home).

- 12 homes at that time had positive cases (6 homes had been identified as 'red' and 6 as 'amber' on the Trust's Community Sitrep).

66. DoH NI social care colleagues developed a regional response plan to stabilise this sector. As part of this, the Belfast Trust carried out a modelling exercise to inform the development of a coherent workforce support plan to respond in the event of 25%, 50% and 75% of homes needing support.

67. Discussion between the Belfast Trust and primary care colleagues confirmed that they wished to retain the primary medical responsibility for the residents of care homes. Belfast Trust had wanted an individual GP practice to take ownership of a specific home rather than multiple GP practices having input to the same care homes, as the Belfast Trust was of the view this was more straightforward for care home staff. Whilst GPs accepted that the model of multiple practices involved with individual care homes was not ideal, GPs were of the view that they had long-term knowledge of these patients and were best placed to provide continuity of care.

68. In response to the nursing home challenge, the Belfast Trust supported the nursing homes through a number of different services.

69. Belfast Trust Care Home Support Team. This was already a well-established nursing team, who normally worked Monday to Friday 9-5pm. The team provided clinical education and advice to care homes on issues such as end of life care, tissue viability etc. This team extended their service to provide support to nursing homes 7 days per week, 9-5pm, providing daily telephone contact and on-site visits when necessary, to residents in nursing home who had Covid 19 Symptoms.

70. Hospital at Home (Acute Care at Home) Service was an established consultant led care of the elderly Multi Disciplinary Team (or MDT) who provided clinical

care to patients in the community. This team was further strengthened with redeployed COE medical and nursing staff from the inpatient service, and were active in providing medical, nursing and AHP care to patients in nursing and residential units, who had Covid-19 symptoms. There was a daily virtual ward round of symptomatic patients with the ability to direct Acute Care at Home to review if necessary or admit to hospital.

71. Primary Care Covid Centre. In collaboration with Primary Care, the Belfast Trust established a Covid-19 Centre in March/April 2020. The Covid Centre operated 7 days a week from 8am to 10 pm, with Out of Hours GPs providing support from 10 pm to 8am. The centre provided clinical medical assessment and care to residents in Nursing and Residential Units. The centre developed a well-defined clinical pathway which included assessing and treating residents in a nursing home, or, if necessary, access to Hospital at Home, the Respiratory Specialist Nursing Team, Care Home Support Team or admission to hospital.

72. Respiratory Nursing Support Team support to Care Homes. Two respiratory nurse specialists (RNS) were on every shift from 8am-10pm, 7 days a week in the Primary care COVID-19 Centre. RNS attended every GP home visit and were involved in calls to nursing home residents. The RNS team also attended any ill, deteriorating patient within the Covid-19 Centre, and took the lead regarding respiratory management and oxygen therapy whilst awaiting transfer to ED.

73. The community respiratory team also maintained their usual community service and provided guidance and support to care homes on respiratory assessment, oxygen assessment and palliative care anticipatory prescribing. They also completed the Home Oxygen Ordering Forms (HOOF A) and sent them to BOC.

74. Multidisciplinary Specialist Input – care homes were also provided with Belfast Trust MDT specialist input when needed, such as the Specialist Respiratory Nursing Team; Physiotherapy, Occupational Therapy, Dietetics etc.

75. Care Home In-Reach Response Team. This involved the development of a small specially created mutual aid response team named the "Care Home In-Reach Response Team" (or CHiRT). Initially, the team included a small number of Belfast Trust staff who were redeployed from other clinical areas in the Trust, as well as a small number of pre-registered medical and nursing students. During the second and third surge, staff were also secured for the team via a Trust wide workforce appeal and Registered Nurses were sourced from agencies and block booked via the Belfast Trust Nurse Bank. This team successfully supported Independent Care Homes in delivering crucial care in instances when the care home staff had been depleted due to Covid-19.

Belfast Trust Care Review and Support Team (or CREST). The service was extended from 5-day Monday to Friday 9-5pm, to a 7 day service 9-5pm. This was an already established team providing communication support to families of care home residents, as well as direct links to nursing homes. The team's role involved monitoring the residents lived experience as well as monitoring of potential complaints or safeguarding issues.

76. Commissioned Service Governance Team. This team also extended their service from Monday to Friday 9-5pm to 7 days a week 9-5pm. This team provided daily Covid-19 data on patients in nursing home, complaints, Adult Safeguarding etc. This information enabled the Belfast Trust to triangulate the Covid-19 information from the Nursing homes, community setting and the acute hospitals.

Children's Community Services

77. The Children's Community Services developed a surge plan in conjunction with the other four Trusts' Children's Services and the HSCB. Alongside this surge plan, a regional action card was developed and kept under review to ensure a consistent approach across the region in relation to the provision of children's services and how these services were prioritised during Covid-19. This resulted in a reduction of face-to-face visits and an increased use of alternative methods of keeping in contact with children and young people and their carers e.g. by telephone, Skype, Microsoft Teams and Facetime etc. Direct visits were undertaken for child protection, visits where children were on the edge of care, or where there were concerns of breakdown either at home or within foster placements. Child protection case conferences occurred using Microsoft Teams.

78. All HSC Trusts saw a reduction in the number of referrals being received into the Children's Gateway Service at the beginning of the pandemic. On 10 April 2020 Belfast Trust placed a reminder via social media about who to contact if there was a concern regarding a child's welfare. All HSC Trusts worked together with the Safeguarding Board for Northern Ireland (or SBNI) to develop key messages about the need for the community to be vigilant regarding children. This was placed in the Belfast Telegraph on Saturday 18 April 2020, and also on the SBNI website.

79. The Police Service of Northern Ireland (or PSNI) also agreed to focus their community efforts on those children or families identified as vulnerable and to provide additional oversight of these families when out in the neighbourhood.

Belfast Trust Workforce during Covid-19

80. Maintaining safe staffing levels, with sufficient appropriately trained staff to provide safe, effective and compassionate care to patients and clients during the pandemic was an absolute priority for the Belfast Trust. The Belfast Trust also focused on ensuring that staff were safe during that time due to the additional risks posed to them by treating and caring for patients and service users.

81. Pre-existing staff shortages in the Belfast Trust were further exacerbated due to staff absence through sickness or self-isolation. Directorates submitted staff absence information via the daily Covid-19 sitrep in order that managers could closely monitor their staffing positions.

82. The need for social distancing led to an increase in remote working and the use of technology such as Microsoft Teams for videoconferencing and online meetings. Human Resources (or HR) and Information Technology (or IT) staff helped directorates provide appropriate training and guidance to support these new ways of working.

83. Many staff also returned back to previous clinical roles or were redeployed to new roles to respond to the changing needs of hospitals and community services. The Belfast Trust ensured that the necessary training and support for affected staff was provided. A central redeployment team was established to support the redeployment of staff, which will be discussed later.

84. Final year medical, nursing and social work students started their careers earlier than usual in 2020 in order to bolster the workforce.

85. A successful workforce campaign was led by HR to enhance overall workforce capacity across all professional groups including a regional workforce appeal, significant engagement with universities and call out to retirees. This generated the following during the first wave of covid-19:

- HSC Workforce Appeal: 11,104 completed applications across HSC. This translated to 3,170 applications to Belfast Trust (750 clinical and 2420 support roles).
- Retire and Return: 45 recently retired staff expressed an interest in returning to assist the Belfast Trust on a short term basis, including 10 consultant staff.
- Final year nursing/midwifery students: 190 commenced on payroll (Queen's University Belfast (QUB)/Ulster University Jordanstown (UUJ)/Open University (OU)) in April 2020
- Final Year Medical Students: FY1s commenced 12 weeks earlier than planned which led to approximately 100 newly qualified doctors commencing post early May 2020.
- Final Year Social Work Students started from 5 May 2020
- Medical Student Technicians (3rd and 4th year QUB medical students): 95 allocated to Belfast Trust (151 applied via expression of interest)
- Appointments expedited through the HSC Business Services Organisation (or BSO) recruitment shared service: 211 new staff commenced post earlier than planned.

Staff Safety & Wellbeing

86. The health and wellbeing of staff during the Covid-19 pandemic was of paramount importance to Belfast Trust senior management team. Staff across

the entire HSC/NHS system expressed great apprehension over the safety of their working conditions, with the three greatest concerns being availability of PPE, workforce shortages and availability of staff testing. The Belfast Trust took additional steps to provide support to staff and their families if they became ill with Covid-19, especially if those staff required inpatient care. As referred to earlier, sadly two members of staff died of Covid-19 related illness. The Belfast Trust took a number of measures to respond to staff concerns, and try to ensure their safety and wellbeing .

87. *Social Distancing/Shielding*. The Belfast Trust followed regional guidance in terms of self-isolation for those suspected of having Covid-19, or whose family member was suspected of being Covid-19 positive, and for staff who required shielding due to medical conditions, pregnancy or those over the age of 70. The Belfast Trust also prepared a daily report on staff absenteeism in order to arrange for appropriate testing to help staff return to work as quickly as possible. The Belfast Trust also followed regional guidance in facilitating staff to work remotely where they were able to do so, which was initially limited by digital capacity. Where staff were required to work on hospital or community premises, social distancing guidelines were strictly followed.

88. *Personal Protective Equipment*. The Belfast Trust took all reasonable steps to ensure that staff had access to appropriate PPE. This was a huge logistical challenge given changing guidance and a national shortage of key supplies. The Covid-19 Oversight Group continuously reviewed stock levels, usage and planned deliveries to manage the Trust's demands. A key element of the Group's role was feeding into regional discussions around current and future PPE requirements and the allocation of PPE across organisations, with mutual aid between organisations as appropriate. The team also managed a receipt and distribution centre (Coolmore Stores) specifically established to manage PPE stocks in the Belfast Trust.

89. Linked to PPE was the requirement to have staff appropriate FIT tested for FFP3 masks. The Belfast Trust trained a number of staff to carry out FIT testing. However, this was complicated by the fact that there were a number of changes in the type of masks available to the Belfast Trust, and the need to then re-test staff for different masks.

90. *Staff Testing/Labs facilities.* The Belfast Trust Regional Virology Laboratory (or RVL) worked at pace to increase their testing capacity and turnaround times from early February 2020. The RVL was among the first twelve UK Covid-19 testing sites and developed a testing platform in February 2020 with initial testing capacity of 360 tests per week, rising to 8,516 tests per week from 18 April 2020. This allowed the Belfast Trust to test staff as well as patients in line with regional testing guidance, with sufficient capacity to test all staff (or family members) suspected of having Covid-19 and deemed appropriate for testing. This position was subject to change as stocks of testing reagents were rationed by Public Health England.

91. Covid-19 testing for patients and staff was originally provided from two testing pods (in close proximity to the RVH and Mater Hospital ED departments) which were procured specifically for that purpose. From 6 April 2020, testing was also available in a local MOT centre staffed by Belfast Trust staff, and from the SSE arena which is run by Deloitte and overseen by the PHA. Belfast Trust testing facilities subsequently moved to Knockbracken Estate. Belfast Trust facilities and staff also provided testing for the Independent sector and the civil service.

92. *Staff accommodation.* Staff accommodation was organised by the Belfast Trust for staff who, for any reason, could not live at home or returned home between shifts. Accommodation and meals were funded by the Belfast Trust with competitive rates negotiated with a local hotel. The Belfast HSC Trust had

secured accommodation options for staff in a Hotel and Self-Catering Apartments (seven facilities) across the Greater Belfast Area. The hotel was used for short-term accommodation and apartments used for longer-term accommodation needs. Hotel accommodation was booked for 1989 nights and 5471 nights were booked within the apartments available.

In total 220 staff availed of this accommodation during the pandemic.
The demand did not exceed capacity

93. *Showering Facilities.* In the absence of sufficient showering facilities on hospital sites and in the community, the Belfast Trust purchased a number of shower/changing units which were positioned in the RVH and BCH car parks. Additionally, four local schools and St Mary's teaching college opened their shower and changing facilities for Belfast Trust staff. Laundry facilities were provided by the Belfast Trust at all sites, where possible.

94. *Canteen and car parking.* On 24 March 2020, the Belfast Trust took the decision to allow free parking across all sites to staff and visitors. This was followed by a Ministerial announcement that monthly payments for parking made by staff through their payroll would be waived between April and June 2020.

95. In line with other UK health trusts, to ensure adequate food and hydration was available for staff, the Belfast Trust took the decision at the end of March 2020 to provide free food to staff in our canteens. The practice was then adopted by other HSC Trusts across Northern Ireland.

96. An out of hours food service was provided for staff working at night and at the weekend. A "grab and go" service was available to assist with social distancing, augmented by donations from supermarkets.

97. *Childcare Support for Staff.* On 24 March 2020, the Belfast Trust issued an on-line survey to staff with regards their childcare needs. Staff who registered their details were then contacted to discuss their childcare needs on an individual basis. By 10 April 2020, this resulted in 983 sessions of care being established within those daycare providers already under contract with Belfast Trust Social Services.

98. *Staff Support*. A number of helplines were established for staff, including a Covid-19 helpline and a confidential psychological support helpline. Staff have also been provided with guidance on looking after their mental health by the Trust's Head of Psychology **CH/05** INQ000471381).

99. *Risk & Governance Assurance*. As the Belfast Trust lead for Risk and Governance, I updated the Belfast Trust's Principal Risk register to incorporate any new or escalated risks associated with Covid-19 (see **CH/06 - INQ000496089; CH/06a - INQ000496091; CH/06b -** This was reviewed and updated on an ongoing basis and considered at Trust Board Assurance Committee meetings for consideration and approval.

100. Incident management and governance responsibilities centrally and at directorate and divisional level continued and staff were reminded of the need to ensure that there was no relaxation in this area. Datix was updated to ensure our ability to categorise, extract and analyse Covid-19 related information from the system.

101. The Belfast Trust weekly live governance call and report (which captured serious and high risk governance issues) continued with robust tracking of actions in place and subsequent sharing for further scrutiny, discussion and action by Executive Team on a weekly basis as appropriate.

102. It was also recognised that review of serious events, requiring input from front line staff, would be difficult to complete effectively due to the pressure they were under. The HSCB wrote to the chief executives of each HSC Trust to offer guidance on processes around serious adverse incidents (or SAIs) and complaints. Similarly, the Chief Medical Officer (or CMO) wrote to chief

executives in relation to mortality and morbidity reviews. In summary, the Belfast Trust established a triage committee led by a Non-executive Director that triaged SAIs, Complaints and deaths to advise if a review should proceed urgently, or could be suspended until such time that staff would be able to complete the necessary process.

103. Risk and governance meetings established to support the Assurance Framework, including the governance steering committee and Assurance Group and Assurance Committee took place as normal, albeit remotely.

104. The Belfast Trust Clinical Ethics Committee (or CEC) provided advice and support on issues arising including providing support to other HSC Trusts establishing their own CECs as a result of Covid-19 by

- helping to develop regional guidance/decision-making criteria
- participating in Regional Ethics calls
- preparing for potential cascade of guidance/frameworks/resources for BHSCT clinicians once agreed

105. The majority of clinical negligence and coroners work, both externally and internally, was paused with only a skeleton workforce to manage any urgent matters. The training and work surrounding Structured Judgment Reviews (SJRs) was also paused. Staff were redeployed to other duties to assist with the COVID-19 response.

106. Receipt and management of external guidelines continued as normal with all information logged, disseminated, monitored and tracked.

107. All new RQIA thematic reviews were paused. Quality improvements plans already underway with responses expected were discussed with directorate colleagues and RQIA regarding submission of returns.

Information

108. With such rapid change happening, the Belfast Trust recognised the vital importance of having access to relevant and timely information to predict and manage demand, keep key staff informed and enable the Trust to provide regular, accurate updates to Silver and Gold Command to inform and guide regional Covid-19 planning.

109. A comprehensive suite of information across a range of issues was developed to meet these challenges **CH/07 - INQ000496086** see example CV sitrep). Refinements over time and the development of trend analysis, run-charts and predictive analysis enabled very informed decision-making and discussion at Executive Team level.

Communications

110. In such an unfamiliar, challenging and frequently changing time, there was a real risk that staff, patients and service users would become anxious, fearful and confused without adequate information being provided.

111. As a result, the Belfast Trust made great efforts to communicate effectively and regularly with staff, patients and the public throughout the pandemic.

Effective and innovative communications was undoubtedly instrumental in influencing public behavior in the early stages of the pandemic.

112. As well as normal management arrangements such as email and team and leadership briefings, the Belfast Trust used a range of media including podcasts, local television, radio and newspapers and social media to communicate with staff and Trade Union colleagues.

113. The following list provides some of the ways in which effective communication took place:

- Daily staff brief which included PHA or other regional updates and staff advice and support see CH/08 INQ000471362
- Weekly newsletter for elected representatives see CH/09 INQ000471388 alongside public liaison daily enquiries from MLAs
- Daily news update and proactive news agenda
- HR guide and FAQ shared with staff and 'AskHRCOVID-19' email established
- Covid-19 Trust Board briefings.
- Regularly updated Covid-19 page on Trust website and Hub microsite
- Use of social media including highly successful video produced by the Trust's respiratory team, weekly Chief Executive podcasts to staff, and HR podcast clinics
- Executive Team member visibility on main sites and in the community.

Patient and family support

114. It was equally important that patients and their families received additional support, particularly if patients were on a care of the dying pathway. A family liaison service was established led by the bereavement coordinators, anaesthetic and patient experience teams. The service involved a daily call to relatives by a doctor and follow up calls as required, and the Belfast Trust procured a number of IPADs to facilitate virtual family visits via Zoom, Face

time or Skype for patients. An outline of the service is attached at **CH/10** **INQ000416504**

Research

115. Recognising the imperative for high-quality research to derive evidence-based treatments for a novel disease, research-active clinicians and QUB academics working in Belfast Trust actively sought to contribute to, and lead, clinical trials. This effort was supported by the Belfast Trust's Research and Development (or R&D) department, clinical trials pharmacy, the Northern Ireland clinical research network and Northern Ireland clinical research facility, whose staff worked tirelessly and flexibly to deliver research.

116. In critical care, clinicians committed to participate in the REMAP-CAP platform randomised trial. The trial opened in Belfast on 7 April 2020, and the first patient was recruited the following day. Through 2020 and 2021, 222 of a total of 331 Covid-19 patients in critical care were recruited to one or more research studies, reflecting a high level of commitment from the research team and broad support from clinical colleagues. Belfast Trust was the first centre in the UK to randomise critically ill patients to several new treatment arms, and among the highest recruiting centres to the trial worldwide during 2020 and 2021.

117. Outside of critical care, clinicians and research staff recruited 226 patients to the RECOVERY trial, again representing a significant contribution to this UK-wide trial which demonstrated the effectiveness of dexamethasone and other treatments for severe Covid-19.

118. Furthermore, QUB clinical academics working in Belfast Trust had leadership roles in the UK response to Covid-19. Examples include leadership of the UK-wide RECOVERY-RS trial which demonstrated the safety and effectiveness of CPAP as an initial therapy for hospitalised patients with respiratory failure; delivering the Novavax vaccine clinical trial in Northern Ireland; and contributing to national groups such as the Urgent Public Health prioritisation committee of the National Institute for Health Research and the National Institute for Clinical Excellence Rapid C-19 panel.

119. The Belfast Trust's commitment to research and, for the first time, the embeddedness of research in clinical practice, was critical in allowing clinicians to contribute to the generation of knowledge and, of equal importance, limiting the impetus to use unproven therapies in an uncontrolled way, as was widespread in many centres. Further, participation in clinical trials helped ensure a seamless transition between giving new treatments in a clinical trial context to giving them as standard care as soon as evidence of benefit became available.

SPECIFIC QUESTIONS ASKED BY THE INQUIRY

120. I will do my best to answer the specific questions asked by the UK Covid-19 Inquiry. Where matters may have been covered previously, I will identify this. If I have been unable to answer a question I will say so. In the exhibit bundle to this statement, I have included Trust Board updates provided by me and other executive colleagues which provide more operational information on how services were flexed up and down depending on the numbers of patients in our hospitals with Covid-19.

Background

121. Belfast Trust provides health and social care services to the local Belfast population (345,000 people at the 2021 census) as well as being the main provider of almost all regional services for the Northern Ireland population (1.9 million people as at March 2021).

122. It is important to note, as previously indicated, that the Royal Victoria Hospital (RVH) is part of the wider Belfast Trust hospital campus. RVH is the regional trauma centre and acute district general hospital for the population of Belfast, but also provides major specialist services for the Northern Ireland population.

123. A total of 1,732 commissioned acute beds are provided across acute, paediatrics, acute mental health and cancer services (the Royal Victoria Hospital provides approximately 600 beds). In terms of commissioned capacity, 56% of the Belfast Trust's bed base is for regional services and 44% for Belfast District General Hospital (or DGH) services.

a. the geographical area covered by the hospital;

105. Belfast Trust provides services across North, West, East and South Belfast and Castlereagh for acute and community services (the Ulster Hospital based in Dundonald is part of the South–Eastern HSC Trust). For regional services, Belfast Trust supports the NI population across 14,330Km2 (5,530 square metres)

c. the demographic characteristics of the patient population including: ethnic diversity, age and level of socio-economic deprivation;

124. The Belfast population of 345,000 (2021 Census) is made up of approximately equal numbers of females (51%) and males (49%), with the following age band profiles: 0-14 years 18% : 15-39 years 37% : 40-64 years 30% : 65+ years 15%.

125. According to the 2021 Census, the largest ethnic group in Belfast were people who identified as White (92.9 per cent), followed by Chinese (1.37 per cent), Indian (1.26 per cent), people of mixed ethnicity (1.2 per cent), and Black African (1.19 per cent), making the Belfast Trust area currently the most ethnically diverse in Northern Ireland. In addition, Belfast has an increasing share of Northern Ireland's international migrants.

126. The Belfast Trust area has some of the most socially deprived areas within Northern Ireland. The Northern Ireland Statistical Research Agency's (or NISRA's) Multiple Deprivation Measures (2017) details the most deprived areas in Northern Ireland and across multiple domains - Health Deprivation

and Disability, Employment Deprivation, Education, Skills and Training, Living Environment, Belfast has the highest proportion of deprived local areas.

127. People in Belfast also experience poorer health and wellbeing outcomes e.g.

- Lower life expectancy for both men and woman
- Higher standardised death rates mainly from avoidable deaths, early deaths from circulatory disease and early deaths from cancer
- Higher hospital admission rates for alcohol and drug related causes
- Higher rates of smoking, in particular during pregnancy
- Lower uptake of screening services

(Source -Belfast: Profiling Health, Wellbeing and Prosperity, Belfast Healthy Cities, 2023)

d. the type of hospital and the services it provides;

128. For acute care, Belfast Trust provides a campus of adult acute hospital services for the population of Belfast and beyond. Acute services are served by the hospitals on the Royal Victoria Hospital site, but also the Belfast City Hospital, Musgrave Park Hospital and the Mater Hospital and together they meet the needs of both local and regional adult acute services.

129. The Royal Victoria Hospital is part of what is commonly referred to as the Royal Group of Hospitals, which also includes Royal Belfast Hospital for Sick Children (RBHSC), Royal Jubilee Maternity Service (RJMS) and the Dental Hospital. The Belfast Cancer Centre and Acute Mental Health Inpatient Centre are based on BCH site. Services in-reach as required across the campus.

130. The Royal Victoria Hospital (RVH) is the regional trauma centre and acute district general hospital for the population of Belfast. The RVH provides major specialist services relevant to the care of major trauma, i.e. general surgery, emergency medicine, vascular, spinal, cardiothoracic, neurosurgery, burns, head and neck cancer surgery, interventional radiology &supporting services, such as critical care and with direct links to plastics and maxillofacial services. The fracture service for the greater Belfast and Antrim populations are also based here.

131. Regional and specialist medical services (both unscheduled and elective care) are also based at the RVH eg Regional Neurology, Hepatology, Infectious Diseases, Endocrinology including the regional diabetic foot services; Stroke Services, including the delivery of mechanical thrombectomy & thrombolysis; Acute cardiology services including regional PCI.

132. Between March 2020 and June 2022, the inpatient wards in RVH covered the following specialties; Burns, Emergency Surgery, Urology & Gynaecology, Fractures, Neurology, Neurosurgery, Regional Trauma Unit, Cardiothoracic Surgery, General Medicine, Adult Cardiology, Respiratory Medicine, Geriatric Medicine, Emergency Surgery, Vascular Surgery, Hepatology, Neurovascular, Infectious diseases, General Medicine, Endocrinology & Diabetes, Gastroenterology, Ear Nose and Throat and Ophthalmology.

133. Belfast City Hospital provides complex regional cancer and elective inpatient surgery (Upper and Lower GI surgery, including HPB, along with breast, gynaecology, urology and renal transplant surgery). The current service fully utilises the existing theatres, ICU and PACU & Interventional Radiology, with access to 24/7 consultant medical specialist input, including Cardiology. Belfast Cancer Centre and the centre for Regional Haematology, Renal and Transplant services; Comprehensive Haemophilia Centre; Ambulatory

Oncology and the Haematology Unit are also on this site. During Covid-19, as indicated above, BCH was the designated "Nightingale" Hospital for Northern Ireland and the local Covid-19 Critical Care Facility.

134. The Mater Hospital offers adult ED service as part of the ED network with RVH. It also offers unscheduled care services for Acute Medicine, Respiratory, Cardiology, Endocrine and Gastroenterology for all ages, over the age of 16 years. Day case Ophthalmology, ENT and endoscopy, supported by diagnostic services on site. During Covid-19, the Mater Hospital was the designated Belfast Trust Covid-19 Hospital.

135. Musgrave Park Hospital (or MPH) provides regional specialist orthopaedic surgery and rehabilitation services, elective and day case orthopaedics, fractures and older people services rehabilitation. The Regional Rehabilitation Service is based in MPH (including the Regional Acquired Brain Injury Unit (RABIU), Neurology Unit, Spinal Cord Injury Unit (SCIU), the Amputee Rehabilitation Unit (ARU), regional specialised seating service and Mitre Rehabilitation Unit). During Covid-19, MPH supported the fracture service with RVH with reduced orthopaedic surgery.

e. the number of staff and wards you were responsible for during the relevant period.

136. As Executive Medical Director of Belfast Trust and the lead for the Covid-19 Oversight Group, I had responsibility for 22,500 staff and around 1,732 beds in total, of which between 543 and 689 were open in the RVH between March 2020 and June 2022.

137. The inpatient wards in RVH covered the following specialties during that time period included: Burns, Emergency Surgery, Urology, Gynaecology,

Fractures, Neurology, Neurosurgery, Regional Trauma Unit, Regional ICU, Cardiothoracic Surgery, General Medicine, Adult Cardiology, Respiratory Medicine, Geriatric Medicine, Emergency Surgery, Vascular Surgery, Hepatology, Stroke, Infectious diseases, General Medicine, Endocrinology & Diabetes, Gastroenterology, Ear Nose and Throat and Ophthalmology.

Staffing Capacity

138. In response to Covid-19, a Central Medical Workforce Redeployment Team of senior medical and administrative managers was created on 19 March 2020 with the remit to optimise and mobilise medical staff at the right time to the right place to provide safe care for patients during the Covid-19 Pandemic. This mirrored the Central Nursing workforce and Allied Health Professionals (or AHP) teams, which existed pre-pandemic.

139. The central nursing, AHP and medical workforce teams coordinated the challenge of ensuring safe staffing during the pandemic and held daily Microsoft Teams meetings with senior medical, AHP and nursing leaders, linking with clinical leads, clinical directors and managers. Communication, engagement and collaboration were vital to promote our shared purpose of safely redeploying medical, nursing and AHP staff with a collective responsibility to provide safe care to all patients. The teams produced a two-way communication diagram to ensure key internal and external stakeholders were engaged with during the management of staff deployment. See **CH/11** INQ000471384 and **CH/12** INQ000471383

140. To ensure and maintain patient and service user safety, service delivery and a safe working environment the Belfast Trust developed in partnership with Trade Unions Interim Change Management Guidelines to support the temporary change of services due to Covid-19 including the redeployment of staff.

141. Medical staff: There were no capacity issues in medical staffing. The collective leadership approach adopted by the central medical workforce team improved engagement and collaborative working across teams and specialties as we managed the challenges of the pandemic and deploying medical staff to critical areas.

142. During the first two surges, there was a downturn in elective activity and medical staff were redeployed to support areas providing care for Covid-19 patients in hospital. These included Intensive Care Units (ICU), ED and Acute Respiratory and Medicine Wards. Medical wards and ICU required increased support from medical staff and the medical specialty-based trainees were redeployed to the wards, and surgical-based trainees supported ICU. In addition, other medical staff were also deployed to support the vaccination and Covid-19 testing centres, as well as the Covid-19 community step-down facility. Consultants were also deployed to hospital wards, ICU and community facilities.

143. The Belfast Trust also issued a 'call to arms' recruitment campaign to increase staffing capacity. This included retired medical professionals who were re-employed to support such areas as the Covid-19 vaccination centres, step down facilities, acute care at home, patient/carer liaison roles for in-patients with Covid-19, mentorship and nMAB work.

144. Regional engagement with Queen's University, Belfast Medical School resulted in part-time employment (15 hrs/wk) of medical students initially in year 3+, working as band 4 (known as Medical Student Technicians (MSTs)) and from 2021 recruited year 1-2 students at Band 2 level working as Student Assistants. However, collectively we referred to this cohort of staff as MSTs. The central team worked collaboratively with HR colleagues to develop a robust process for the engagement and deployment of MST to support medical and nursing colleagues. Across the Belfast Trust, we placed 211 MSTs supporting acute medical wards, ED, care homes, Covid-19 testing centres, Covid-19 vaccination centres and step down facilities and Covid-19 Centre for general practice. See exhibit **CH/13** INQ000471368

145. Nursing staff:_The Pre pandemic gross vacancy position in March 2020 for Nursing and Midwifery in the Belfast Trust was 18%. Further breakdown of this demonstrated a Band 5 RN vacancy of 23%, but minimal Intensive Care Vacancies within Belfast Trust of 10 WTE RN vacancies & 6 WTE Non-registrant vacancies.

146. To maintain safe staffing in line with *Delivering Care Policy Standard* we utilised temporary workforce solutions within the Belfast Trust. This was challenging during the pandemic as the availability of temporary staff was reduced.

147. The gross vacancy position in May 2022 for Nursing and Midwifery in Belfast Trust remained at 18%. Further breakdown of this demonstrated band 5 RN vacancy decreased to 15% although there was an increase in Band 3

and Band 6 vacancies.

148. Allied Health Professionals: Across AHP services, there was an 8% vacancy rate in April 2020. The breakdown across the five professions across 2020 to 2022 was as below:

Profession	Total WTE	Vacancies		
		Apr-20	Sep-20	Mar-22
Allied Health Profession Division	**1080.4**	**8%**	**8%**	**14%**
Podiatry	97.47	8%	3%	9%
Speech and Language Therapy	171.5	7%	9%	21%
Nutrition and Dietetics	134.09	12%	10%	16%
Physiotherapy	406.43	8%	11%	13%
Occupational Therapy	265.74	7%	6%	10%

The reasons for any staff shortages for example: pre-pandemic staff vacancies, the need to self-isolate, staff who were shielding, staff redeployment, or other reasons.

149. Vacancies for the Belfast Trust in March 2020 stood at around 3,027 with 1,327 vacancies in Nursing (Professional and support), 138 in Medical (this would have included training grades at the time), 343 in Social Care, and 155 AHP's.

150. In Unscheduled Care the vacancy numbers were as follows; 632 in total, 354 in Nursing, 57 in Medical, and 88 AHP's (Vacancies above are defined as posts for which requisitions had been raised, these figures do not reflect budgetary vacancies which are provided separately).

151. The Table below captures the number of staff who were recorded on HRPTS as off work for reasons associated with the pandemic. Those on 'Public Service Duties Paid' were off due to contracting Covid-19 and those recorded against 'Risk Assessment (Paid)' were either shielding or self-isolating. With effect from 1 October 2022 those off with Covid-19 were coded against Influenza.

No. of staff	**Year**					
Absence Reason	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**	**Grand Total**
Public Serv Duties Paid	716	2552	5241	2298		10807
Risk Assessment (Paid)	1402	6608	6161	762		14933
Influenza				3712	4175	7887
Grand Total	**2118**	**9160**	**11402**	**3060**	**25740**	**33627**

Covid 19 testing

152. The introduction and availability of Covid-19 Testing was in line with regional guidance and HSC testing arrangements. The Belfast Trust had sufficient workforce capacity to support the introduction of Covid-19 diagnostic testing, including staff available to undertake and complete the tests, the laboratory infrastructure to complete the diagnostic elements of testing, and the Occupational Health workforce required to support staff results.

153. Staff testing was incorporated with all testing arrangements identified as a 'HSC Worker' and did not identify Belfast Trust staff specifically. Whilst it is not possible to quantify the specific impact on workforce capacity as a result of testing, however this undoubtedly had a positive impact. The introduction of staff testing provided support to staff and allowed them to act appropriately in

relation to self-isolation and household isolation when a positive test was received. This helped prevent the spread of Covid-19 both within the workplace, in social circles and society as a whole, in line with extant DoH NI guidance

154. Covid-19 testing also allowed staff to end isolation at a time that was safe to do so, with staff receiving specific advice and in line with then current Regional guidance on this. This provided reassurance both in relation to patient safety within the health setting and to staff themselves.

155. The Belfast Trust had designated 'Covid Testing PODS' which provided the availability for patient and staff testing from 1 March 2020 until 6 April 2020 before transferring to the Balmoral DVLA Testing Centre on 7 April 2020, following Department of Infrastructure request for enhanced Testing Sites/Pillar 1 Testing requirements. This centralised area covered all the Belfast Trust Testing requirements including staff, and since this presented a significant increased demand for testing, in excess of 60 staff (not all full time) from many groups of services, were redeployed to support Belfast Trust Testing requirements.

156. With regards to the Belfast Trust Regional Virology laboratories (RVL) workforce to complete testing:

- Samples were originally sent to Colindale, PHE.
- In-house testing in RVL commenced on 7 February 2020 with a capacity of 8 per day

a. Covid-19 antibody testing of staff (if applicable)

157. The purpose of C-19 antibody testing was to assist in Covid-19 research (SIREN study) by determining if individuals had a Covid-19 infection in the past. It did not have an impact on workforce capacity. Staff antibody testing began in Sept 2020 and by 31 October 2020, 23,930 HSC staff had taken part in the antibody testing programme in Northern Ireland. LAMP testing commenced for asymptomatic staff on 15 January 2021 and finished on 31 March 2022. Asymptomatic staff were then encouraged to use Lateral flow tests from 01 April 2022.

b. The creation of temporary registers for doctors, nurses, midwives and pharmacists to enable trainees and retired staff to work in these roles;

158. Belfast Trust implemented a number of resourcing workstreams at pace in order to support existing staff and meet the patient care demands of the Covid-19 pandemic. A number of these resourcing initiatives saw the creation of temporary registers to enable trainees and retirees to work

159. Nursing students were employed as Band 3 and Band 4 Student Nurses in order to support nursing staff (**CH/21 - INQ000496092**). Medical students years 1 and 2 were recruited to Band 2 Student Assistant roles and Year 3 & 4 students were employed in Band 4 Medical Student Technician roles.

160. The UKFPO (UK Foundation Program Office) introduced early entry to participate in the Foundation Programme as a Foundation Interim Year 1 (FiY1) doctor which was termed "FY0" internally (Foundation Year 0). Approximately 68 staff were employed directly by Belfast Trust in partnership with NIMDTA for 15 hours per week to support foundation Doctors on the wards. They were aligned to Medical Education within the Trust and EPortfolio Tutors at Queen's

University. Belfast Trust provided a supporting role for the wellbeing of all doctors undertaking their FiY1 placement in Belfast Trust **CH/15** – **INQ000496088**.

161. The Belfast Trust enhanced its workforce by recruiting Bank (casual workers) to the following roles:

- Allied Health Professionals (AHPs) (Band 5,6,7)
- Social Work (Band 5,6,7)
- Social Care (Band 2,3)
- Admin (Band 3,4,5,6)
- Patient and Client Support Services (PCSS) (Band 2,3,4,5)

Workforce Appeal Staff April 2020 - 2022

Distinct Count of NINO	Column Labels							
Row Labels	Admin & Clerical	Estates	Medical & Dental	Nursing & Midwifery	Professional & Tech.	Social Services	Support Serv/User Exp.	Total
Assoc Specialist			3					3
Specialty Doctor			8					8
F1 Level Doctor			56					56
F2 Level Doctor			2					2
Specialty Registrar			22					22
Consultant			41					41
Band 2	13	2	27	8	4	6	65	125
Band 3	24			92	3	21	12	152
Band 4	3		110	331	21	16	1	482
Band 5	1			31	23	62		117
Band 6	1			6	9	30		46
Band 7				5	2	7		14
Total	**42**	**2**	**269**	**473**	**62**	**142**	**78**	**1068**

162. The Northern Ireland regional SARS-CoV-2 sequencing response during 2020 was under the COG-UK programme, which we delivered as a joint Belfast Trust-QUB team. HSC-commissioned sequencing under CR126 and CR143 came later, as per the dates of those business cases. Through Tripartite secondment agreements three staff employed by Queen's University undertook Laboratory work to support the Belfast Trust to deliver Covid-19 whole genome sequencing. This work was undertaken both on Belfast Trust premises (Kelvin Building, Royal Victoria Hospital Site) and QUB (Wellcome- Wolfson Institute for Experimental Medicine).

163. Other temporary workforce provisions included the redeployment and recruitment of vaccinators to support the delivery of Covid-19 vaccinations for the public of Northern Ireland and staff.

An outline of any constraints on the ability of the hospital to increase staffing capacity.

164. Despite initial interest being quite positive (receiving over 3,000 applications), when it came to discussion around job offers and follow up, interested parties realised the potential impact it could have on their own health, or those family members who were perceived as vulnerable, and interest dissipated. This resulted in 25% drop off in the first three months, increasing to 30% drop off after six months, (up to 50% for clinical roles). This resulted in much less actual support being provided. Most interest was also expressed for Non-Clinical roles where there was much less need.

Any responses or measures taken to address or alleviate staffing shortages:

165. As described previously, agreement was made with Belfast Trust and other HSC Trusts in the Region to accommodate Final year Medical, Nursing and Social Work Students in employment earlier than anticipated and in lieu of their final year results and permanent placement. As also described previously, temporary registers were created for retired medical and nursing staff to return to work.

166. A regional approach was taken, in conjunction with DoH NI in respect of enhanced rates for AfC staff working additional hours. Within Belfast Trust, Medical Staff working on Covid-19 wards worked revised rotas to support patient care. A Covid-19 Resident Rate was established in January 2021 in respect of additional hours worked by medical staff during this period

167. Medical staff: Clinical services continued to provide non-Covid-19 patient care, and through the Central Medical team, volunteers were sought for redeployment balancing the needs to provide both Covid-19 and non-Covid-19 care. In total, 358 medical trainees, 139 consultants (including 15 retired

medical consultants/GPs), and 211 medical students were redeployed to care for 2,622 ward patients and 211 patients in critical care from April 2020 to March 2021. Staff also were invaluable in supporting community settings as already mentioned.

168. Nursing staff: Within the Belfast Trust the nursing workforce modelling was dynamic and remained responsive to the changing service need. Consideration was not only given to increasing staffing capacity in response to the pandemic but also to the rebuild of services and dealing with usual winter pressures.

169. A number of plans were implemented to meet the service need during the Covid-19 pandemic and most effectively utilise the Nursing workforce to ensure safe and compassionate care for our patients. For example;

- Initially, as services were downturned, our nursing staff were upskilled and asked to redeploy to areas of greatest need; including Covid-19 inpatient wards; Critical Care and to provide Mutual Aid to the Independent Nursing Homes.
- Non-ward based nurses (including specialist nurses) were upskilled and redeployed to meet the dual priorities of Covid-19 and non-Covid-19 services.
- The Central Nursing Workforce team undertook regular analysis of the workforce need (using Telford methodology) enabling Service Managers and Divisional Nurses to make informed decisions regarding skill mix and ensure patient safety within the Delivering Care Standards. This analysis would reflect the evolving nursing requirements within service areas thus enabling Service Managers and Divisional Nurses to make informed decisions regarding skill mix and ensure patient safety within the Delivering Care Standards. A number of factors were taken into consideration when reviewing/ analysing the workforce demand:

- Workforce – availability of staff both Registrant and Non-registrant staff, to include planned and unplanned absence to ensure effective workforce planning and efficient deployment of staffing resources (high level of sickness absence and CEV reduced availability of staff); appropriate rostering of staff and shift patterns, as optimal rostering of staff supports effective management of staffing resource available to deliver on the workload demands of a ward or department; skill mix of staff, so we could match the duties and responsibilities to the care needs of the patients and therefore deploy the staffing resources to meet these needs; Recruitment of staff was undertaken by HR through the Workforce Appeal, working collaboratively to place staff, with the appropriate skills in the wards/departments; transferability of skills to meet the demand in a particular ward/department to ensure any additional training and development needs of staff were met
- Environment and Support – Need for additional staff to support IPC requirements e.g. PPE use, also to include the geographical layout of the ward as this had an impact on workforce planning – reviewed in line with changing COVID guidance (e.g. Red, amber and Green areas); ward size, bed numbers, single rooms; support provided within a clinical area by other members of staff e.g. there were a range of tasks that could be undertaken by individuals who are not identified as working within the family of nursing e.g. admin staff, ward housekeeper.
- Activity – the assessment of the care needs of patients was ever changing and the workforce evolved to meet the patient acuity/ dependency; this was communicated at daily safety huddles, and the workforce modelling was adapted to meet the service need. E.g. Enhanced Respiratory Care, ICU, ward. Weekly workforce huddle with Divisional Nurses to review service provision, care needs of patients and deployment of staff Professional Regulatory Requirements – compliance with NMC regulatory standards and guidance in relation to helping to strengthen the workforce capacity and supporting staff to deliver care.

- New staff groups such as Critical Care Scientists, Dental Nurses, Dental Technologists, Medical Students and Nursing Students were added to the roster system for the first time to support and supplement the workforce.

170. The Belfast Trust Nursing Workforce Strategy was implemented in July 2021.The Covid-19 pandemic exacerbated what already had been a serious nursing workforce shortage in the Belfast Trust. The Belfast Trust had an average nurse vacancy rate of 18%, with considerably higher vacancy rates in band 5 nursing where the vacancy rate averaged 24%. Additionally, sickness absence rates amongst nurses had risen, putting additional pressure on the Belfast Trust's depleted workforce.

171. To meet the nursing shortage, Belfast Trust developed an International Nurse Recruitment (INR) programme. The aim of the Belfast Trust was to increase its nursing workforce to reduce its gross vacancy rate from 18% to a more reasonable/manageable level of 5% or less.

- From 1 March 2020 to 28 June 2022 Belfast Trust successfully recruited 578 international nurses.
- As a result, Band 5 vacancies reduced from 23% to 15% within that time frame.

172. "Helping Hands" Initiative: From November 2021, there was a growing concern about the potential impact of an anticipated Covid-19 surge together with seasonal increases on already pressurised Belfast Trust services and staff. Belfast Trust developed the "Helping Hands" initiative which was an internal workforce appeal created to provide support to high priority services. All Belfast Trust non-medical staff were targeted to identify those willing to work additional hours, or be partially redeployed beyond their substantive role, in clinical areas covering one of four duties: admin, housekeeping, family liaison or dementia support. Staff were paid in line with their AfC Terms and Conditions and their normal pay frequency.

173. A steering group was established to oversee the operation of the Helping Hands initiative comprising HROD, Trade Unions, Central Nursing and the

Trust Planning team. Each element of the Helping hands process (from recruitment to induction) was designed and implemented in five weeks. It was not available to agency workers or those on placement. Staff sought permission from their line manager before registering their interest. Trade union colleagues played an essential role in raising awareness of the scheme on the ground and encouraging volunteers to participate. The involvement of Trade Union from the outset also allowed for robust discussions within the steering group and provided another mechanism for service areas and volunteers to highlight any issues or concerns and for these to be resolved.

174. The steering group recognised the importance in ensuring Helping hands volunteers were properly inducted to their new environment. In order to support volunteers and ensure patient safety, "host" services were provided with induction guidance and volunteers completed an online training pack (attached). Both of these resources were designed in partnership with Nursing colleagues and Trade Union representatives.

The induction included;

- Roles and responsibilities for a Helping Hands volunteer
- Duties they were NOT to undertake
- Tour of the ward/clinical work space
- Handover arrangements
- Access to appropriate systems
- Ensuring mandatory training included an appropriate level in Infection Prevention and Control, Data Protection, Safeguarding, Patient/Client confidentiality, fire routes and protocols, risk assessment requirements etc.
- Review and detail actions required if they are witness to an incident
- PPE guidance
- Review of relevant Trust policies eg. Zero Tolerance, COSSH, ,Manual handling etc.
- Pairing Helping Hand volunteers with a 'buddy' on the ward/clinical work space

175. *Impact on patient safety.* 40 Helping Hands volunteers provided support to clinical areas such as Emergency Departments, Care Homes, Clinical wards and the Trust Vaccination Centre between December 2021 and February 2022. In total 2,113 additional shifts, equating to 8,500 hours of additional support on wards and in patient facing areas, was provided. By removing some of the administration, housekeeping, family liaison or dementia support tasks from clinical staff, they were able to focus more time and attention on treatment, clinical tasks and decision

making.

240 “Helping Hands” volunteers provided support to clinical areas e.g. Emergency Departments, Care Homes, and Vaccination Centre between 17 December 2021 and 28 February 2022. In total 2,113 additional shifts were provided equating to 8,500 hours of support. An evaluation of the initiative took place and 71% of Helping Hands staff who volunteered had a "strongly positive" or "positive" experience. 75% of service areas strongly agreed or agreed that the Helping Hands appeal relieved pressure on clinical staff in their area.

a. by the Department of Health.

176. The DoH NI provided resource to establish a Workforce Appeal that went live on 3 April 2020. It was to seek interest from members of the public who would be willing to take on temporary employment in the Health and Social Care system to support frontline staff and alleviate workforce pressures. Interest was taken in broad groups, categorised through geographical area and job family (instead of by Trust and specific job roles). Whilst the agreement was regional, and funded through the DoH NI with support from Health Sector Talent (funded by DoH), each HSC Trust had the autonomy to recruit at its own pace within regionally agreed principles.

177. Section 13 of the Coronavirus Act 2020 allowed the DoH NI to indemnify a person on a temporary basis in respect of a qualifying liability during the Covid-19 response period. This allowed for a cohort of medical staff to be employed by the Belfast Trust to support the Covid-19 response.

178. The DoH NI also provided indemnity in respect of liability to allow Medical Consultants employed by HSC Trusts to provide a range of services to HSC patients, as outlined in the Heads of Terms agreed between the Independent Hospital and the HSCB (the Services). Those services were in support of the HSC response to Covid-19 **CH/16 - INQ000377176**

179. A range of pay incentives were implemented by the DoH NI, including paid overtime for Band 8a until March 2022. A HSC Staff Recognition Payment was announced in February 2022 for all staff, with payment made in July 2022 **CH/17 - INQ000496093**

180. Pension regulations were suspended to allow more hours to be worked with no financial penalty for those in receipt of an HSC Pension. New measures introduced by Government, aimed at alleviating the pressure on organisations employing key workers, enabled staff who could not take all their holiday entitlement due to Covid-19 to carry over leave, into the next two leave years, 2021/2022 and 2022/2023 **CH/18 - INQ000471364** The DoH NI also provided funding and provision to facilitate the payment of unused contractual annual leave 20/21 and 21/22 to increase workforce capacity **CH/19 - INQ000496095**

181. A Regional Covid-19 Rapid Response Payment Initiative was developed by HSC Trusts and noted by the DoH NI. The payment scheme was initially launched in January 2021. A revised scheme launched in November 2021 was in place until March 2022.

182. Guidance was also issued by DoH NI entitled "*Regional Principles for Nurse Staffing in Surge Demand during COVID-19".* Whilst recognising everything should be done to maintain Delivering Care standards, it was accepted that nurse staffing levels across acute hospital-based environments would be challenging to maintain. This guidance was designed to support HSC Trusts to use a risk-based approach to varying staffing levels, commensurate with the demands placed on services as a result of the Covid-19 pandemic.

183. The Nursing and Midwifery Council (NMC) put actions in place to expand the nursing and midwifery workforce and provided flexibility to change the nature of the programme for undergraduate pre-registration nursing and midwifery students, so that they could opt to undertake the final six months of their programme in clinical placement. The four countries of the UK worked with the Nursing and Midwifery Council (NMC) and others to publish joint statements on expanding the nursing and midwifery workforce in the Covid-19 pandemic, outlining how the contribution of students could be maximised.

184. 199 pre-registration nursing and midwifery students arrived into the Belfast Trust to complete their training. The students were in the final six months of their training from QUB, UU and OU. These transition students were brought into the Belfast Trust under emergency measures which supported them to meet the NMC requirements for registration, while also contributing to the needs of practice during the pandemic.

185. The Belfast Trust also deployed Military Medical Technicians to support the workforce pressures within Belfast Trust during the Covid-19 wave attributed to the Omicron variant.

In relation to redeployment of staff, a summary of the practical effects on the hospital of redeploying staff:

a. **to different specialisms or wards within the hospital;**

b. **to other hospitals;**

c. **to the Nightingale hospital and/or care homes during the relevant period.**

The practical effects of redeployment may include the impact on capacity, patient safety, whether the staff were sufficiently skilled to work in the roles to which they were deployed, staff morale and well-being, increased risk of burnout etc.

186. Data collected from the 'Learning from Covid' survey (Jun-August 2020) undertaken by the Belfast Trust indicated there were both positive and negative outcomes experienced by staff and service users as a consequence of redeployments (CH/20 - INQ000496083).

187. Team-working was reported as a widely positive experience across Belfast Trust. Whilst there were many examples of teams working together productively (with high levels of commitment, camaraderie, support and a sense of 'we are all in this together), teamwork for others was negatively affected by a number of issues including redeployment. Redeployment resulted in the fracturing of some teams, resulting in low morale and frustration both for those redeployed, and also those that remained. Managers also reported finding it challenging at times to get staff back when needed, and, as a result, they would be cautious about facilitating redeployment again in the future.

188. Communication was also impacted. Individual staff and managers reported that when staff were redeployed, they were often unsure regarding lines of accountability and communication. This resulted in a loss of communication within some teams. 24% of staff redeployed indicated they needed more frequent opportunities to connect with their 'home' team during their redeployment.

189. A high degree of inequity was reported by staff. Some staff were not redeployed at all, whilst others were redeployed several times. 21% of

respondents to the staff survey reported having been redeployed at least once. 20% of staff who were redeployed were redeployed three or more times. This sense of inequity in redeployment within teams contributed to a reported breakdown of relationships in some areas.

190. Although some staff indicated they were consulted on the redeployment process, and the options available, others said they were not. Some staff also reported having concerns about the role they were redeployed into, which had a significant impact on their feelings of safety and wellbeing. Other issues noted were the often open-ended nature of redeployments, with no end or review date specified. This caused uncertainty and a sense of insecurity for some in relation to their substantive post and future role in the Belfast Trust. During this period the Belfast Trust's Engagement Score declined, as indicated in the table below.

Year	Pre Covid (2019)	June 21	March 22	November 22	June 23
Engagement Score	3.77	3.62	3.62	3.64	3.75

191. The perceived quality and quantity of training provided for staff prior to and throughout a period of redeployment impacted the experience of staff redeployments. Where staff felt training was inadequate, they reported feeling clinically unsafe in their new role. However, staff that felt the training provided was sufficient, felt they had benefited from the experience because of the additional skills they required working in the new role.

192. The senior ICU nursing team in critical care held daily safety huddles and regular staff briefs throughout the day. There were weekly staff meetings to highlight and to address concerns, and to keep staff fully appraised. Any reported critical incidents were reviewed in a timely manner and subsequent learning appropriately disseminated at the regular safety huddles and weekly meetings. When redeployed staff approached the ICU 'Nurse in Charge' (NIC) citing perceived concerns in their redeployed role, the staff member was fully supported by the NIC. If applicable, further training was provided by the ICU education team at the bedside.

193. Service user feedback suggests that in some instances service users missed out on treatment, care or support that they should have received. For example, aftercare services and community support teams, who would have provided vital help to families, were not available as members of the team had been redeployed to other roles.

194. A sense of inequity or unfairness was expressed by both staff and service users. Indeed, this was a thread that ran consistently through all the other themes identified in the data.

195. Regional Intensive Care Unit. Targeted work was carried out in the RVH

Regional Intensive Care Unit (RICU) by the 'RICU change team', led by staff from the unit and supported by Human Resources. The survey of nurses "RICU- staff feedback" and Doctors "RICU Medical staff feedback" provided insight into areas of strengths as well as areas for improvement. The change team met monthly to bring forward change ideas such as improvements in;

- communication
- wellbeing support (physical and psychological)
- staff recognition
- service planning
- induction of redeployed staff
- clarity of roles and responsibilities
- support and development of zone co-ordinators.

196. Medical staff: The central medical team actively listened and engaged with all services areas, hearing concerns and addressing issues. We deliberately "flattened the hierarchy", and communicated and engaged with key patient-facing staff, involving and empowering them in decision-making. Reflection was an integral part of our learning after each Covid-19 surge. Using findings from the "Learning from COVID" Trust-wide survey which identified three key themes (Engagement, Communication and Involvement), and qualitative feedback from trainees, we refined our processes into three key redeployment phases – Planning, Placement, and Return. This was supported by eight Action Cards focused on improving the experiences of trainees, and their education and training during deployment. Covid-19 areas also provided redeployed medical staff with local induction and orientation and job shadowing. Efforts were made to team redeployed staff with experienced staff to provide practical support, maintain morale and well-being. To promote the well-being of our medical student technicians, external (retired) medical staff were employed as mentors.

197. Regular feedback was encouraged and reviewed. We engaged and listened to redeployed doctors as they shared their experiences to promote improvements for future cohorts of deployed staff. Some of those redeployed during surge 1 reported they were surplus to need, and such staff were released back to their base specialty. Taking this on board, during the second phase of Covid-19 (October 2020), trainee medical staff were redeployed to a number of Covid-19 inpatient wards or ICU for a defined one to three week period, then returned to their base specialty. Having trainees redeployed for a

defined period before returning to their substantive service, lessened the impact of their medical training requirements, which was supported by our Director of Education and NIMDTA. Weekly Deanery engagement supported trainee redeployment in keeping with Four-Nation guidance.

198. Our daily calls promoted "open-door", collaborative, two-way discussion with medical, clinical and managerial staff to facilitate feedback and allow for issues to be addressed early. As mentioned feedback was sought, which included a redeployment survey. Redeployed trainee comments included: "*Redeployment process and logistics very good"; "Supportive, friendly medical and nursing teams"; "Clear timescales for redeployment"; "study and annual leave accommodated".* Medical student feedback showed 88% agreeing the role was useful for their medical education with 94% recommending the role.

199. Use of real-time data was vital when we moved into the de-escalation phase. Our challenge was to balance providing continued support to Covid-19 areas, whilst recognizing the emergence of non-Covid-19 service rebuilding plans. We have no specific data on burnout related to Covid-19 but note the evidence of increased burnout in UK trainees since 2020 recorded in the GMC National Training Survey report 2023. These results show highest trainee burnout within Northern Ireland, with Emergency Medicine, Medicine and Surgery highest. The rates for trainers within Northern Ireland are also the worst.

200. Nursing staff: To enable us to identify potential staff for redeployment, we reviewed all Telford staffing models, Nurse to Bed Ratio (NTBR) and skill mix requirements for every ward and department taking account of the Regional Principles for Nurse Staffing in Surge Demand during Covid-19, within the

context of Divisional business continuity plans and Delivering Care staffing ranges.

201. We utilised all non-ward based Registered Nursing staff in line with Business Continuity plans and had a collaborative approach to maximising our nursing workforce resource to deliver safe and compassionate care across wards and departments. The nursing workforce was supplemented with non-registered healthcare support staff and other members of the MDT to maintain our overall workforce numbers within the normative staffing levels.

202. Nursing and AHP Staff redeployed to Critical Care/Nightingale Hospital. A flexible pragmatic and staged approach was undertaken, with an emphasis on team-working rather than a ratio approach. Healthcare staff deployed to critical care surge areas were required to work outside their normal practice area and this caused anxiety for many, including the critical care nurses who were supervising them. Any changes in working practice were supported to ensure safe practice, safe patient care and staff wellbeing, appropriate supervision and delegation of care. Orientation and support of staff in the critical care environment was key. Skills were developed with day-to-day supervised practice using the Step 1 competencies to guide practice.

203. Training of all nursing and AHP staff was a continuous process throughout the pandemic and took place alongside those already in teams managing Covid-19 patients. The Central Nursing Team worked collaboratively across the directorates and divisions to identify and respond to immediate educational requirements of staff in order to support the management and delivery of care.

204. The Education, Regulation and Informatics team within Central Nursing worked with internal and external education providers to develop induction and

education programmes designed to support evolving service requirements in response to the pandemic. The following programmes provided nursing and support staff with knowledge and skills required to deliver safe and effective care within various clinical settings:

- Belfast Trust Fundamentals of Care Upskilling Programme for Health Care Professionals
- Belfast Trust Critical Skills Training
- Clinical Education Centre (CEC)
- RBHSC – Provision of Paediatric Programmes

205. In addition to existing programmes, educational teams across Critical Care and Paediatric areas met to design and deliver upskilling programmes, to expand the capabilities of staff who would be redeployed from other departments within the Belfast Trust to work in these specific areas. During Surge 2, Central Nursing Team worked with the Resuscitation Team and Clinical Education Centre to deliver Covid-19 Vaccination Core Skills training and facilitate induction to the Belfast Trust Vaccine Centre. During Surge 3, the training and upskilling programmes were extended to deployed Military Medic Technicians.

A summary of the impact, if any, long Covid has had on staffing capacity;

206. Across the organisation, staff absent as a result of Covid-19 was captured and reported on a weekly basis. Throughout the pandemic, staff were redeployed to priority areas which may have included cover for those off long term as a result of contracting Covid-19.

207. The Belfast Trust Occupational Health Service has been providing support and guidance to staff who are experiencing symptoms of long Covid, in line with NICE guidelines, since March 2021. The service is supported by a dedicated multi-disciplinary team including occupational therapists, nurses,

clinical psychology, respiratory physiotherapist and an occupational health physician.

208. Staff absent due to Covid were supported by the provision of full pay until 1 October 2022 when the DoH NI confirmed the temporary arrangements associated with Covid-19 absence would be withdrawn.

In the event that the hospital experienced the death of a staff member/ members from Covid-19, please describe the impact this had on other staff. Please also specify the number of individuals that died and their role(s) within the hospital;

209. The Occupational Health Department were made aware of the death of two members of staff from Covid-19. One staff member was a Band 3 Support Services Supervisor within PCSS. The other was a Band 2 Home Care Worker. The staff members' teams were understandably very upset and required support through their line managers, the Bereavement Co-ordinator, and Staffcare (24 hour confidential counselling service). Individual and group counselling was offered to any staff who had been impacted by the death of their colleague.

In relation to the proposal for the Covid-19 vaccination to be a condition of deployment ("VCOD") for healthcare workers in the hospital, please explain:

- ***a. any steps taken by the hospital to assess the likely impact of VCOD on staffing capacity;***
- ***b. the number and proportion of staff who indicated that they did not intend to have a vaccination and therefore would be unable to continue in their role; and***

c. the impact of the VCOD proposals on staff morale, relations between vaccinated and unvaccinated staff, and relations between management and staff.

There was no VCOD policy for healthcare workers in Belfast Trust. The PHA developed regional FAQs that strongly encouraged vaccination, but Belfast Trust did not make this a condition of employment. Staff were not asked to indicate if they were willing to receive a Covid-19 vaccination. No staff were redeployed as a result of not being vaccinated. These FAQs were reviewed regularly by regional HR colleagues and discussed and agreed with Trade Union colleagues through the regional Joint Negotiating Committee.

210. The PHA guidance stated:

> ***"Am I eligible to get the COVID-19 vaccine? (Updated April 2022)***
>
> *Staff are encouraged to get the Covid-19 vaccination and to keep up to date with their booster doses. You can also book to receive your annual flu vaccine at the same time as your COVID booster via the link above.*
>
> *If you have further queries about the COVID-19 vaccines such as safety, side effects, pregnancy, fertility, breast feeding, you can visit PHA's Vaccine FAQ page, found here: https://www.publichealth.hscni.net/covid-19-coronavirus/northern-ireland-covid-19-vaccination-programme/covid-19-vaccination-programme"*
>
> The relevant webpage has now expired, however PHA will have all published iterations of the guidance they issued.

211. The Belfast Trust did not implement its own VCOD policy. It did encourage staff to get their Covid and Flu vaccinations.

212. The effective redeployment of health and social care employees was one of the core elements of the response of HSC Trusts to the Covid-19 pandemic. As the demand for health and social care services increased, the number of Belfast Trust employees available to provide services was likely to decrease due to sickness absence or a requirement to self-isolate or shielding. The Belfast Trust therefore developed "Guidelines on the Emergency Redeployment / Relocation of Staff During Covid-19 Pandemic **CH/21** INQ000471365

Bed capacity

213. There was no change in discharge policy to generate additional bed capacity for Covid-19 patients. As described previously, additional bed capacity was created by reducing elective activity, re-profiling sites, and redeploying staff from non-patient facing to patient facing roles.

set out whether the hospital took any steps prior to 17 March 2020 to free up general and/or ICU bed capacity in anticipation of increased demands for hospital beds.

214. This is addressed in detail elsewhere in this statement. In addition, in April 2020, the ground and second floor of the BCH "Nightingale" Hospital were designated as Covid-19 ICU bed floors. In recognition of the reduced level of patients requiring ICU and/or ventilation compared with earlier surge plan

projections, the Belfast Trust took the decision on 24 April 2020 to consolidate all ICU beds on to level 2. Furthermore, where previously there had been three floors identified for non-ICU Covid-19 patients in the "Nightingale" hospital, this had been consolidated on to two floors. This left five floors of the BCH Tower block free. Scenario planning took place to enable the Belfast Trust to adapt services between the BCH "Nightingale" and Mater hospitals, in particular to meet future changes in bed requirements.

215. Main Belfast Trust sites were configured, as of October 2020, as follows:

- BCH – green site to facilitate regional general surgery priority 1b and 2 time-critical surgery, and protect vulnerable immunocompromised patients in the cancer centre, haematology, respiratory and nephrology wards. It was the Belfast Trust objective to maintain the BCH site as a green site for as long as possible to allow these critical services to continue.
- RVH – amber site, with Covid-19 and clinical Covid-19 patients cohorted in ward 7A with a capacity of up to 12 beds. RVH also has the ED, unscheduled care pathway for patients, and the regional specialties such as vascular, cardiothoracic, trauma, stroke, PCI and neurosurgery.
- MIH – red site with Covid-19 ward and ICU patients, general, respiratory, geriatric medicine and ED (for ambulance transfers only)
- MPH – Withers orthopaedics was a green site, managing suitable fractures and urgent elective orthopaedics, categorised as P2. Meadowlands was amber.

216. RVH Critical Care Unit (RICU) transferred to the Phase 2B Critical care building on the 21 October 2020, following the final completion of Estates work and commissioning of the building. This made the placement of the

unscheduled patients requiring ICU much easier as they could be cared for in side-rooms, regardless of their infection status eg Flu, Covid19.

An outline of any steps taken to increase ICU capacity at the hospital, and how many additional ICU beds were created as a result of such steps. Please explain whether decisions relating to how to increase ICU capacity were taken at hospital, Trust or national level, any obstacles or practical difficulties in increasing ICU capacity at the hospital, and whether the hospital received support in addressing such difficulties.

217. Prior to the Covid-19 pandemic, the Belfast Trust had four adult Intensive Care Units, located in:

- Royal Victoria Hospital
  (i) Regional Intensive Care Unit (RICU)
  (ii) Cardiac Surgical Intensive Care Unit (CSICU)

- Belfast City Hospital
- Mater Infirmorum Hospital.

The commissioned bed capacity in March 2020 is detailed below.

Site	**Commissioned Beds**	
	Level 3	**Level 2**
Regional Intensive Care Unit	19	8
Cardiac Surgical Intensive Care Unit	10	8
Belfast City Hospital	5	4
Mater Infirmorum	3	3
Total	37	23

A Level 3 bed is required for:

- Admission receiving advanced respiratory monitoring and support due to acute illness

- Admissions receiving monitoring and support for two or more organ system dysfunctions (excluding gastrointestinal support) due to acute illness

A Level 2 bed is required for:

- Admissions receiving monitoring and support for one organ system dysfunction (excluding gastrointestinal support) due to an acute illness
- Admissions solely receiving advanced respiratory monitoring and support due to an acute illness meet Level 3
- Admissions solely receiving basic respiratory and basic cardiovascular monitoring and support due to an acute illness meet level 2
- Admissions receiving pre-surgical optimisation including invasive monitoring and treatment to improve organ system function
- Admissions receiving extended post-surgical care either because of the procedure and/or the condition of admission
- Admissions stepping down from level 3 to level 2

218. Nurse staffing requirements differ between Level 2 and Level 3 beds: a patient receiving Level 3 care requires 1:1 nursing care whereas a Level 2 patient requires 1:2 nursing care. Based on the commissioned levels of capacity, staffing within the units should be as follows:

Unit	**Registered Nursing Requirement per Shift**
RICU	27 +2 Nurse in charge
CSICU	14 +1 Nurse in charge
Belfast City Hospital	7 + 1 Nurse in charge
Mater Infirmorum	5+1 Nurse in charge

219. In response to the Covid-19 pandemic, the Critical Care Network for Northern Ireland (CCaNNi) requested all HSC Trusts to develop plans to be implemented to meet predicted critical care demand. Potential case numbers

based on DoH NI modelling was received on 24 March 2020. Several scenarios were projected:

Scenario	Features	Patients requiring ventilation in N.I.
1a (surge)	Social contact reduced to 15, R0 = 1.05	166
1b (surge max – hypothetical off-model)		350 - 500
2 (extreme surge)	Social contact halved to 17, R0 = 1.19	1000
3 (Reasonable worst-case scenario)	no social distancing, R0 = 2.38	15000

220. The original DoH NI modelling paper has already been referred to in this statement. It was suggested that scenario 1b was a likely scenario. It was clear, if that suggestion turned out to be correct, that the number of patients with Covid-19 infection requiring admission to critical care could not be met by the existing critical care capacity and that a major reconfiguration of the Belfast Trust's critical care service would be required.

221. Key planning priorities at this stage included identification of:

- additional critical care bed capacity and suitable locations for critical care beds outside existing ICU facilities
- appropriately trained staff (medical, nursing, allied health professionals) and training requirements for additional staff
- additional equipment & pharmaceuticals (e.g. ventilators, dialysis machines, infusion pumps)

222. The Belfast Trust had several critical care objectives to meet from March 2020 including:

1) provision of critical care for patients with severe Covid-19 infection

2) ongoing delivery of critical care in the Regional Intensive Care Unit (RICU), which is the regional centre for services including neurocritical care, trauma and orthopaedics, interventional cardiology, thoracic surgery, vascular surgery, as well as providing critical care for Belfast Trust patients
3) provision of cardiac surgery

223. Due to the highly infectious nature of the SARS-CoV-2 virus, strict infection control measures were necessary to protect non-infected patients. This required physical separation of Covid-19 and non-Covid-19 patients. The Belfast Trust developed a staged plan to manage increasing numbers of critically ill patients with Covid-19 infection. The initial step in the surge plan was to maintain normal critical care services on all four sites by utilising two isolation rooms on ward 7A RVH (Infectious Diseases) as additional critical care beds. This capacity was exceeded on 30 March 2020 and the Belfast Trust implemented the next stage of its surge plan and opened the Mater ICU for critically ill Covid-19 patients.

224. The Mater ICU had discharged non-Covid-19 patients from 14th March 2020, before admission of the first critically ill patient with Covid-19 infection on 23rd March 2020. This location was chosen to facilitate the ongoing provision of critical care services for regional specialties in RVH and BCH. However, the Mater ICU had a maximum capacity of 6 beds. This capacity was exceeded on 30th March 2020 and a second location was opened In the Mater hospital in the Day of Surgery unit on 31 March 2020. While this location did not conform to the technical standards required of a critical care unit, it provided the space to ventilate up to 12 patients.

225. On 2 April 2020 there were 12 critically ill patients with Covid-19 infection in the Mater hospital. However, provision of critical care for these patients in two separate locations in the Mater (ICU & Day of Surgery unit) was too difficult to support with the human resources available. Consequently, on 3 April 2020, the smaller of the two Mater locations (the Mater Hospital ICU) was closed and the 6 patients were transferred to the BCH ICU. At this stage, it was planned that the Mater Day of Surgery Unit would continue to care for up to 9 patients with Covid-19 resulting in critically ill Covid-19 patients potentially being treated across 3 sites, BCH, Mater and RICU (patients with Covid-19 infection who also had a medical condition requiring treatment in the regional centre).

226. However, on 6 April 2020, due to the increasing number of Covid-19 patients, all critically ill patients in the Mater Hospital were transferred to the BCH ICU, along with staff. There was thereafter no ongoing critical care service in the Mater for a period. Instead arrangements were put in place to facilitate the short-term ventilation of critically ill patients who presented to the Mater Hospital with Covid-19 infection, prior to transfer to an ICU in another hospital. It was planned that BCH ICU could expand to accommodate 15 patients initially and, if required, beds could be opened in a post-operative recovery ward to accommodate a further 7 patients. This would allow for up to 22 critical care beds in BCH ground floor.

227. Utilising BCH ICU for further surge capacity would protect the regional critical service in RICU. Any further increase in critical care beds for patients with Covid-19 infection would require the reconfiguration of additional ward areas in the BCH Tower Block. These additional clinical areas, while providing space, were not compliant with standards for a critical care facility e.g. frequency of air exchanges.

228. On 7 April 2020 the second floor in the BCH Tower was modified and prepared to function as a critical care area with potential capacity for twenty-four more critical care beds. The maximum demand for critical care for patients with Covid-19 patients in Belfast Trust in the first wave of the pandemic occurred on 11 April 2020 with 22 Covid-19 positive patients being treated. These patients were located in BCH ground floor ICU and the second floor of the BCH Tower Block.

229. On 16 May 2020 the number of patients requiring critical care had reduced sufficiently to permit the remaining patients critically unwell with Covid-19 to be transferred to the Mater Hospital and allow re-commencement of elective surgery in BCH. Upon relocation of the Covid-19 critical care to the Mater Hospital, the ICU in the BCH Hospital was temporarily closed until it re-opened as a 'green' pathway for major elective surgery on 14 July 2020.

230. The last patient requiring Covid-19 related critical care in the Mater Hospital was discharged from ICU on 10 July 2020. There was thereafter a period of several weeks when there were no patients with Covid-19 infection requiring critical care in Belfast Trust. A small number of cases presented at the end of August 2020 and were initially managed in the Day of Surgery recovery ward in the Royal Victoria Hospital, separate from RICU. This area could accommodate a maximum of three patients if required.

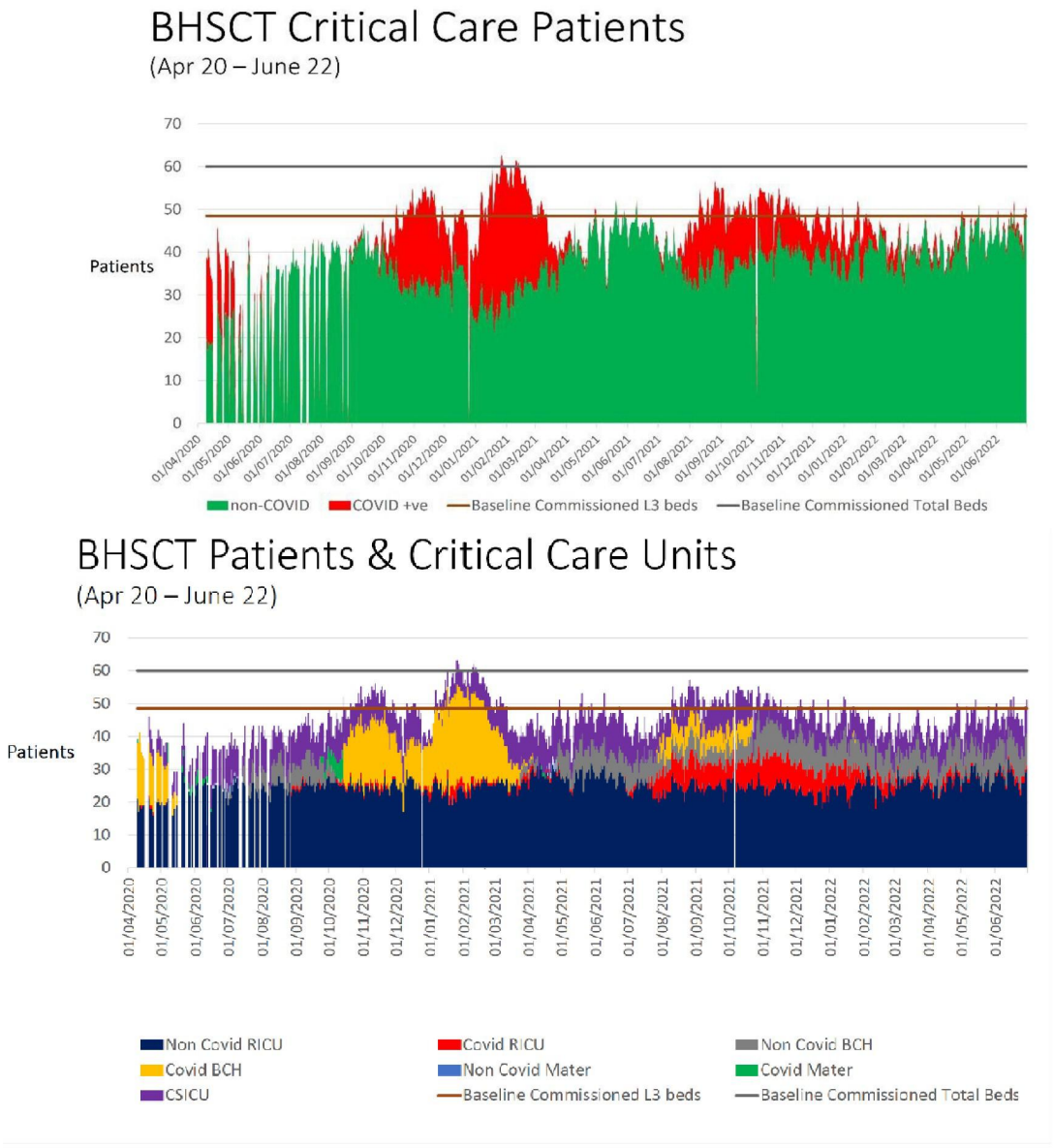
231. On 24 September 2020, the Belfast Trust relocated the critical care unit for patients with Covid-19 infection to the Day Procedure unit at the Mater Hospital, transferring two patients from the RVH. However, by 13 October 2020 there were 9 Covid-19 patients requiring critical care in the Mater Hospital. They were transferred to the BCH ICU and the 2nd floor of the BCH Tower was reopened once again as a temporary critical care unit for patients with Covid-19 infection.

232. Due to increasing Covid-19 patient numbers in November 2020, the BCH ICU further expanded to the 3rd floor of the BCH Tower Block, providing an additional 12 beds with a total capacity of up to 36 critical care beds.

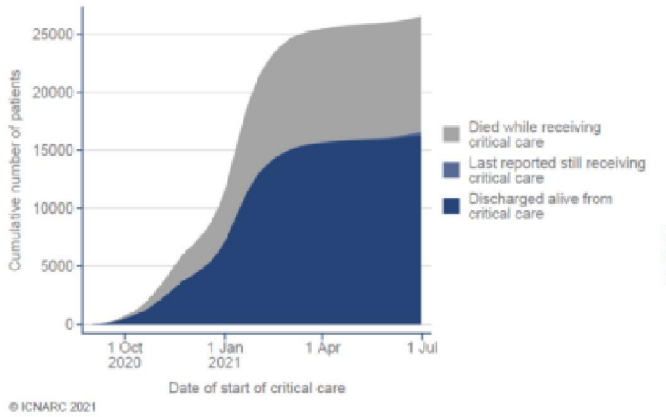
233. In February 2021, there was expansion into the 3rd floor in the BCH Tower Block which would provide a further 12 critical care bed spaces increasing capacity to 48 beds. The maximum number of patients in the BCH occurred on 3rd-4th February 2021 (29 patients). During this time, there continued to be a number of patients with Covid-19 infection requiring treatment in RVH RICU due to the requirement for the regional specialist service provided on that site, and the occasional Covid-19 patient required treatment in CSICU. The maximum number of adult Covid-19 patients requiring critical care in Belfast Trust was reached on two occasions; 21 and 25 January 2021. Thirty-three patients were managed between BCH and RICU (21 Jan: BCH 27, RICU 6/ 25 Jan: BCH 28, RICU 5).

234. There was a gradual reduction in the number of critically ill patients with Covid-19 over the ensuing weeks. In April 2021, the BCH ICU started admitting non-Covid patients requiring major elective surgery.

235. From April 2021 until the latter half of July 2021, there was an intermittent, small requirement for critical care for Covid-19 patients in Belfast Trust. During that period RVH RICU became the critical care site for patients with Covid-19 infection. (The RICU service had moved into a new purpose-built 32-bedded unit in November 2020 with patients being nursed in single rooms, as well as having additional isolation facilities.) Between August 2021 to December 2021 there was a median of 7 and maximum of 11 patients with Covid-19 in RICU.



236. During the period from 20 March 2020 to 31 December 2022, 413 patients with Covid-19 infection were admitted to critical care in Belfast Trust. Of these 413 patients, 331 patients were discharged from critical care, and 82 patients died in critical care. This was an ICU survival rate of 80.5% (UK data, excluding Scotland, reported a ~63% survival rate up to June 2021).



ICNARC Report on COVID-19 in critical care: England, Wales & N.I., 6 July 2021

Figure 34. Cumulative outcomes *

Cumulative outcomes for patients critically ill with confirmed COVID-19 admitted from 1 September 2020 to date by date of admission to critical care.

237. Decisions taken to increase ICU capacity in the Belfast Trust were taken at several levels. In February/March 2020 the critical care network led on the regional surge plan. The number of critical care beds each HSC Trust was expected to deliver to meet the regional demand was identified. In addition, Belfast Trust had created the Covid-19 Oversight Group to prepare for, and lead on, the delivery of services during the pandemic. Local planning was undertaken by the ACCTSS Divisional teams with input provided by the Covid-19 Oversight Group. The Covid-19 Oversight Group endorsed all decisions relating to relocation of critical care to Hospital sites.

238. *Nurse staffing*. Critical care staffing models are based on professional standards e.g. Faculty of Intensive Care Medicine (GPICS). A Level 3 ICU bed requires 1 nurse:1 patient, and a Level 2 bed requires 1 nurse: 2 patients. Belfast Trust nurse staffing has always been based on this model.

239. In March 2020, the Mater and BCH ICUs had 71.12 WTE registered nursing staff available for the commissioned beds, as detailed below. (Band 2 and 3 staff are considered non-registrant).

Band	BCH	Mater
8A	1	0
7	2	1
6	22.01	19.06
5	18.15	8.9
3	4	0.5
2	1	1
Total	47.16	30.46

240. Each Level 3 ICU bed requires 4.48 WTE critical care nurses (registrant) per week to deliver care. Therefore, 16 Level 3 beds could be appropriately staffed with the combined nurse staffing from the Mater ICU and BCH ICU sites. Once this number of beds was exceeded, additional staff would need to be redeployed into critical care from other clinical areas, or nurse staffing ratios would have to deviate from professional standards.

241. The Belfast Trust was required to maintain commissioned capacity of 19 Level 3 and 8 Level 2 beds in RICU. On 25 May 2020, an additional Level 3 bed was opened in RICU as part of the reallocation of beds from the Mater site to accommodate additional surgical demand from BCH.

242. It was clear that planning for a huge increase in staffing numbers, including medical, nursing and allied health professionals, would be required to deliver care for the anticipated number of patients. A major concern was that the

additional staff required were unlikely to have the knowledge or skills necessary to care for critically ill patients, which would be a significant risk to patient care.

243. It was also evident in the early stages of the pandemic the Level 3 / Level 2 classification of critically ill patients could not be applied in the setting of Covid-19 infection; each patient required care by 1 nurse. The additional burden for staff wearing PPE in critical care had an impact upon staffing arrangements, as there was a maximum time staff could wear PPE.

244. Upon opening Covid-19 critical care beds in the BCH Tower on floor 2, a new nurse staffing model was established based on opening beds in 'pods' of

4. This model was based on 2 critical care nurses per pod with the support of additional redeployed registered nurses. The staffing numbers per pod of 4 patients are detailed below:

Model of required Staff					
	Number of Beds				
Staff member required	**4**	**Hours /day**	**Total hours / day**	**Total hours / week**	**WTE Staff per week required**
Critical Care Nurse	2	24	48	336	8.96
RN	3	24	72	504	13.44
HCA	1	24	24	168	4.48

Nurse in Charge (4 pts)	0.5	24	12	84	2.24
Total					**29.12**

245. At its peak, the Belfast Trust achieved the capacity for 75 ICU beds; [BCH 38 beds, RICU 32 beds, CSICU 5 beds]. As all beds in the BCH Tower Block were utilised as Level 3 beds, Belfast Trust was providing the equivalent of 68 Level 3 beds across the BCH and RVH i.e. the Belfast Trust was delivering 183% of its commissioned Level 3 capacity.

246. Based on the above, and utilising the modified staffing model, the table below shows that 276.64 WTE were required to staff the 38 BCH beds.

9.5	**Multiplier**				
	Number of Beds				
Staff member required	**38**	**Hours /day**	**Total hours / day**	**Total hours / week**	**WTE Staff per week required**
Critical Care Nurse	19	24	456	3192	85.12
RN	28.5	24	684	4788	127.68
HCA	9.5	24	228	1596	42.56
NIC (4 pts)	4.75	24	114	798	21.28

Total		**276.64**

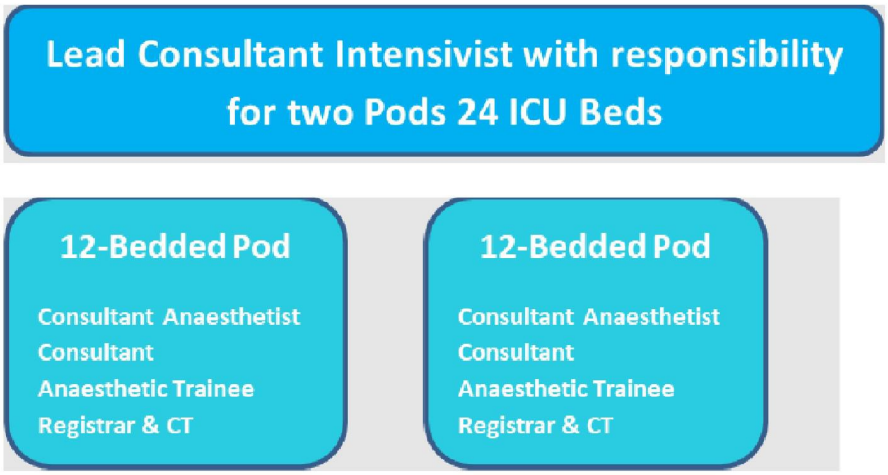
247. Thus, at peak surge, the Belfast Trust had a shortfall of 199.02 WTE staff from its baseline staffing in March 2020. The maximum number of nursing staff redeployed to critical care was 245.82 WTE. During the pandemic 60% of redeployed staff came from the Belfast Trust's perioperative staff, theatre sessions within the Belfast Trust had to be extensively restricted. At the peak of the pandemic, all surgery on the Mater and BCH sites was ceased. Emergency surgery was provided on the BCH site for Covid-19 inpatients requiring emergency surgical procedures.

248. Staff redeployed from other areas needed to be upskilled and received fundamental training in the basics of critical care. Focused critical care training was provided out of necessity as "just in time training". The objective was to train as many staff as quickly as possible. Between March and April 2020, seven hundred and fifty nursing staff completed critical care nursing practice training, involving a combination of theory and practical skills and expanding the ABCDE approach. As the pandemic progressed constant feedback was taken from nurses who had been trained and redeployed into Critical Care. To facilitate this training, staff had to be released from their usual place of work and a downturn of work in these areas was required to facilitate this training.

249. Severe hypoxic respiratory failure was a feature of many of the critically ill patients with COVID-19 infection. Nursing patients in the prone position was an important aspect of the management of this clinical problem. It was anticipated a significant number of patients would require to be nursed in the prone position on a regular basis. This manoeuvre can involve 6-8 staff members Given the pressures on nursing and medical staff to maintain the number of beds required it was not possible for these staff to also be responsible for proning. 38 Allied Health Professionals were redeployed to support, and specific training was provided. The Belfast Trust was supported by twenty members from the military

for a 4-week period from 2 February 2022. Whilst they were not registered healthcare professionals, they assisted in Health Care Assistant roles.

250. *Medical staffing*. Medical staff also needed to be redeployed from other areas to cope with demand. A working group was established to identify medical staff who could be utilised in critical care. A surge plan was developed for medical staffing based on 'pods' of 12 beds and staffing as follows:



251. Consultants and trainees, principally from anaesthesia, but also from some of the specialties whose clinical activity had been reduced, were redeployed to work with critically ill Covid-19 patients. From 18 March 2020 a focused training programme for the medical staff (from outside the Division of Anaesthesia, Theatres and Critical Care) was delivered to familiarise these doctors with the key essential information they may need to look after the critically ill Covid-19 patients. Thirty Consultant/SAS doctors and forty trainee doctors were redeployed from other specialties to work with Covid-19 patients at the Mater Hospital, BCH and RVH sites. Most of the support from Consultant/SAS doctors was stood down by the end of April 2020 and the support from trainee staff stood down in May 2020. From October 2020 until March 2021 support from

other clinical specialties was limited to trainee doctors, with between four and eight trainees being redeployed to the BCH ICU.

252. The responsibility of caring for patients who were critically unwell with Covid-19 lay with the funded staffing cohort within Anaesthetics and Critical Care. During this time, the staff adopted significantly different working patterns, including fulltime resident consultant staffing, from job-planned rotas to ensure units had appropriate medical cover.

In relation to the hospital's ICU capacity during the relevant period:

a. summarise the steps taken by the hospital to try and ensure ICU capacity, when the ICU reached:

i. 85% capacity;

ii. 92% capacity;.

iii. 100% capacity;

253. The Belfast Trust had a baseline commissioned capacity of 37 Level 3 and 23 Level 2 beds across the 4 adult critical care areas. To address the demands of the Covid-19 pandemic, the Belfast Trust increased critical care capacity in line with the CCaNNi surge plan. The Belfast Trust opened additional critical care beds in pods at predetermined patient numbers as per the surge plan below. The surge plan was based on the number of Level 3 patients being cared for in the Belfast Trust (excluding CSICU). The Belfast Trust was to manage demand locally up to a maximum of 67 Level 3 patients. When the number of patients exceeded this, the Belfast Trust was expected to trigger a regional escalation plan in which healthcare staff from other HSC Trusts in Northern Ireland would be required to staff the additional critical care beds. The

level of escalation on the surge plan was reviewed daily, both within the Belfast Trust and with CCaNNi.

Steady State Level 3 Equivalent		**34.5**
Local Escalation	**Level 1**	**40**
Local Escalation	**Level 2**	**54**
Local Escalation	**Level 3**	**66**
Regional Escalation	**Level 4**	**68**
Regional Escalation	**Level 5**	**80**
Regional Escalation	**Level 6**	**92**
Regional Escalation	**Level 7**	**104**

254. Between 9 April 2020 and 31 December 2020, the Belfast Trust exceeded baseline Level 3 commissioned occupancy on 50 days. During 2021, the Belfast Trust exceeded baseline Level 3 commissioned capacity on 112 days. Peak Belfast Trust critical care occupancy during the pandemic occurred on 5 February 2021 with 54 patients in critical care (BCH - 27; RICU - 27). At this time, the Belfast Trust was operating at 145% capacity of commissioned Level 3 occupancy.

255. At various stages, additional 12 bedded ICU areas were opened in BCH Tower Block on floors 2 & 3. At maximum surge, the BCH Tower Block was able to provide an additional 48 physical beds. These beds were in addition to the capacity provided in the RVH Regional Intensive Care Unit which fluctuated between 28 and 34 beds. At peak surge, the Belfast Trust had 75 ICU beds

available, the number of staffed beds were as follows; 38 BCH, 32 RICU and 5 in CSICU. During maximum surge, when the region was under pressure for critical care capacity, a schedule for admissions was circulated by CCaNNi to inform HSC Trusts of the sequencing for admissions.

b. whether clinicians expressed concerns regarding the impact of operating at 85%, 92% and 100% capacity on patient safety;

256. Clinicians did express concerns about working above capacity in relation to staffing skill mix, availability of equipment, and only being able to deliver care based on the principal of doing the best for the most. There were concerns expressed that professional standards were not being met and that critical care was being provided in areas that did not meet the standards for a critical care unit. The new clinical areas required patients to be nursed closely together which, on occasions, facilitated the spread of hospital-acquired infections including Clostridium difficile (or C diff), Glycopeptide Resistant Enterococci (or GRE), and Carbapenemase-Producing Organisms (or CPO). In addition, these clinical areas had inadequate provision of isolation facilities in which such patients should have been nursed.

With the resources available at that time, Infection, Prevention Control (IPC) procedures were performed to the highest standards practically possible given the forced physical footprint of the Nightingale ICU . Senior ICU clinicians, nursing staff and IPC colleagues completed regular reviews and risk assessments, with appropriate reporting and escalation to the Public Health Agency.

c. whether the hospital transferred patients in need of intensive care to ICUs at other hospitals, and if not, why not.

257. How the hospitals within the Belfast Trust were utilised collectively has been discussed earlier in this statement. Throughout the pandemic the Belfast

regularly accepted patients from other HSC Trusts across Northern Ireland. CCaNNi published and updated admission schedules indicating to which units patients (both Covid-19 and non-Covid-19) were to be admitted in absence of capacity in the base hospitals. The Belfast Trust participated fully in the

CCaNNi scheduling process. This schedule, involving all of the HSC Trusts in Northern Ireland, indicated to hospitals when to expect admissions to ICU.

Whether the hospital was part of a Critical Care Network and if so:

a. the number of patients transferred to the ICU of a different hospital during the relevant period;

b. the number of patients transferred from a different hospital to the hospital's ICU during the relevant period; and.

c. whether the hospitals identified in your response to a. and b. above were within or outside the Critical Care Network of which the hospital was a member.

258. All of the hospitals within Northern Ireland were part of the Critical Care Network for Northern Ireland.

- **2020** – Belfast Trust received 166 admissions from 213 regional transfers related to Covid-19, which represented 78% of transfers. Belfast Trust transferred 23 patients to other hospitals related to Covid-19, this represented 10% of transfers. In relation to Non Covid-19 transfers, the Belfast Trust received 113 admissions from 213 transfers which represented 53% of transfers and shows the Belfast Trust was still accepting regional non Covid-19 referrals throughout the pandemic.

- **2021-** Belfast Trust received 172 admissions from 341 transfers related to Covid-19, this represented 50% of 2021 transfers. In totality, Belfast Trust transferred 119 patients to other hospitals in the same period, this represented 35% of transfers. In relation to Non Covid-19 transfers, the Belfast Trust received 167 admissions from 325 transfers, this represented 51% of transfers.

- **2022-** Belfast Trust received 30 admissions from 43 transfers related to Covid-19, this represented 70% of transfers in 2022. In totality, Belfast Trust transferred 8 patients to other hospitals, this represented 18% of transfers. In relation to non covid-19 transfers, the Belfast Trust received 129 admissions from 180 transfers, this represented 71% of transfers.

In relation to medical equipment/ medicines set out any issues (for example shortages of equipment, the practicalities of obtaining additional supplies, problems arising from outdated buildings and infrastructure) the hospital experienced regarding:

a. ventilators;

259. Within Belfast Trust there was existing equipment available at the start of the pandemic, this was collated from the 4 Hospital sites (BCH, MIH, MPH and RVH) and supported the increase in critical care beds. Ultimately a total of 75 Critical Care bed spaces were set up in the BCH Tower Block, and the existing equipment utilised was as follows,

- 67 Ventilators -Various makes/models
- 28 Anaesthetic Machines – Various makes/models
- 313 infusion/syringe pumps - Various makes/models
- 75 High Acuity Monitors - Various makes/models
- 48 Feeding pumps
- 14 Blood Gas Analysers
- 8 Ultrasound Machines
- 9 CRRT Machines
- Associated consumables

Total amount of Belfast Trust equipment after procuring via capital and revenue schemes (Local Belfast Trust response)

	BHSCT
Type of equipment	Onsite

Ventilator	126
Portable vent	22
Anaesthetic machine	76
Monitor	203
Pumps	1,336
Ultrasound machine	**50**
CRRT	**23**
Temperature management	**13**

Further equipment was allocated to Belfast Trust from CCaNNI (Regional response) and further equipment allocation from NHS England stock allocation (National Response).

b. CPAP machines;

260. The Belfast Trust was allocated an additional 159 CPAP machines from NHS England stock. The majority of this equipment was returned as it was not needed. In critical care CPAP was generally not used as the majority of patients were managed via a mode of ventilation.

c. oxygen, including the supply of piped oxygen to beds;

261. The increased demand for oxygen on all sites was extensive. A NHS England Estates and Facilities Alert indicated that demand from multiple wall oxygen outlets may exceed the maximum capacity of the VIE delivery system [Vacuum Insulated Evaporator; main storage vessel for bulk medical oxygen supply]. This had the potential to cause a rapid drop in the pressure in oxygen supply pipes, leading to a failure of oxygen delivery systems throughout the hospital, including to patients on mechanical ventilation. There was also a risk of rapid and unpredictable depletion of the VIE. Therefore, close monitoring of

oxygen consumption was required, and additional oxygen generators were installed to meet predicted demand. Ultimately, no oxygen supply issues were encountered at any stage.

262. Extensive work was required in both the Mater Hospital and BCH sites to ensure piped oxygen was available at the bed spaces where ventilated patients were likely to be managed. In order for MIH DPU, BCH Day of Surgery Unit, and the second and third floors of the BCH Tower Block to be suitable for critical care patients, the medical gas infrastructure had to be reviewed and additional outlets installed for Medical 4bar Air, Vacuum and Oxygen at each bed space. Estates installed additional Oxygen and Air for each bed space where possible.

d. renal replacement therapy machines;

263. Renal failure was a frequent complication in critically ill patients with Covid-19 infection, with 25-30% of patients requiring dialysis. Dialysis was provided by either a continuous renal replacement therapy (CRRT) or intermittent haemodialysis (IHD). IHD requires the availability of dialysis water points to connect to the dialysis machines. Apart from the renal unit, these points were not provided on the wards in the BCH Tower Block. Therefore, additional dialysis water points had to be installed on each floor to ensure that intermittent haemodialysis could be provided when indicated.

e. any other medical equipment or medicines such as anaesthetic drugs

264. The Belfast Trust's pharmacy procurement team ensured that there were no shortages of any medications required by critically ill patients in the Belfast Trust. Plans had been drawn up for alternative treatment strategies in the event of shortages of key medications (e.g. sedatives and muscle relaxants), but these did not require to be implemented. When Remdesivir was identified as

a drug of outcome benefit in patients with Covid-19 infection, its availability was determined by national allocation.

265. During the early period of the Covid-19 pandemic, there was an international shortage of replacement fluids for continuous renal replacement therapy. However, the critical care staff liaised with the nephrology service and arrangements were put in place for patients who required dialysis to receive intermittent haemodialysis if CRRT could not be provided. There is no clear evidence that outcomes from intermittent dialysis are inferior to those with CRRT. No patients were required to undergo peritoneal dialysis, however there was significant use of intermittent haemodialysis for patients in ICU, facilitated by the renal dialysis team.

f. Buildings and Infrastructure

266. To support MIH DPU, BCH Day of surgery Unit, and floors 2 and 3 in the BCH Tower Block to open additional critical care beds, the medical gas infrastructure had to be reviewed with additional outlets installed by estates for Medical 4bar Air, Vacuum and Oxygen at each bed space. Additional power outlets were required and installed; 4 gang extension leads were deployed where this was not possible. There were no UPS/IPS sockets installed due to limited resources and time pressures, this is a recommendation under HBN 04-02.

267. Between May and August 2020, there was preparation for Surge 2 with the reconfiguration of floor 2 in the BCH Tower Block, remedial estates work was completed in clinical areas post surge 1, including two new designated fluid storage areas, one new large store, and improved donning and doffing areas.

268. In September 2020 there was a plan to move the ICU in the Dempsey Building to Ward F to enable an increase from 6 to 14 beds. Estates works were completed to prepare the area for use. Due to the increase in the number of beds required, BCH Tower Block remained the Covid-19 Critical Care unit.

269. In October 2020 Floor 2 in the BCH Tower Block opened as a Critical Care floor with capacity for 24 patients.

In November 2020 Floor 3 in the BCH Tower Block was prepared for a further 24 beds.

270. Ultimately a very significant effort from staff meant that ways were found to make sure there was sufficient equipment, and that buildings were adapted sufficiently to cope with what was occurring.

An outline of what use, if any, the hospital made of any agreement with the private healthcare sector to provide services for NHS patients during the pandemic, including to:

a. ***increase staffing capacity.***

271. I am not aware of any agreement with the private healthcare sector to provide additional staffing capacity for the Belfast Trust. Private healthcare staff did support the elective surgery lists delivered at private healthcare facilities referred to in response below.

b. ***ensure an adequate supply of medical equipment.***

272. There was no agreement with the private healthcare sector for supply of medical requirement.

c. ***maintain treatment for non-covid conditions; and***
d. ***carry out elective surgery.***

273. In March 2020, the then regional Health and Social Care Board (or HSCB) (HSCB was stood down on 31 March 2022, with its responsibilities transferred into the DoH NI), in partnership with Health and Social Care Trusts, negotiated

and established regional agreements with local private healthcare sector providers to provide elective care services for cancer and time critical inpatients and daycases. This was delivered through weekly operating lists at private provider facilities.

274. The first contracts were signed as follows:

Kingsbridge Private Hospital	14 April 2020*
North West Independent Hospital (NWIH)	21 April 2020
Ulster Independent Clinic (UIC)	05 May 2020

** (Independent Sector signatory 352 Medical Group Ltd re: Kingsbridge Private Hospital at 811-815 Lisburn Road, and facilities at 6 Lisburn Road)*

Subsequent contracts were issued:

Kingsbridge Private Hospital	30 June 2020 to 31 March 2021
NWIH	30 June 2020 to 31 March 2021
Ulster Independent Clinic (UIC)	30 June 2020 to 31 March 2024
Kingsbridge Northwest (formerly NWIH)	01 August 21 to 31 March 2022**

*** (Independent Sector signatory 352 Medical Group Ltd re: Kingsbridge Private Hospital at 811-815 Lisburn Road, facilities at 6 Lisburn Road, and Kingsbridge Private Hospital North West at main street Ballykelly)*

275. The arrangements established with the above providers enabled HSC Trust surgeons to access operating lists at the private hospitals for elective NHS cancer and time critical patients. Surgeons operated as part of their NHS contracted time, with the nursing and other clinical and support staff provided by the Independent Sector providers.

276. During the period from 1 March 2020 to 28 June 2022, for Belfast Trust, 4,522 NHS cancer and time critical inpatients and daycase patients were treated at the private facilities above under the regional agreement.

277. Belfast Trust staff accessed facilities at Ulster Independent Clinic from March to July 2020 for the delivery of ambulatory outpatient services with 1,840 patient attendances in the period.

278. The Belfast Trust also had an agreement with Hillsborough Private Clinic from 6 April 2020 until 28 April 2020 for the treatment of NHS referred patients. 110 daycase patients were treated in that period.

279. The Belfast Trust also had separate contracts in place with Private Independent Sector providers during this period for delivery of assessment and treatment of NHS referred patients for cancer and time critical conditions.

280. In summary 10,372 Inpatient and Daycases, 2,547 new outpatients assessments (and 7,347 pre-op/post-op/and follow up review care attendances) and 32,907 diagnostic tests were delivered under these contracts for the period 1 March 2020 to 28 June 2022.

Infection Prevention and Control (IPC)

281. The Belfast Trust followed regional guidance, which was provided by the regional IPC Cell (a group established during Covid-19, chaired by PHA). The Belfast Trust did not form its own guidance. Regional ICU developed their own

derogated risk assessment in October 2020. RBHSC implemented its own derogated risk assessment in PICU. In May 2021, testing prior to having an Elective procedure was introduced. The Belfast Trust took the decision that elective patients, who had a positive Covid-19 test within 90 days of their planned procedure but who were out of isolation and asymptomatic, did not require this screening based on best evidence due to the risk of false positive tests which could lead to the unnecessary cancellation of their procedure.

Whether the hospital had sufficient capacity within its IPC team(s) to respond to the needs of your service. If not please explain:

a. **What the hospital did to expand the capacity of those IPC teams?**

282. An Infection Prevention and Control or IPC Nursing Team Workforce Review was undertaken in September 2019 due to the increased workload demands on the IPC service pre-pandemic. This review recommended recruiting additional staff to meet these increasing demands and a Business Case was submitted. However, it was not funded.

283. In 2020, the PHA directed that the Belfast Trust IPC team was to provide Covid-19 IPC support to Care Homes, Independent Sector Homes and Supported Living Facilities (in total an additional 4,100 patients/clients). A request was submitted to PHA for funding to recruit additional IPC Nurse staff to meet this need. This specialist expertise was not available outside the IPCN Team, and staff within the team were already designated to support Care Homes, which meant their posts were back-filled by temporary appointees who required training and support, adding further pressure to the IPCN Team. Non recurrent funding was received from the PHA to support this change. The Belfast Trust appointed a Band 8A Lead IPCN to support the Community Team and a Band 7 IPCN. In November 2020, the PHA asked the Belfast Trust to submit a renewed Business Case to inform a regional review of IPCT funding.

The Business Case was submitted to the PHA, but no recurrent funding followed.

284. Key actions that were taken to expand the capacity of the IPC team included:

- Non-IPC nurses redeployed from other departments on a short-term basis. Training and support was provided to redeployed staff by the IPCNs.
- IPCNs were allocated to all major sites in the Belfast Trust to ensure IPCN presence, and also to reduce the risk of nosocomial spread among the team.
- As described, non-recurrent funding from PHA supported the recruitment of Band 8A x1 and Band 7 x1. The IPCT prioritised essential work to increase capacity in the team.
- MS Teams was invaluable to run outbreak meetings and education as required.
- Unfortunately, the Infection Control Doctor (ICD) provision was reduced from1.0 WTE to approximately 0.5 WTE due to the concurrent maternity leave of two 0.25 WTE ICDs leading to a 50% reduction in ICD capacity for approximately 1 year during the pandemic.

b. How successful these actions were

285. The redeployment of additional staff to the IPC team was welcome but unfortunately provided limited additional support. Staff tended to be redeployed for short periods of time and therefore developed limited, basic IPC skills. This was demoralising to the IPC team due the repeated cycles of induction and

training with staff moving back to their permanent roles after short periods of time.

(i) why staff were redeployed for short periods of time?

The IPC Nursing team is a small team that provides IPC Nursing advice Trust wide, including the community. At the onset of COVID, a business case had been developed to increase the capacity of the team in order to enable them to deliver their work plan. At the same time, the team were experiencing significant staffing pressures as a number of senior staff had retired within a short period of time. The remaining members of the team were more junior, less experienced and required significant support and this added to the work force related pressures within the team.

Staff were redeployed from other services that were paused during the early stages of COVID, for example, Ophthalmology Outpatients, to assist the IPC Team with providing staff with PPE training. This was to allow IPC Nurses to provide specialist IPC advice. Deployed staff required to be trained by IPC so that the advice they gave to Trust staff was accurate and up to date with continually evolving IPC guidance. They were deployed to the IPC team for 6 to 8 months. When their service restarted, they were called back to their area of employment. This was frustrating for the IPC team as new staff were then redeployed as they became available from other services or the nurse bank, and the cycle of induction, training and supervising a new cohort of staff with no previous IPC experience began again. This added to the pressures experienced by the team.

A Letter from the CMO, dated 15th May 2020, outlined expectations from Trusts, to address the challenges now faced in the Care Home sector in order to maximise opportunities to control outbreaks through effective infection prevention and control, and correct use of PPE. The IPC team were asked that when a new outbreak was notified, that a senior Infection Prevention Practitioner visited the Care Home and made an onsite assessment of the homes IPC practice and made arrangements for training or onsite support if that was required, including the testing of staff and/or residents. There was no capacity within the team to provide this service, redeployed staff were trained and utilised to assist with the provision of this service, however they also required the advice and support of the IPC team, as this role was new to them. This request from PHA increased the already heightened work force pressures on the IPC team. Money was made available to the team to recruit staff to provide support to the care Homes, however, the experienced IPC staff from within the team needed to be deployed into these roles as staff with IPC expert knowledge did not exist outside the team. The positions of these staff was them filled by bank and agency staff, these staff required training and additional support.

(ii) whether the period of redeployment was extended in the event that concerns were raised by the IPC team about the length of redeployment?

The concerns of the IPC team regarding staffing pressures during COVID were escalated to the Executive Director of Nursing for Nursing and User

Experience. The period of redeployment for staff, who were not required to return to their areas of work to restart a service, was requested from their manger and an extension agreed. Bank staff were offered and given 'block bookings' of 3 months. However these staff could often only commit to working 1 or 2 days per week which made work planning difficult.

286. Reconfiguring the team across multiple sites impacted on the flexibility to move IPC resource as required. In addition, because the demands on the IPC team were so great, their actions became more reactive in that they focused on halting transmission, rather than proactively focusing on prevention of nosocomial infection. Use of MS Teams provided a digital resolution to providing training and allowed the IPCNs to attend multiple outbreak meetings daily. There was however, limited opportunity for the team to de-brief after incidents.

A summary of how the hospital disseminated and implemented IPC guidance to its staff including notifying staff when changes were made to IPC guidance during the relevant period

287. Rapid changes in guidance, particularly in the first surge of Covid-19, resulted in the interpretation and dissemination of guidance to staff being, at times, challenging. The Belfast Trust disseminated and implemented IPC guidance to its staff (including notifying staff when changes were made to IPC guidance) in the following ways:

Digital Resources:

- Covid-19 Oversight Group disseminated guidance updates to all users via email and corporate communications messaging.
- A Covid-19 section was created on the Trust Hub which centralised

information and linked with the IPC Team page and PHE. Alerts were placed on items on the Hub so staff knew what information was 'new'.

- Presentations and embedded resources were available on the Trust Hub and updated as guidance changed. These resources were

emailed to the Independent Care home managers and support team for dissemination.

- The IPCT created posters to aid staff to safely Don and Doff PPE, which were available on the Hub. Circulation of amended posters occurred through Divisional and HCAI group members.

Educational sessions:

- January and February 2020. IPC Link person meetings (RVH, MIH, MPH, Community and Mental Health) raised awareness of Covid-19.
- February 2020 to April 2020. Commencement of weekly education sessions.
- April 2020. Commenced 'Zoning' strategy, the IPCT visited all acute wards with updates and provided educational resources to all wards.
- December 2020 – February 2021. Undertook weekly "Learning from Covid-19 Outbreaks" educational sessions.
- March 2021 to March 2022. Undertook monthly acute and community (including private care homes) Covid-19 update sessions via MS Teams.
- IPC team attended Belfast Trust and site specific sit rep meetings to provide guidance.

Examples of any difficulties the hospital encountered in disseminating IPC guidance to staff and how the hospital addressed those challenges

288. Changes to IPC guidance were frequently received by the Belfast Trust late in the working week. In the first surge of Covid-19, the Belfast Trust initially shared this information on receipt, but we realised that information going out at weekends tended to cause confusion amongst staff. Learning from this, we tried to disseminate information earlier in the working week.

289. The Covid-19 Oversight Group met with Divisional teams with their Director, initially twice weekly, to coordinate the Belfast Trust response and address their concerns. As part of this arrangement, the Covid-19 Oversight Group also met with the IPC team weekly to address issues and concerns in respect of IPC, and in particular management of nosocomial infection.

A summary of any difficulties the hospital encountered when implementing IPC guidance and how the hospital addressed those challenges

a. The ability to reconfigure Emergency Departments ("EDs"), wards and waiting areas to separate Covid-19 patients from non-Covid 19 patients ("hot" and "cold" areas or equivalent terminology) and visitors

290. The ED departments were unable to implement a one-way system. Due to the differing configurations within all three ED departments within the Belfast Trust, each area implemented individual risk assessments, with input from the IPCT, infectious diseases and clinical teams. The initial assessment for suspected Covid-19 was commenced on presenting to the ED. The Mater ED was for patients with Covid-19 arriving by ambulance, or on transfer from RVH ED. The Mater ED was thus closed to walk in patients. RVH ED was for non-Covid-19 and walk in patients. RBHSC ED expanded into the OP department to manage social distancing and suspected Covid-19 cases.

b. Whether the new layouts, one-way systems or reconfigured wards impacted staffing ratios and the ability of staff to cover all the beds

291. During Covid-19 outbreaks, as a control measure, staff cohorts were created for each positive, contact, and unaffected patient group. This was then reported at the Outbreak Control Group, though this measure was challenging, particularly for night duty, where staffing levels are reduced. Further pressure

was experienced when staffing levels were affected by staff absence due to Covid-19 infection.

c. The number of single rooms to enable isolation

292. The estate of buildings within the Royal Victoria Hospital site varies, and therefore isolation facilities were not readily available in all patient areas (circa 200 side rooms). This constraint, particularly during periods of a Covid-19 surge or increase in Covid-19 outbreaks, led to a delay at times in implementing timely appropriate IPC precautions. Implementing 2m social distancing within bays was challenging as the majority of bays throughout the Belfast Trust contain six beds. To comply with the 2m social distancing guidance, bays would have needed to reduce to four beds, which would have significantly reduced the bed capacity of the Belfast Trust. Where isolation in single rooms was not practicably possible, the Belfast Trust cohorted patients where it was appropriate.

d. Ventilation in wards

293. The Royal Group of Hospitals Estate or RVH site constitutes a variety of buildings ranging from those constructed over 100 years ago to modern day buildings. The primary methodology utilised for heating and ventilating the vast majority of clinical areas is the Heating, Ventilation and Air Conditioning (HVAC) system. This system pulls air through an intake point, conditions it, and then distributes the air through to occupied spaces. There are 206 points of fresh air intake located across the RVH site.

294. There are a number of clinical spaces across the RVH site that have no mechanical ventilation and are completely dependent on natural ventilation (manual opening of windows) to cool the environment and provide air changes

within the ward/department. Acute site side rooms were all assessed by the Estates Team and some areas required work to be carried out to adjust their ventilation flows (RVH Ward 4E and 4F, Ward 5E and Ward 5F).

295. From 2020 to 2023, the Royal Victoria Hospital site was undergoing significant demolition works in preparation for a new children's hospital. This led to a potential increased risk of Aspergillus infection in immunocompromised patients. As part of the mitigations for Aspergillus, windows facing the demolition works were sealed, reducing airflow. This was considered necessary but was contrary to Covid-19 guidance, which advised increasing ventilation by having windows opened.

296. The Belfast Trust therefore engaged Professor Adilia Warris MD PhD FRCPCH FECMM, Antimicrobial Resistance Researcher, University of Exeter to help understand if the risk of Covid-19 infection was greater than that of Aspergillus. The final advice received was that the risk of Covid-19 was not greater than that of Aspergillus to immunocompromised groups of patients. Due to the various patient groups within the various buildings throughout the Belfast Trust, the risk had to be assessed by the individual Service Groups. All wards in the RVH were risk assessed using a risk assessment template. This was a dynamic risk assessment, repeated regularly by the relevant ward managers for their respective wards to ensure the mitigations in place were appropriate to the patient profile. HEPA Filtration Systems could also be requested from the Estates department to assist with cleansing the air. Consideration for HEPA filters formed part of an individual risk assessment for ward areas and could be supplied if identified as a 'high risk' category.

297. Carbon Dioxide (CO2) measurements can be used as a broad guide to ventilation within a space. CO2 monitoring was carried out on two occasions,

September 2021 and January 2022 on several pre-selected wards. On both occasions, results demonstrated the levels to be in the normal range.

Regarding testing as an infection control measure, please set out:

a. When the hospital introduced PCR and/or lateral flow Covid-19 testing for asymptomatic staff and patients, and the reasoning behind the timing of these decisions

298. Asymptomatic patients discharged to care homes were screened for Covid-19 from 25 April 2020. PCR and/or lateral flow Covid-19 testing for asymptomatic staff and patients commenced in January 2021. This was confirmed by the Testing guidance, and as per the 'NI move to the current guidance' communicated by the PHA.

b. **When the hospital first started testing symptomatic patients for Covid-19 with, and then without, a relevant travel history or other risk factors for infection.**

299. The Belfast Trust commenced its own in-house testing for patients who met the symptomatic and epidemiological criteria in February 2020. The Case definition for Testing patients changed on 10 March 2020, as per the CMO's letter, to include patients who met the symptomatic definition, regardless of epidemiological links.

c. Whether there was a shortage of test kits, reagents or other testing supplies during the relevant period?

300. From April 2020 to April 2021 there was a shortage of COBAS 6800/8800 test kits used for diagnostic Covid-19 testing. During the period of the

pandemic, the Belfast Trust was informed every Thursday via teleconference initially, and then via email, from Public Health England (PHE) of the total allocation of these kits for the Regional Virology Laboratory (RVL) for the week ahead.

301. In addition the Belfast Trust was notified on 16 April 2020 of no allocation for MagNAPure reagents and deep well plates which were also on allocation during this period by PHE. These were essential for Covid-19 testing on FLOW lines, which were part of RVL capacity and for essential non-Covid-19 testing.

302. Rapid Covid-19 testing kits, Cepheid used on the GeneXpert were also on allocation to Northern Ireland from May 2020 to June 2021. These were shared across Northern Ireland via Regional Procurement and Logistics Service (PaLS). These test kits were prioritised for certain patient groups (see below) as per the Expert Advisory Group (EAG), DoH NI, Northern Ireland 'Interim Protocol for Testing' (versions 1-9), as demand for this test exceeded supply during this period.

303. There was also a shortage of lysis buffer required to inactivate all samples for Covid-19 testing. However, through PALS the Belfast Trust organised a Direct Award Contract (DAC) for Supply of Lysis Buffer from Queen's University Belfast (QUB) Genomics Core Technology Unit. This DAC was in place from 1 October 2020 to 31 October 2021.

d. Whether there were any negative consequences from delays to test results being available to clinical teams, and in particular, whether this led to onward transmission within the hospital from patients not recognised as being infected.

304. To my knowledge, there was no issue with delays with test results being available. Of note, RVL did not have any delay in turnaround time.

e. Whether individuals in certain staff roles or patients being treated for specific illnesses were prioritised for testing

305. Covid-19 Interim Protocols for Testing, as agreed by Expert Advisory Group on Testing (DoH NI), were followed. This enabled certain staff groups to receive more regular testing under certain conditions. Eg staff working in specialities with vulnerable patients eg oncology and haematology should only be tested regularly if there is evidence of nosocomial spread of infection in the unit.

306. All patient samples were tested, however, some patient groups had priority testing on rapid Cepheid COVID-19 test as follows:

- Emergency haematology/ oncology admissions
- Admission to Regional ICU
- Organ donors and recipients
- Patients attending for primary PCI in RVH for return to host hospitals
- Urgent admissions where patients must be placed in a multi bedded bay
- Urgent surgery / procedures (where waiting for batched test is not appropriate)

Again this was as per Covid-19 Interim Protocols for Testing as agreed by Expert Advisory Group on Testing, DoH NI.

e. **How frequently staff and patients were tested, and the reasons for this frequency?**

307. The Covid-19 Interim Protocols on Testing (Version 1-9) as agreed by the Expert Advisory Group on Testing (DoH NI), was followed throughout the pandemic. There were several versions of this issued as follows:

Version 1 – 3 – Issued *March – 4 May 2020 (Copies not available.)*

Version 4 – Issued 4 May 2020

Version 5 – Issued 23 May 2020

Final Version 6 - Issued 9 July 2020

Version 6.1. Amendment – Issued 23 July 2020

Version 7 – Issued 15 October 2020

Version 8 – Issued 20 July 2021

Version 9 – Issued 6 October 2021.

HSS(MD) 50/2022 of the 'Updated COVID-19 Testing Guidance to Support Clinical Pathways'- Issued by CMO on 08 November 2022

g. If the hospital policy differed from national guidelines at any time, please explain why?

308. Hospital policy did not differ from national guidelines. Covid-19 Interim Protocol as agreed by the EAG on Testing (DoH NI), was followed. Versions 1 to 9 of the protocol were issued between March 2020 and 6 October 2021.

In the event that the hospital experienced nosocomial outbreaks of Covid-19 infection, affecting patients and/ or staff, an explanation of what steps the hospital took in response to such outbreaks. Please explain whether the hospital followed any guidance (whether national or local) in responding to such outbreaks

309. In total, there were 235 nosocomial outbreaks during the relevant time period, of which 165 occurred in hospital sites and 70 in community facilities. In the event of a nosocomial outbreak, the following actions were taken:

- Daily outbreak meetings were held with the relevant Service Group and the IPCT when positive results were identified. The meetings were de-escalated when no further cases were reported.
- The IPCT sent a summary email to update the Covid-19 Oversight Group and PHA about the situation and agreed actions following the meetings. The Service Group completed minutes.
- Opening the relevant ward to new admissions was dependent on the number of patients and staff affected in the outbreak.
- Patients identified as Covid-19 patient contacts were placed in a cohort bay until single rooms became available. There were no new admissions to the cohort bay during this time.
- Face to face visiting was paused during outbreaks on wards until January 2021 as the DOH NI issued guidance to restrict visiting, except in exceptional circumstances.
- PCSS enhanced the cleaning within the ward to three times a day, and using a chlorine releasing agent at the time an increased incidence or outbreak was identified.
- Ward staff completed enhanced cleaning of shared equipment within the ward.
- When a Definitive Nosocomial Acquisition was identified, the application of the 'Covid-19 Interim Protocol for Testing' guidance

prompted a staff screening exercise for core staff to identify any asymptomatic carriers.

- Occupational Health followed up staff members who had tested positive for Covid-19 and advised according to PHE Guidance.
- Occupational Health carried out contact tracing following the identification of a staff member who had tested positive for Covid-19.
- The IPCT advised staff on patient management on receipt of a positive result as per the current PHE Guidance.
- The IPCT advised ward staff to carry out patient contact tracing following identification of a patient who had tested positive for Covid-19.
- The IPCT advised that all staff within the outbreak ward should include a visor as part of their PPE.
- The Service Group continued to carry out daily practice audits.
- Until 2022, outbreaks were closed 28 days (two incubation periods) since the last reported Covid-19 positive result. This was in line with PHA guidance.

Personal Protective Equipment ("PPE") and Respiratory Protective Equipment ("PPE")

A description of the practical steps the hospital undertook to obtain the quantity of PPE and RPE it required and whether these steps changed during the relevant period. This may include details of:

a. requests made of the Trust;

b. requests made of other hospitals and/ or other Trusts;

c. requests made of non Health and Social Care Trust suppliers; and

d. requests from the Department of Health.

The Inquiry is also keen to understand how long it took from making a request for PPE/RPE to the PPE/RPE being delivered to the hospital

The Inquiry understands that during the pandemic, the Business Services Organisation ("BSO") delegated responsibility to the Health and Social Care Trusts for the coordination, management and supply of high demand items, including PPE and cleaning products. Please explain:

a. when the decision to delegate responsibility was taken;

b. at the time the decision to delegate responsibility was taken, the Trust's ability to fulfil these responsibilities for example, ordering the items online, arranging delivery of the items and establishing storage for the items; and

c. whether the delegation of this responsibility affected the supply (both in terms of both quality and quantity) of PPE, cleaning products or other high demand items.

310. . Covid-19 had an unprecedented impact on the global demand for, and supply of personal protective equipment (PPE), and also a selective component of PPE, referred to as Respiratory Protective Equipment (RPE). For the purposes of simplification, when referring to PPE in this answer it will encompass both PPE and RPE, unless the context requires a specific reference to RPE.

311. Coolmore Stores at Belfast City Hospital opened in March 2020 as part of the Emergency Planning response to Covid-19. This occurred to assist with the effective management and distribution of PPE. PPE items were demand managed. This meant this equipment could not be ordered through the usual eProcurement route. This was an important decision made by the Covid-19 Oversight Group, which was endorsed and supported by the Belfast Trust Executive Team. The decision was taken to ensure that appropriate management of potentially limited supplies could be monitored and responded to, and also to reduce the risk of ward areas stockpiling PPE.

312. The store subsequently moved to new premises at Falcon Road in May 2021, when the service was delivered in partnership with Business Support Organisation (BSO). BSO was providing procurement and logistics services.

313. The store provided PPE to hospital wards and facilities, the Independent Sector (which includes nursing and residential homes), domiciliary providers and direct payment clients.

314. BSO delivered PPE stock to Coolmore store on a daily basis. Initially deliveries were made both during and outside working hours, including weekends, then moved to deliveries generally being Monday to Friday between 8am and 5pm.

315. As the system was a 'Push' system, the staff in the store did not always know what was being delivered to them. There was however daily communication between the store manager and the Belfast Trust representatives on the PPE Supply Cell Call to request stock if levels were low for specific items.

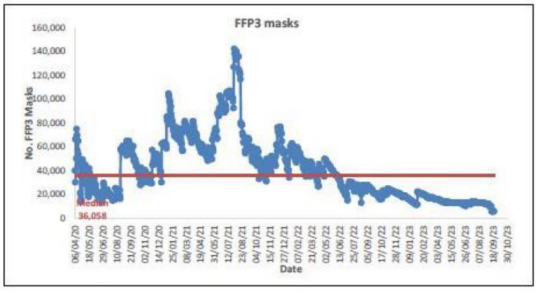
316. On the 31 March 2020, a letter was provided by the DoH NI Regional Emergency Planning Team relating to PPE. It addressed some frequently asked questions which reflected a variety of concerns that had been raised by HSC staff and the wider community in relationship to PPE and Fit testing. This letter explained the process, including how to engage with an independent tester of FIT testing (Fit2Fit testing CH/22 - INQ000471363 From the 6 April 2020, there was daily PPE stock level reporting from the Belfast Trust PPE store, which continued to 29 May 2020. This ensured real time data for senior decision making actions. From the 29 May 2020 to 21 Sept 2023, stock level reporting was conducted weekly. On the 21 Sept 2023 the process of ordering PPE transitioned back to usual business. The below run charts are an example of how the Belfast Trust ensured that stock data on FFP3 masks, anti-fog

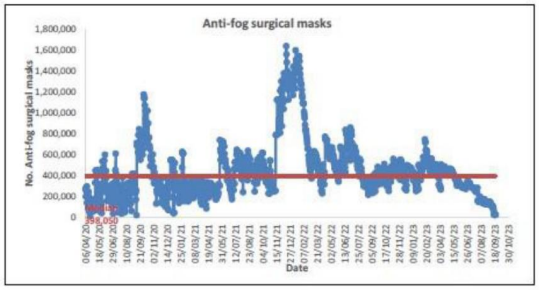
surgical masks, gloves, aprons, fluid repellent gowns and Visors/eye protection was available to assist the Covid-19 oversight Group and the Executive Team:

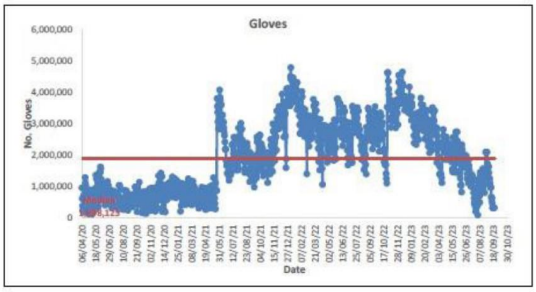
Belfast Health and Social Care Trust
caring supporting improving together

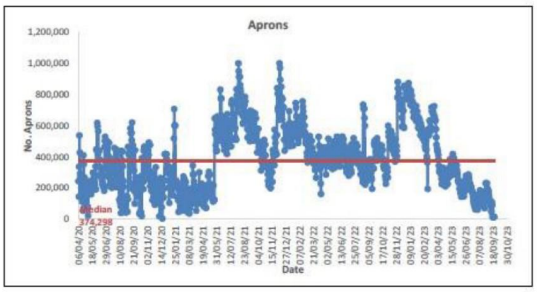
Safety & quality

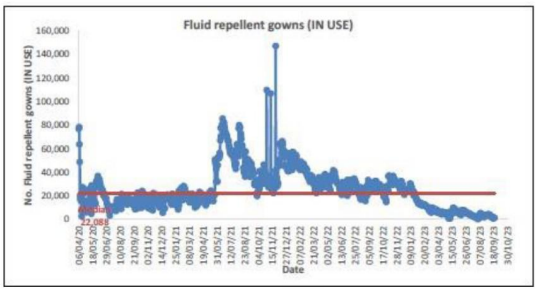
PPE Stock Levels (21 September 2023)

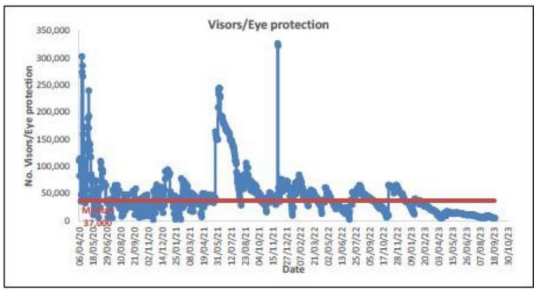












317. Hand sanitiser was also managed through the store until May 2020. Thereafter it was available to order again through the usual eProcurement routes.

318. On the 8 April 2020, the Covid-19 Oversight Group provided assurance to the Belfast Trust Senior Leadership Group that *"Regional Procurement (BSO) have informed all Trusts that FFP3 1863 and 1873 masks have been revalidated by Regional Procurement and are safe to use. BSO did not get an opportunity to re-label the masks with the new revalidated date. Please can you re-assure staff that these masks are safe to use."*

319. From 9 April 2020 Belfast Trust began using a PPE online order form to allow staff who were responsible for ordering PPE items for their wards/areas to complete and submit their PPE orders online. The PPE Team had access to the data for each order submitted to support the PPE team's processes of fulfilment of PPE orders. Most orders made up were delivered the same day, but some that were made up at the end of the day would go out first thing the following morning. The standard operating procedure for PPE distribution is attached **CH/23 - INQ000471380**

320. The PPE team deactivated the online PPE order form on 27 Sept 2023 because the process for ordering PPE transitioned back to "business as usual" ordering arrangements.

321. The Minister of Health gave a direction that assurance was to be sought from HSC Trusts in relation to PPE and asked for the below Audit to be completed by 17 April 2020. This endeavoured to ensure that there were uniform standards being adopted across the region.

COVID-19 PERSONAL PROTECTVE EQUIPMENT (PPE) AUDIT

DRAFT TERMS OF REFERENCE

Aim

The aim of this audit is to provide assurance to the Minister for Health regarding the appropriate receipt, storage, distribution and use of Personal Protective Equipment (PPE) across the Health and Social Care system during the current COVID-19 pandemic.

The audit should examine the areas listed below, bringing forward conclusions and recommendations to the Minister.

- The adequacy of current PPE stock levels – focusing specifically on critical items that are either in short supply or are experiencing increased usage during the current pandemic wave.
- Whether the PPE is being used appropriately, and in line with extant guidance - particularly critical items that are in short supply or have increased usage.
- Arrangements for the receipt into stock, storage, and subsequent distribution and delivery mechanisms for PPE from warehouse to point of use in health and care services.
- The robustness of measures for demand modelling across all areas, and the extent to which such modelling feeds into all supply decisions.
- The extent to which mutual aid principles, across the NI health and social care sector and the UK, are being properly applied and are effective.
- An assessment of readiness for continuing response during the current pandemic wave and by way of preparation for a second wave of COVID-19.

Timescale

Audit to be completed by 5pm on 17 April 2020.

Membership

NR DoH Internal Audit – Lead for this audit team

NR DoH Internal Audit

NR MoD TBC subjected to agreement.

NR, Consultant in Global Health PHE seconded to DoH – Clinical advice

Linda Kelly, Deputy Chief Nursing Officer DoH formerly Assistant Director Safe and Effective Care SHSCT – Nursing advice

Therese Molloy, Director WHSCT – formerly Procurement lead BSO during H1N1 pandemic.

NR DoH Nursing - Secretariat

322. Staff involved in PPE distribution. The team based in Coolmore store working within PPE distribution was initially made up of the following staff, all of whom had been involved through redeployment:

- 2 x managers
- 4 x admin
- 10 x floor staff (making up the orders)

323. During the initial few weeks, given the number of orders being received, and the volume of stock each order required, the above number of staff was required. However, as the service stabilised, and orders were being placed by

many areas on a weekly basis, the PPE distribution service was managed with less staff:

- 2 x managers (important to ensure cross-cover at all times)
- 2 admin staff, ideally with a 3rd person able to support these roles and provide cover during absences); admin cover for 2 roles is required Mon to Fri, 8.30am to 4.30pm
- 6 x floor staff (making up orders)

324. Transport staff were also required to deliver the PPE orders across sites. An arrangement was made with the Transport Manager to utilise transport staff, and these staff remained part of the transport team. Three sets of drivers (working in pairs) worked well, and provided useful flexibility for getting out urgent orders.

325. In addition to the above, support was also provided to the staff in the PPE store from the following:

- Senior Manager, Quality Improvement and Patient Safety – support provided to the store manager as required.
- Staff working within the Covid-19 Oversight Group.
- Domestic staff (113 approx..2 hours per day within the store)
- Staff in the Quality Improvement and Patient Safety team to extract data and updating the ordering system.

326. Deliveries were made across the various Belfast Trust sites. Many deliveries were made directly to wards and services and included: Acute Mental Health Inpatient Centre (BCH site), BCH, Cancer Centre, Mater Hospital, Muckamore Abbey Hospital, Musgrave Park Hospital, RBHSC, RVH, RMJH, Community (including Health and Wellbeing centres). In addition to this, the PPE store supplied stock to a small number of private Independent Sector providers (Kingsbridge, Ulster Independent Clinic, Cathedral Eye Clinic) and to the Northern Ireland Hospice and Marie Curie hospice.

The use of up to data, and transparent wide sharing of the data by the Covid oversight Group with the Executive Team, Senior Leadership Weekly meetings, bi-weekly Divisional and directorate meetings, ensured that staff anxiety about potential PPE shortages was reduced by these facts.

327. Some sample PPE communications, aimed at reassuring staff, are set out below:

PPE Activity

25/3/20 – 30/4/20

1,761 orders for PPE have been processed by the newly formed team.

Over 400 teams have received PPE from Coolmore stores across Acute, Community & Independent sectors

On average **80** orders are placed a day (excluding weekends)

11,858,803 items of PPE have been dispatched from Coolmore stores, BCH.

Safety & quality

HSC Belfast Health and Social Care Trust

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328. A breakdown of the PPE Distributed between 1 April 2020 and 31 March 2021 is as follows:

- **20,448,417** gowns, caps and aprons
- **20,946,478** surgical masks
- **4,515,674** visors & eye protection
- **678,975** FFP3 Respirators
- **62,793,243** gloves
- **51,583** items of hand sanitiser
- **281,694** other PPE items dispatched including hoods, scrubs & wipes

Examples of any occasions where the hospital was provided with PPE and/or RPE that was unsuitable (for example PPE/RPE that did not fit some staff; PPE/RPE that was not fit for purpose; PPE/RPE that had expired), the problems this presented and how this was addressed, whether at hospital, Trust, or national level.

329. Following a communication from the Health and Safety Executive Northern Ireland (HSENI), arising from an anonymous complaint HSENI had received, the Belfast Trust Chief Executive, on the 27 March 2020, wrote outlining the approach to PPE for those in community settings, such as home care staff. The issue was taken very seriously. The letter from the Chief Executive is reproduced below. This letter was followed up with a bespoke communication to Belfast Trust staff provide staff in order to provide reassurance on the issue of PPE.

Belfast Health and Social Care Trust

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Chief Executive
Dr Cathy Jack

Chairman
Mr Peter McNaney, CBE

27 March 2020

Via Email: NR @hseni.gov.uk

NR
HSENI
83 Ladas Drive
BELFAST
BT6 9FR

Dear NR

Re: Health and Safety Executive Northern Ireland (HSENI) request for information
Re: HSENI Anonymous Complaint from Domiciliary Worker

In relation to the your email dated 26th March 2020, please be advised of the control measures currently being adopted by the Belfast Trust Home Care service with regard to COVID-19 and the concerns raised within the anonymous complaint to the HSENI.

1. **Personal Protective Equipment (PPE)**:

Gloves/Aprons: The Trust provides personal protective equipment in the form of gloves and aprons to Home Care staff.

Masks: According to current Public Health advice, masks and visors are not required by Home Care staff. FFP3 masks are only required when managing a patient/client with possible/confirmed COVID-19 who is undergoing an Aerosol generating Procedures (AGP) and when there are COVID-19 patients in High risk unit (ICU/ITU/HDU).

In cases that the Service User is symptomatic Home Care service staff have been advised through a newsletter issued to them by Home Care service management to undertake the following:

- It is important that before you undertake any duties on each call you ensure that the service user is physically well.
- Stay about 3 large steps (2m) from them and ask if they are suffering from a high temperature or have a new persistent cough.
- If the service user is well you can continue to provide service as normal.
- If the service user reports as having symptoms (new persistent cough and / or high temperature) you must withdraw and contact the office or out of hours service

- Reassure your service user that someone will be in contact with them as a matter of urgency about their care and support.
- It is important that you protect yourself and other service users from the COVID-19 virus but we must remain diplomatic and caring.

The Service will keep this guidance under review and amend their advice if this changes.

2. **Provision of hand sanitiser**:

The Home care staff have access to hand sanitisers to fulfil their role.

3. **Guidance from line managers:**

All Home Care staff were sent a newsletter by mail advising on control measures to follow when entering a service users home. This Newsletter also provided information with reference to issues such as PPE, laundering of uniforms and notifying staff of the Occupational Health helpline in relation to concerns about underlying health conditions or other COVID-19 related questions. (A copy of this Newsletter will be forwarded to the HSENI on request).

4. **Personal Safety / other persons in the home**:

As per guidance from line managers above advice given in newsletter issued to staff.

5. **Two person working**:

Staff will work either in a 'by one' or 'by two' service. The Trust acknowledges that staff working in pairs will not be able to maintain a 2m distance rule due to the type of home care they are required provide. If staff feel they are symptomatic, they are advised to contact their Manager.

6. **Risk Assessment**

The Home Care Service's risk assessment will be monitored and reviewed and take direction from information and guidance provided through Public Health.

If you have any queries in relation to this correspondence, please contact NR Lead Health & Safety Manager by email NR @belfasttrust.hscni.net or phone on I&S

Yours sincerely,

Personal Data

Dr Cathy Jack
Chief Executive

Belfast Health and Social Care Trust
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COVID-19 Newsletter March 20

Informing Home Care Staff across the City

Issue 2

Interim guidance for Home Care Workers during COVID -19 Pandemic

It is important that before you undertake any duties on each call you ensure that the service user is physically well.
Stay about 3 large steps (2m) from them and ask if they are suffering from a high temperature or have a new persistent cough.
If the service user is well you can continue to provide service as normal.
If the service user reports as having symptoms (new persistent cough and / or high temperature) you must withdraw and contact the office or out of hours service.
Reassure your service user that someone will be in contact with them as a matter of urgency about their care and support.
It is important that you protect yourself and other service users from the COVID-19 virus but we must remain diplomatic and caring.

Childcare

The Department of Education published its guidance in respect of school provision for children of key workers. The following link is the statement from the Minister of Education, which also includes links to a letter to schools, FAQs and Guidance to Schools.

https://www.education-ni.gov.uk/news/statement-education-minister-covid-19-response

There has been some confusion regarding this and hopefully the following will clarify:

1. Definition of key workers includes:

   Health and Social Care: This includes doctors, nurses, midwives, paramedics, social workers, home carers and staff required to maintain our health and social care sector

   The guidance states that if workers think they fall within the critical categories above they should confirm with their employer that, based on their business continuity arrangements, their specific role is necessary for the continuation of this essential public service.

   As your employer we can confirm ALL our staff, whatever their role, are necessary for the continuation of health and social care services, therefore all employees of Belfast Health and Social Care Trust are key workers.

2. The rules apply to school age children up to and including Year 10.

3. There is no need for both parents to be key workers. The purpose of opening schools is to ensure that key workers can still attend their place of work and provide vital services.

4. The Minister for Health, Robin Swann, has been clear that all sectors providing health and social care services - statutory, independent, private, voluntary and community - are essential, as well as those who will be working on Covid-19 efforts such as students and academics.

Your Belfast Trust ID badge should provide sufficient identification and proof that you are a key worker, but should schools require a letter please contact Human Resources and we can provide this for you. For further information please contact the HRIS team on 028 961 59615.

Occupational Health Advice

If you have any concerns about underlying health, conditions or other COVID-19 related questions the Trust's Occupational Health Department has a helpline for staff:

Important message from our Chief Executive

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COVID-19 Newsletter March 20

Informing Home Care Staff across the City

Issue 2

The Chief Executive of Belfast Health & Social Care Trust yesterday issued a message to **all** Trust staff. You can view the message on YouTube at:

https://youtu.be/9GUrmUsgH2c

Personal Protective Equipment (PPE)

Appropriate Personal Protective Equipment will be provided when:

1 a service user has symptoms of the coronovirus (a new and persistent cough and/or temperature over 37.8)
2 A new persistent cough and /or
3 A temperature of over 37.8
4 Or if a member of the service user's house is self-isolating

If a service user is presenting with coronavirus symptoms:

When carrying out personal care (Showering, toileting, washing, dressing / undressing) staff should use surgical mask, visor, apron and gloves.

When carrying out meal preparation, laundry, cleaning and assistance with medication staff should use a surgical mask, apron and gloves.

The Trust continues to secure supplies of PPE but currently we in a position only to use masks, visors and aprons with confirmed or suspected COVID-19 cases.

Some guidance on laundering of uniforms

If staff are caring for a service user who has symptoms suspicious of the coronavirus or are providing care in a self-isolating household then:

- A clean uniform should be worn at each shift
- Uniforms should be laundered:
  - Separately from other household linen;
  - In a load not more than half the machine capacity;
  - At the maximum temperature the fabric can tolerate, then ironed or tumbled-dried.

We value you – look after yourself and one another

As a member of staff of Belfast Health and Social Care Trust and a Government recognised "Key Worker" if you or a family member has symptoms of COVID-19 the Trust will ensure that you are tested as a matter of urgency.

If you or a member of your household is symptomatic, please contact your manager who will refer you for a test.

Once again I'm afraid I'm using the term "unprecedented times" but unfortunately that is where we are at present. It is important as key Health Service workers that we maintain our services which continue to be a major and essential input to society. It is easy in the current climate to get bombarded with news and information some of which can cause more concerns than answer questions but we must be patient with ourselves and with one another.

For most of us our working environments are not conducive to social distancing but please remember that the main advice coming from the World Health Organisation is frequent and thorough handwashing. In addition to handwashing it is important to:

Sneeze into a tissue or if you have no tissue then into the crook of your arm. Bin any tissues and wash your hands.

In addition to the Chief Executive's message, the Home Care management team want to thank all of you for the level of professionalism and responsibility that has been maintained over the past few weeks. It is important as key Health Service workers that we maintain our services that continue to be a major and essential input to society.

It is easy in the current climate to get bombarded with news and information some of which can cause more concerns than answer questions but we must be patient with ourselves and with one another

It's okay to be frightened, it's okay to worry but together we will come through this.

The Home Care Service) 331 Cregagh Road BELFAST BT6 0LE I&S
The Home Care & Intensive Home Care Services Shankill Wellbeing & Treatment Centre 83 Shankill Rd BT13 1PD I&S
We are always interested in your feedback, comments or suggestions about this newsletter or any aspect of our service.

330. Concerns were also raised by staff through email, and on social media. in respect of PPE. The concerns were responded to by the senior manager of the PPE store. The concerns related mainly to two specific items – Tiger and DSBJ masks. The issues are reflected in the below quotations from staff:

- "The (DSBJ) mask uses elastic ear loops rather than ties. The fit for many people is too loose. Many people have described to me the mask slipping down in use. For me the 'Tiger' mask is marginally better. With both brands as soon as I begin to talk the mask migrates down so the interior becomes potentially contaminated. Clearly if you replace it, which many people by reflex, then you have contaminated your mouth."
- "The metal nose strip is too pliable. When you put it on you mould it to your face. The hack the Trust suggests is shortening the elastic ties which then straightens the nose strip and leads to fogging of your protective eyewear."
- "There is no anti fog strip along the top. This worsens the situation described above. I literally can't see at this stage which is clearly dangerous to me and patients when doing procedures with needles or blades."

331. A search of Datix (the incident reporting system used in Belfast Trust) thankfully reveals very few reported incidents related to availability of PPE. None

of these were graded catastrophic or major on the datix system. Day to day escalation of PPE issues was through the covid oversight group to executive team ensuring that there were adequate supplies of PPE available. The

Belfast trust considers this to be evidence of how well the PPE distribution centre functioned.

332. The Belfast Trust Health and Safety Annual Report 2020-2021 also highlighted a number of Covid-19 related queries from the HSENI and Belfast City Council (only the PPE related issues from the report are referred to below):

- HSENI queries in relation to the Trust sufficient supply of PPE for staff, sufficient supply for ICU staff, staff using tight fitting masks face fit tested and arrangements in place for ongoing fit testing. (3 April 2020).
- Letter received by HSENI from the Royal College of Nursing raising concerns about the lack and adequacy of personal protective equipment for front line Nurses across Northern Ireland (6 April 2020).
- Complaint received by the HSENI re Tiger Medical Surgical Masks (7 May 2020)
- HSENI contacted by an organisation representing Medical Staff to establish if Health Trusts are using or have used "Tiger" fluid resistant surgical masks, stock levels and instructions provided to your colleagues to ensure they were correctly worn to provide a secure fit. (10 June 2020).

- Tiger Medical surgical masks- A request for photographs and a sample of the surgical masks. (8 June 2020).
- Fit Testing- the incorrect setting on the Portacount by the Trust contracted fit testing service (using a weighted instead of single exercise test setting).

333. In relation to all anonymous complaints received by HSENI, the Belfast Trust Health and Safety team investigated with visits to the respective sites and discussion with managers in these Service Areas. The Belfast Trust provided the HSENI with formal responses to all these complaints through the Chief Executive's Office. There was no further action from the HSENI.

A summary of the hospital's practical arrangements for fit testing of PPE for healthcare workers and any issues that arose with fit-testing during the relevant period. In the event that no or only a limited number of fit tests were carried out, please provide the reasons for this.

334. At the start of the pandemic, there was already a process in place for Fit testing of staff in keeping with the Belfast Trust's *"Regulations of Fit Testing Policy – Provision of Respiratory Equipment (RPE) v4 November 2013/2014".* Practical arrangements were challenging however due to the follow issues:

- Only one Fit-tester employed by Belfast Trust.
- A lack of funding for this service on a recurrent basis.

- A reliance on an external company from the Republic of Ireland (Fittest.ie) to increase fit testing capacity at times over the preceding ten years.
- No formal contract in place regarding external contractors within Northern Ireland.
- A delay in increasing the capacity of fit-testing initially as a result of lack of trained personnel either within the Belfast Trust or external to the Belfast Trust
- A very large number of staff requiring to be fit-tested at the same time, during the very early weeks, in preparation for the pandemic.
- A lack of live data collection that enabled daily reports of completed testing, and passes and fails on masks.
- A clear source of masks that met the demand of the staff requiring masks.
- Infection Control teams were initially central to the process of agreement of masks being considered for use with staff, with no consideration if masks were fit for purpose from a fit-testing perspective

335. Capacity vs Demand for Fit Testing. Prior to the pandemic, the Belfast Trust could carry out five tests per day (25 per week). Demand obviously soared due to the pandemic. Fittest.ie confirmed its ability to meet the required increase in demand by increasing the number of their trained fit testers. By early March 2020 there were 200 tests being conducted per week, rising to 2,400 per week by 13 April 2020. This enabled the Belfast Trust to carry out fit-testing twenty hours per day, over seven day periods, for a number of months. This ensured all appropriate staff had been tested, or were retested if the mask changed. Fit testing was carried out on every site within Belfast Trust on either a regular

basis (for central sites) or a planned as required basis (for those sites outside of Belfast e.g. Muckamore Hospital and Knockbracken Healthcare Park).

336. Mask Availability. The type of mask available to be worn changed very regularly, with sometimes little or no notice that a new mask was being introduced, and that had an inevitable impact on fit-testing. The initial masks used were up to twelve years old, although they had been re-tested within the manufacturer's specification and were confirmed fit for purpose. Within the Northern Ireland region, there was an agreement with the PPE Supply Cell that each HSC Trust would be allocated certain masks. Some of the older masks did not afford as good a seal as the newer masks allowed, and, as a result, there was a higher fail rate recorded with these older masks.

337. Staff, at times, became confused due to the frequent changing of mask design, which in turn required them to be re-fit tested. This reality was caused by supplies of a certain mask running low, necessitating a change in mask, and consequent re-fit testing for that design.

338. Belfast Trust was involved in a successful collaboration (along with colleagues from Supply Cell Team, Business Services Organisation, all HSC Trusts in Northern Ireland, and a commercial partner (Denroy)) in the development of a new mask for use in Northern Ireland. The "Denpro" mask was manufactured and tested throughout the Northern Ireland region. This was to aid the shortage of masks to the region but also reduced the need for re-fit testing.

339. In June 2020, Belfast Trust identified a number of staff (less than one per cent) as having been incorrectly fit tested. This issue was raised regionally and resulted in a Serious Adverse Event (SAI) investigation led by the Public Health Agency. The total number of staff ultimately affected by this issue within the

Belfast Trust was 1,385. All staff involved were invited back for a fit test to ensure the mask was re-fitted to the UK standard. The Trust did not undertake analysis of characteristics of staff who had been incorrectly FIT tested, the focus was on the result of Pass or Fail.

340. The impact of the discovery of this problem to the fit-testing process was reduced confidence that it was a safe test; having to plan extra fit tests into already very tightly controlled schedules; the extra reporting from the fit test team to the SAI investigation team overseeing the initial response. It did allow the Belfast Trust to review all the assurance processes in place for fit testing. The "Regulations of Fit Testing Policy – Provision of Respiratory Equipment (RPE)" was updated in August 2020 to include recent best practice, and legal advice related to male beards and the wearing of FFP3 masks. Reproduced below is the 29 June 2020 reply to the HSENI in respect of this issue

29 June 2020

Via e-mail: NR @hseni.gov.uk

NR
Principal Inspector
Health and Safety Executive Northern Ireland (HSENI)
83 Ladas Drive,
BELFAST
BT6 9FR

Dear NR

Re: Fit Testing/ Portacount Email from the HSENI on 23/06/2020.

Please see information below in relation to the queries raised with regard to fit testing on 23 June 2020:

Q. Please can you confirm that all your colleagues who require to be Face Fit Tested have in fact passed the Test with a minimum score of 100 in each of the 7 different stages of the test. If this is not the case can you confirm how many incorrect results you have within your Trust and how you intend to address the issue as a matter of urgency.

The Belfast Trust have completed a review of 13,652 fit testing certificates. The Trust can confirm that on review it was identified that a total number of 1385 staff were detected as having an incorrect fit test result. The Trust are currently working on advising all affected staff with the intention to ensure that all staff have been contacted by 26 June 2020.

The Trust have already began to put in place arrangements for all affected staff to be re-fit tested and is working towards competing these re-fit tests by 3rd July 2020, dependent of staff availability.

The Trust will also review procedural controls to include reviewing regular review of fit test certificates both hourly and at the end of working day with schedules signed to confirm that this has been undertaken.

The Trust have advised all staff that if they have any concerns about their fit testing outcome they are requested to contact the Occupational Health Helpline on (028) 9063 0010.

Yours sincerely

Personal Data

Dr Cathy Jack
Chief Executive

cc
Mr Chris Hagan, Medical Director, Joint Chair of the Trust Health & Safety Committee
NR UNISON, Joint Chair of the Trust Health & Safety Committee
NR Executive Director of Nursing & User Experience
NR Operational Director, COVID-19 Oversight Group
NR Senior Manager, Nursing, Governance & Experience, Nursing & User Experience
NR Co-Director, Risk & Governance, Medical Directorate
NR Senior Manager, Corporate Standards & Risk, Risk & Governance, Medical Directorate
NR Lead Health & Safety Manager, Risk & Governance Department, Medical Directorate

341. Confirmed fit testing funding stream. There was initial agreement that the costs for fit-testing could be moved from the Division of Medical Specialities, and placed within Covid-19 arrangements for funding of the exponential rate of testing that was required. This allowed for a Business Case to be developed and approved that enabled three trained fit testers to be appointed to Belfast Trust on a permanent basis. Three new fit testing portacounts were also purchased.

342.

Visiting restrictions

. The Inquiry is aware that visiting guidance was issued by the Department of Health at the start of the pandemic stating that all visiting was suspended save in a number of specific circumstances. The Inquiry is also aware that the guidance changed throughout the relevant period. In relation to the guidance on visiting, please set out:

a. how it was applied in the hospital;

343. From March 2020 throughout the Covid-19 pandemic, the Belfast Trust visiting arrangements followed the Regional Principles of Visiting Guidelines **CH/24 - INQ000353609**. The exception to this was in the Division of Cancer and Specialist Services, who followed the National British Society of Blood and Marrow Transplantation and Cellular Therapy (BSBMT) Guidelines issued on 18 April 2021, these guidelines were reviewed monthly (**CH/25 - INQ000471325**

344. The Belfast Trust exercised discretion to facilitate visiting in special circumstances these included:

- Vulnerable- where an advocate was required.
- Elderly- where an advocate was required.
- End of life.

In these circumstances, dynamic Risk Assessments were completed by the affected service area and appropriate PPE was provided to facilitate these arrangements. Visitors were asked to support the Belfast Trust's Covid Safe measures by completing a Lateral Flow Test at home prior to attending the hospital, and to postpone their visit if they had any symptoms of infection.

345. The Belfast Trust communicated arrangements for visiting with the public across social media platforms and encouraged the public to support the approach of the Belfast Trust. Posters and information were available to the public at all entrances to facilities and ward areas. The Belfast Trust reviewed this information regularly to ensure it reflected changes in guidance and operating arrangements in the Belfast Trust.

346. Regional guidance changed throughout the relevant period. Visiting arrangements moved between no face-to-face visiting to some form of visiting arrangements, dependent on community spread of the virus. When revised guidance was received from the DoH NI, it was reviewed to ensure the Belfast Trust was able to facilitate the changes. This was to try to prevent any unintended harm to patients in respect of safety and quality of care, quality of life, continuity of care, outcomes, and emotional and psychological distress.

347. When visiting restrictions were relaxed, the Belfast Trust developed a Standard Operating Procedure and a template for recording the details of all visitors CH/26 – INQ000471377.This was disseminated for use across all wards and departments of the Belfast Trust. Each ward was responsible for ensuring implementation and application of these.

348. All wards used a Risk Assessment tool CH/27 INQ000471386 and adhered to the applicable visiting arrangements, unless there was a Covid-19 outbreak in the ward area. Each ward area completed its own standardised dynamic risk assessment on a regular basis. The Trust reviewed practice across all areas regularly. These checks ensured the risk assessments were being completed, and operative visiting guidance was being followed.

349. The nature of the estate of the Royal Victoria Hospital constrained some wards relaxing their restrictions where there was a Covid-19 positive patient admitted or an outbreak. This is due to limited numbers of side wards, and bays in most wards in the Royal Victoria Hospital accommodate six patients. The Belfast Trust worked to cohort patients where it was appropriate, enabling the other bays to be open for visiting.

350. The Belfast Trust encouraged visitors to wear facemasks, and provided PPE and hand sanitising stations at the entrances to its facilities and wards as part of the overall Covid-19 safe practices. This caused some challenges at ward level as this practice was not mandatory and the Belfast Trust was not able to enforce it. As society began to engage in greater social interaction and movement, it became increasingly difficult, for instance, to encourage the public to adhere to HSC requests to continue to apply a mask when visiting our facilities.

351. The Belfast Trust established a Safe Working Group **CH/28** – INQ000471382, the purpose of which was to ensure a safe restart of services stood down or reduced during the Covid-19 pandemic. The aim of the group was to assure patients, service users and staff that the Belfast Trust was taking all reasonable steps to ensure their health and safety, whilst minimising the risk of infection in line with guidance from the Northern Ireland Executive, PHA, PHE and the HSENI.

352. From August 2021, the Belfast Trust was required to provide a weekly report to the DoH NI on the visiting arrangements it has in place **CH/29** I NQ000471385. This information was summarised and published on the DoH NI Covid-19 webpage dealing with visiting HSC sites.

In February 2022, the DoH NI introduced the Care Partner arrangement CH/10 INQ000416504 A care partner is an identified person (usually a relative) who provides defined additional caring support to patients such as assistance at meal times or encouraging social interaction. This was in addition to the visiting arrangements as defined in the DoH NI visiting guidance. This concept was encouraged by the Belfast Trust. Wards advised families about this arrangement and the Belfast Trust communicated information about the arrangement on social media. The uptake of this was poor across the Belfast Trust. At this time, visiting arrangements were:

- Visiting permitted twice a week by one of two nominated visitors, unless local risk assessments for the area advised that this could not be safely accommodated.
- Following a risk assessment at ward level, only one of these two nominated people was permitted to visit at any time throughout the patient's stay in hospital.
- No visiting if any symptoms of Covid-19. All visiting must be booked in advance through the Nurse in Charge on the ward.
- Care Partner arrangements implemented within the hospital setting. In addition to normal visiting arrangements and in line with DoH NI guidance.
- Virtual visiting remained the preferred option

353. The Belfast Trust continued to facilitate visiting in special circumstances:

- vulnerable patients – where an advocate was required.
- elderly patients – where an advocate was required.
- end of life care.
- Inpatients in the Children's Hospital.
- inpatients in the Maternity Hospital.

b. whether the hospital produced its own visiting guidance including whether the hospital exercised its discretion to allow visits to the hospital and if so, in what circumstances;

354. The Belfast Trust visiting arrangements followed the Regional Principles of Visiting Guidelines from March 2020. The Belfast Trust did not produce its own visiting guidance. The Belfast Trust did exercise discretion to facilitate visiting in special circumstances. These included:

- vulnerable- where an advocate was required.
- elderly- where an advocate was required.
- end of life.

Dynamic Risk Assessments were completed by the relevant service area, and appropriate PPE was provided to facilitate these arrangements.

c. how the hospital practically facilitated contact between patients and their loved ones, in particular regarding end of life contact e.g. via use of online or telephone contact or additional PPE, including details of how often staff were able to facilitate such contact;

355. Following the introduction of visiting restrictions March 2020, the Belfast Trust sought to establish practical ways to facilitate contact between patients and their loved ones. Early on, the concern felt by families became increasingly evident, as there was an increase in complaints and concerns received from relatives about their difficulty in getting through to ward telephones to speak with ward staff for reassurance about their family member. Wards were encouraged to identify a staff member responsible for 'keeping in touch' with next of kin for the patients who were unable to keep in touch independently using their own phones or devices, or where this was requested by patients and their families.

356. A 'Patient Liaison Hub' began operating on 22 April 2020 CH/30 – INQ000471370), to respond to the incoming telephone demand on the switchboard and the wards coming from relatives of patients in the BCH "Nightingale" and Royal Victoria Hospital sites. The Patient Liaison Service Hub (PLS) operated from 0900hrs to 1700hrs seven days a week.

357. The main objectives of the PLS Hub included;

- Answering all incoming patient related calls made via switchboard in a timely manner.
- Managing the expectations of the caller(s).
- Screening calls to ensure only contact from Next of Kin or Point of Contact, where possible and deemed appropriate.
- Cohorting routine patient enquiries and delivering to the Nurse in Charge.
- Escalating calls when required directly to baton or ward phone.
- Providing signposting to national guidance regarding general enquiries about management of Covid-19 where applicable.

358. It became evident that many patients in Belfast Trust were unable to use smartphones/tablets, independently, to connect with their families. While wards were provided additional iPads, staff facilitating video calls between patients and their families was ad-hoc due to clinical pressures. On February 2021, the PLS started a Virtual Visiting Service (VV) pilot. The Belfast Trust advertised this on the Belfast Trust's social media platforms. The virtual call was set up by the PLS. The call was provided by a facilitator who went to the patients' bedside. The facilitator's role was to assist the patient with the call to their family. Consent was obtained from the patient and nursing staff prior to the call taking place.

359. The Belfast Trust was able to facilitate an average of 11 virtual visits per day including weekends. Each virtual visit was allocated 30 minutes. This service was additional to services provided at ward level across the sites. The VV service was the most commonly requested service for elderly, stroke, acute medicine and neurology wards. Stakeholder evaluation was very positive and the continued use and demand of the service demonstrated the value of the service CH/31 –INQ000471369). Virtual Visits continued until 7 April 2023, when the service was stopped due to reduction in demand and need as restrictions relaxed.

360. As referred to above, in February 2022, the DoH NI introduced the Care Partner arrangement. This was in addition to the visiting arrangements as defined in the DoH NI's visiting guidance. This concept was encouraged by the Belfast Trust, wards advised families about this arrangement and the Belfast Trust communicated information about the arrangement on social media. The uptake of this was poor across the Belfast Trust.

361. Throughout the restrictions on visiting, the Belfast Trust also exercised discretion to facilitate visiting in special circumstances. These included:

- vulnerable- where an advocate was required.
- Elderly- where an advocate was required.
- end of life.

Dynamic Risk Assessments were completed by the service area and appropriate PPE was provided to facilitate these arrangements. Visitors were asked to support the Trust's Covid Safe measures by completing a Lateral Flow Test at home prior to attending the hospital and to postpone their visit if they had any symptoms of infection.

362. Management of Bereavement. The Belfast Trust's Bereavement Co-ordinator, the Bereavement Team and bereavement volunteers provided a

service for patient's families. Where applicable they would telephone the nominated point of contact for the patient in order to find out '*What Matters'* to their loved one. This is about healthcare professionals understanding what matters to an individual in their life, to help with meaningful conversations with individuals, plan care, improve patient outcomes and enhance experience of care. This important information was laminated and displayed at the patient's bedside. This team provided a support call following the patient's death to the patient's point of contact within 24-48 hours, and again 4 weeks later.

363. PPE. PPE appropriate to the area (hand sanitiser/face mask/gowns/aprons) was provided at the entrances to all facilities and at the entrances to each ward/ department. Staff assisted visitors in donning/ doffing as required.

d. whether a policy was in place for patients with communication difficulties, cognitive impairments, or with limited English to be accompanied by someone who could facilitate communication between the patient and hospital staff;

364. The Belfast Trust visiting arrangements followed the Regional Principles of Visiting Guidelines from March 2020. The Belfast Trust did not produce its own visiting guidance for patients with communication difficulties/ cognitive impairments/ limited English.

365. The increased use of facemasks during the pandemic, although necessary to reduce the spread of infection, made lip-reading and understanding visual cues from facial expressions impossible. For deaf patients, opaque facemasks created a serious communication barrier. In November 2020 (CH/43 –the Health & Social Care Board (HSCB) and Public Health

Agency (PHA) advised there was a transparent facemask available which met IPC requirements. This information was shared across all Divisions. Services were responsible for ordering the transparent facemask as a non-stock item as required see exhibit CH/32 INQ000471327

e. whether and when the visiting policy was reviewed in the hospital and whether any replacement guidance was introduced; and

366. As referred to above, from March 2020 throughout the Covid-19 pandemic, the Belfast Trust visiting arrangements followed the Regional Principles of Visiting Guidelines The exception to this was in the Division of Cancer and Specialist Services, who followed the National British Society of Blood and Marrow Transplantation and Cellular Therapy (BSBMT) Guidelines issued on 18 April 2021. These guidelines were reviewed monthly

367. When revised guidance was received from the DoH NI into the Trust, it was reviewed by the Belfast Trust to ensure that the Belfast Trust was able to facilitate changes so to prevent any unintended harm to patients in respect of safety and quality of care, quality of life, continuity of care, outcomes, and emotional and psychological distress. The Trust also considered how best to protect both visitors who were coming to the hospital and staff.

368. No replacement guidance was introduced in the Belfast Trust.

f. any other concerns or issues about how practical/ workable any national and/ or Trust level visiting guidance was during the relevant period.

369. While the Belfast Trust encouraged visitors to wear facemasks, this was not mandated, therefore, the Belfast Trust had no powers to enforce this. As shops/bars reopened, and social interaction for the public increased, staff reported challenges persuading visitors to wear facemasks in our facilities.

370. The estate of the Royal Victoria Hospital hindered some wards in relaxing their restrictions where there was a Covid-19 positive patient admitted or an outbreak. This was due to limited numbers of side wards and bays in most wards. The Royal Victoria Hospital was also undergoing significant demolition works during the pandemic. As discussed previously, there was a risk of Aspergillus impacting upon our vulnerable patients, and Covid-19 positive patients were particularly at risk. As part of the mitigations for Aspergillus, windows facing the demolition works were sealed, reducing airflow. This was contrary to Covid-19 guidance which advised increasing ventilation by having windows opened.

Whether the hospital considers that visiting restrictions had a negative effect on patient experiences and the experiences of family members/ loved ones and healthcare staff.

371. Visiting is such an important time for both the patient and their family. It is vital in order to have a family centred approach to care. Undoubtedly, visiting restrictions during Covid-19 had a negative effect on patient experiences, and that of family members/loved ones. The Belfast Trust actively put in place services to support contact with family members during this time, and did make exceptions (risk assessed) for more vulnerable patients and at end of life. Staff reported challenges in the management of the restrictions and dealing with the various changes that came about from the updates to arrangements following the reviews of the Regional Visiting Guidelines.

372. The Belfast Trust was aware that some visitors and families tried to circumvent the restrictions in place. Front of house staff in the Royal Victoria Hospital reported groups gathering at the front doors of the hospital or in the foyer area. The Belfast Trust removed seating in the foyer to make gathering in that location less attractive, and staff were encouraged to ask patients to return to their wards, and for groups to disperse if this was observed. Staff were asked to cite the risk of the spread of Covid-19 through social interaction. At times, this led to some individuals being verbally aggressive toward staff. As social interaction amongst the public increased, staff reported that the public did not understand why hospital were maintaining stringent restrictions around visiting. Staff also reported challenges with some visitors who chose not to wear facemasks in our facilities.

373. A review of patient/service user feedback submitted on Care Opinion from March 2020 to March 2023, identified 51 related stories. 82% of these stories were rated as not critical.

Whether the hospital considers that the guidance on visiting struck the right balance between minimising the risk of infection, and enabling patients to benefit from the support and comfort of visitors and/or carers.

374. The Belfast Trust considers the guidance on visiting was appropriate to prevent any unintended harm to patients (in respect of; safety and quality of care, quality of life, continuity of care, outcomes, and emotional and psychological distress), visitors and staff. It was acknowledged at an early stage in the pandemic, following the initial implementation of restrictions, that families needed reassurance that their loved one was being cared for, and the Belfast Trust put in place a 'keeping in touch' on each ward until the PLS service was established. The Belfast Trust ensured more vulnerable patients were supported by a loved one while in hospital and exercised discretion where it

was possible. The Belfast Trust ensured that the safety of patients, visitors and staff was the priority throughout this time. The Belfast Trust developed the Virtual Visiting service to support patients who were not able to use devices independently to keep in touch with loved ones. This service was very successful and received excellent feedback.

Details of how patients with conditions other than Covid-19, particularly ischaemic heart disease, colorectal cancer and hip replacement surgery, received care and treatment during the relevant period (1 March 2020 to 28 June 2022). including:

a. whether elective or non-urgent procedures at the hospital were suspended, and if so, when and for how long, and whether this was a decision taken at hospital, Trust or national level;

375. Elective Capacity in the Belfast Trust was reduced, restarted and reduced on four occasions between March 2020 and October 21, when plans were implemented to gradually rebuild theatre services. This is documented in Trust Board papers and surge planning. This was a regional decision taken to release theatre staff to provide care in the increased capacity intensive care units, as critical care demand and beds increased.

b. any challenges for the hospital in continuing to provide care and treatment for conditions other than Covid-19;

c. any changes to the care and treatment pathways provided by the hospital for conditions other than Covid-19; and

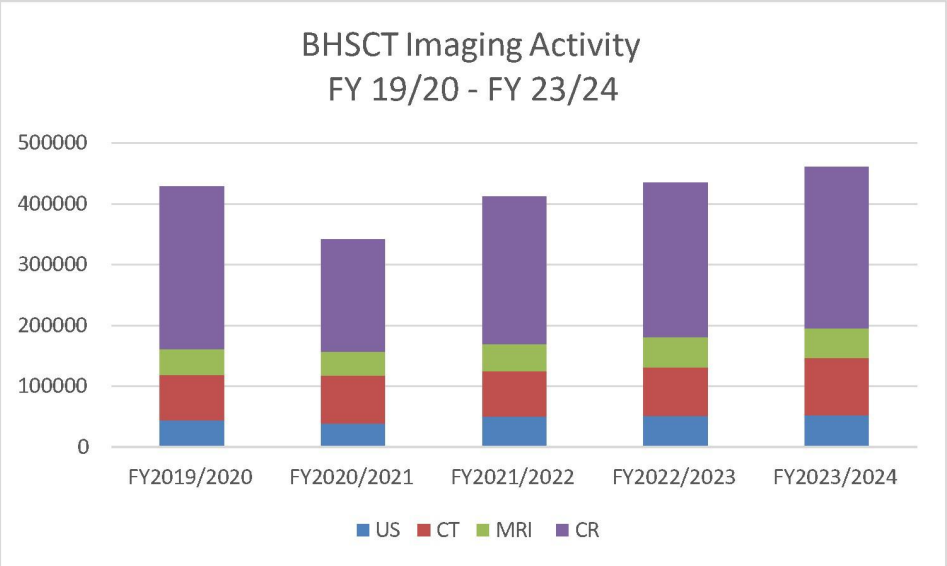
d. any local innovations to enable non-Covid-19 care and treatment to be maintained, or to address increased waiting times and backlogs.

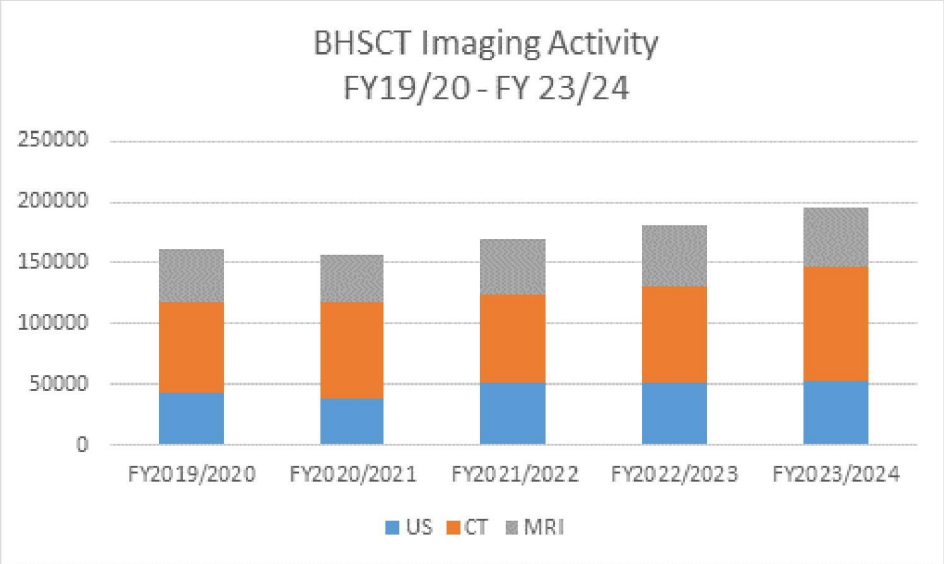
376. I will answer questions 36 b. c. and d. together. Due to the necessary diversion of resources into caring for Covid-19 patients, as well as the requirement for social distancing, many non-Covid conditions had to be managed differently than prior to the pandemic.

Diagnostics and investigations

377. *Imaging*. The Covid-19 pandemic created significant challenges in delivering imaging activity, especially during the first wave. There was a significant reduction in total diagnostic imaging examinations, with variable impact on different imaging modalities and procedures. Routine non-urgent diagnostic work, initiated by referrals from both primary care and secondary care teams, were deferred. Waiting times for red flag, confirmed cancer and urgent referrals increased due to the necessary adaptation of strict scheduling templates and social distancing measures.

378. To illustrate the challenges, below is a snap-shot of imaging activity across CT, MRI, US and plain film imaging from FY19/20 to FY 23/24 (FY 23/24 is extrapolated).





379. Prioritisation and revalidation occurred, in line with Royal College of Radiologists (RCR), NICE or specialty criteria and guidelines, of existing imaging referrals in relation to asymptomatic and symptomatic patients. This was undertaken to improve flow, trying to ensure our patients were in the right place at the right time with the appropriate care. Interventional Radiology (IR) continued to provide emergency treatment, whilst maintaining some time-critical elective services throughout the pandemic. This highlighted the adaptability of IR in supporting many specialties. The number of IR ablation procedures increased as a result of the downturn in surgery and lack of surgical capacity. The IR service also supported surgical colleagues to include CT chest imaging in acute abdominal CT imaging where emergency surgical intervention was required.

380. Interventional Neuroradiology Services recovered quickly and the Stroke thrombectomy service was maintained throughout the pandemic.

381. The service deployed additional imaging equipment in response to the pandemic, including the deployment of home reporting workstations. Redeployment and orientation of imaging staff across imaging services was

enabled to ensure preparedness for Covid-19. There was a reconfiguration of staffing numbers working in and out of hours across all sites to deal with the impact and demand of Covid-19 imaging in response to the changing demands on each site. Additional staff were deployed to out of hours services.

382. In the Summer and Autumn of 2020 the service began to increase imaging activity and address waiting times for diagnostics and interventional procedures that were impacted by the first wave of Covid-19. The service continued to work with imaging colleagues across Northern Ireland in the development of contingency plans for rebuild. The regional modular CT scanner at MPH opened in November 2020, to support regional rebuild, It was to tackle lengthy CT waiting times and is still in operation.

383. Breast screening was suspended, however the rebuild plan was successfully completed on target in July 2023 where nearly 100% of eligible clients were offered their mammogram appointment within the intended 3-year cycle.

384. *Pathology*: Pathology resources were generally unaffected, particularly as fewer specimens were being received. This was due to fewer outpatient clinics, patients being later to present with symptoms due to reluctance to attend hospital, and fewer procedures requiring the taking of biopsies.

385. *Phlebotomy*: A major problem was encountered in getting blood tests taken, especially for the monitoring of chronic conditions. Primary care did not have the capacity to take on the burden of this work. Belfast Trust rapidly set up a Phlebotomy Hub at a non-acute site to service these clinics, with electronic requesting of blood tests and drive-through facilities. These blood tests were

transported regularly throughout the day by courier to the laboratories at Royal Victoria Hospital and Belfast City Hospital.

386. *Endoscopy:* The normal capacity in the Belfast Trust for Endoscopy pre-pandemic was as follows

Site	Weekly Sessions
BCH	29.5
Mater	9
RVH	26
Total	64.5

Normally the service averages 6 patients per list for GI lists, and EUS/ERCP/Resp average 4 patients per list. Due to constraints in relation to aerosol generating procedures during Covid, the number of patients treated on lists was reduced to 4 for GI and 3 for EUS/ERCP/Resp.

387. Due to the Mater and BCH sites being used to treat Covid-19 patients, the Endoscopy services on these sites were stood down in March/April 2020. Staff were redeployed to assist in ICU and theatres. The Belfast Trust continued to provide Endoscopy on the RVH site at a reduced rate of 10 sessions per week and 1 respiratory session. This represented 17% of normal capacity.

388. Following the reduction in lists, the Endoscopy triage group was established to ensure appropriate triage of waiting lists and new referrals. This ensured patients were treated in strict order of clinical priority. BCH Endoscopy recommenced on 27 April 2020 with 1 room being operational and providing 6

sessions per week. In total this meant 17 lists per week being provided, which represented 26% of normal capacity being delivered.

389. In May 2020 the Belfast Trust secured Independent Sector activity as follows:

- Ulster Independent Clinic- 2-3 sessions per week
- Kingsbridge- 1 session per week

The independent sector capacity enabled the Trust to provide 21 lists per week which equated to 32% of normal capacity

390. In June 2020 BCH Endoscopy increased capacity to 2 rooms, providing 20 sessions per week. Two rooms were also reinstated on the RVH site, providing 12 sessions per week. The Belfast Trust was then able to deliver 36 sessions per week, which was 56% of normal capacity. In July 2020 RVH increased to 3 rooms, providing 26 sessions per week. The Belfast Trust was then able to provide 50 sessions per week in total. This equated to 77% of normal capacity.

391. From August 2020 the BCH had returned to normal levels of 29.5 lists per week. The Belfast Trust was then providing 59.5 sessions per week, equating to 92% of normal capacity. Due to redeployment of staff and shielding, lists in the Mater did not get re-instated until late May 2021. The Belfast Trust was then able to deliver 100% commissioned capacity.

392. In February 2021 the PHA requested the assistance of the Belfast Trust in clearing the backlog of bowel cancer screening patients created by dealing with Covid-19. The Belfast Trust saw 97 patients from the Northern HSC Trust, with 9 cancers being discovered.

393. Service Budget Agreement performance for the Belfast Trust in relation to Endoscopy has been as follows:

Date	SBA	Delivered	Percentage
April 2020-March 2021	12418	6641	53%
April 2021-March 2022	12418	9359	75%
April 2022-March 2023	12418	11286	91%
April 2022- Jan 2023	8279	8499	103%

Chronic disease

394. Chronic disease management (including ischaemic heart disease, heart failure, diabetes, chronic kidney disease, rheumatology and dermatology) is largely outpatient-based. As a general principle, there was no significant problem with staffing resources for outpatient work. However, the need to keep patients who were not acutely ill away from acute hospitals meant that face to face clinics were vastly reduced, and, during pandemic peaks, were cancelled altogether. Clinic reviews became predominantly virtual (by telephone) which was not ideal for many specialties, but went some way to resolving the difficulty seeing outpatients in hospitals.

395. Chronic diseases which required acute intervention, such as ischaemic heart disease requiring surgery, encountered the same challenges as other

diseases requiring surgery ie drastically reduced operating theatre resource. This is discussed below.

396. Chronic kidney disease patients who had a suitable cadaver match were a special case. Although live donor transplants were greatly reduced due to the pandemic, Northern Ireland was able to take advantage of the great reduction in deceased donor transplants in the rest of the UK (where the first peak was earlier than in Northern Ireland), and was able to accept organs which had to be rejected by other UK centres, and would consequently have been wasted. The Belfast Trust renal transplant team was successful in transplanting 83 patients between April and June 2020. The majority of these cases were performed in the RVH, with a small number performed with Human Tissue Authority (HTA) approval in the Independent Sector. Prior to the pandemic, renal transplants were performed in BCH. However, BCH which had become the "Nightingale" Hospital. Renal transplant surgery returned to BCH in June 2020, after the first Covid-19 wave. BCH ICU was based on Level 2 in the BCH tower block from October 2020 and as such the ground floor and theatres was a green area, meaning renal transplant surgery could be performed in BCH theatres as normal.

397. *PCI (*percutaneous coronary intervention) *and Stroke thrombectomy.* The RVH is the regional centre for both PCI and stroke thrombectomy and thrombolysis. Both these services were maintained on the RVH during the pandemic. National Institute for cardiovascular outcomes research (NICOR) and Sentinel Stroke National Audit Programme (SSNAP) audit data from that period are reassuring and activity was maintained.

398. *Stroke*. During this time we saw in increase in the numbers of stroke patients requiring thrombectomy and Northern Ireland as a whole was the only

region within the UK that maintained thrombolysis rates (there was a fall in England and Wales) This is confirmed in the SSNAP data. The face to face TIA service was also maintained through the SDAS (Stroke Day Assessment Service).

Cancer treatment

399. Patients with cancer that required surgery, including colorectal cancer, encountered the same challenges as other diseases requiring surgery ie drastically reduced operating theatre resource. Some cancer patients had neo-adjuvant chemotherapy whilst awaiting surgery, decisions underpinned by discussions at MDM and consideration of national guidance. More detail on this issue is provided elsewhere in this statement.

Elective surgery

Surgical theatre resources in Belfast Trust were vastly reduced during the pandemic. Prior to March 2020 the Belfast Trust was delivering an average of 275 weekly sessions. This was already reduced from the funded level due to nursing workforce pressures. On 16 March 2020, to allow for staff to be trained in the care of Covid-19 patients, planned weekly theatre sessions were reduced to 125. This reduced further in week commencing 6 April 2020, to only 48 sessions for emergency surgery, as the first surge peaked. All MIH theatre activity ceased. All elective surgery in MPH ceased, with 5 sessions provided for emergency fracture surgery and no elective surgery performed (including joint replacement surgery). BCH theatre capacity ceased at this time with 48 sessions provided in RVH.

400. On 16 March 2020 I established a Belfast Trust surgical prioritisation committee consisting of a group of 4 senior clinicians, chaired by the Chair of the Clinical Ethics Committee. Its purpose was to prioritise the greatly reduced

resource for elective surgery. This group existed until 21 April 2021. The major challenge was a lack of theatre staff (both theatre nurses and anaesthetists) as staff had been redeployed to "Nightingale" wards to care for Covid-19 patients. Furthermore, the need for Covid-19 precautions considerably slowed down throughput in theatre. A further challenge was the lack of availability of ICU and HDU beds for postoperative care for major procedures. There was also a shortage of surgical beds at ward level.

401. Various approaches were adopted to try to maximise capacity. These included:

(i) Extended working day in theatres and use of weekend operating time for elective work.

(ii) Involvement of all regional capacity, including in the Independent Sector. In January 2021 a Regional Surgical Prioritisation Group to oversee regional theatre capacity and match with suitable patients was established . The regional group met weekly. However in the early stages of the pandemic, Belfast Trust patients requiring surgery were disadvantaged due to the Belfast Trust providing many regional surgical services. This fact pushed other non-regional but time-critical cases, eg colorectal surgery, down the priority list when theatre resources were very scarce. The number of patients requiring access to theatres was very closely monitored by Belfast Trust theatres and surgical teams.

(iii) In April 2020 the Federation of Surgical Specialty Associations (FSSA) published a 'Clinical Guide to surgical prioritisation during the COVID pandemic' CH/33 – INQ000226460). From this time onwards, all Belfast Trust patients waiting for surgery were prioritised in line with the FSSA guidance. Only those patients who were categorised within the P1-P2 were allocated to theatre

lists. However, the number of patients being added to the prioritisation list exceeded those being treated and the number of patients waiting gradually increased. The P2 categorisation was further sub divided within Northern Ireland given the limited theatre availability and to provide clinical consistency regionally.

2A – Cancer with a limited treatment window (eg rectal cancer post neoadjuvant RT with 2-week treatment window)

2B – Proven cancer (biopsy proven or cancer in which the diagnosis is clinical / radiological and the surgery provides both treatment and pathological confirmation eg testes and ovarian cancer)

2C – Suspected cancer (diagnostic procedure eg EUA + biopsy)

2D – Benign

The total number of patients waiting and treated by specialty was monitored on a weekly basis **CH/34** – INQ000471329) Patients waiting within the P2 categories were deemed as time critical.

(iv) Allocation of specialty-specific theatre lists based on the relative numbers of patients who were deemed high priority for time-critical surgery. It was felt unethical that scarce theatre resources were allocated on a pro-rata basis, based on the number of patients waiting, which would have meant that lower priority patients from one surgical specialty would be operated on more quickly than higher priority patients in another specialty. From 7 May, 2020, there was a drive to utilise available theatre capacity according to the priority levels within the RCS specialty specific guidance . This made an objective attempt to standardise priority across / between

specialties. Theatre lists were thus allocated based on the volume of priority 2 cases (non-emergency but time critical, and deemed to be necessary within 30 days) known to services. Surgeons in all specialities were requested to review waiting lists and allocate all patients a priority status based on the RCS guidance. Although there was a general dissatisfaction amongst surgeons due to their reduced operating time, feedback after the prioritisation group disbanded in 2021 demonstrated that the majority felt it was fair and equitable in the extraordinary circumstances within which we were operating.

(v) Independent Sector cases – started in May 2020 to take urgent benign cases and other cancer cases which did not need HDU post operatively, especially breast cancer cases.

(vi) Setting up of Post-operative Anaesthetic Care Units (PACUs) in the theatre recovery unit in BCH allowed complex cancer patients to have surgery without the need for an ICU bed. PACU beds opened in May 2020 in BCH, but provision fluctuated during Covid-19 surges and with downturn and upturn of lists.

(vii) Maximising of medical therapy or IR treatment for patients with chronic disease who would in pre-pandemic times have been offered surgical intervention eg ischaemic heart disease.

402. Joint replacement surgery, such as knee surgery, fell into priority 3. That type of surgery ceased early in the pandemic. However, the orthopaedic team presented a case for a more nuanced approach to consideration of the critical time window, given that elderly patients awaiting joint replacement were likely to become dependent and immobile if the opportunity for surgery was missed. National guidance on arthroplasty was used to demonstrate that many cases awaiting joint replacement "where delay would prejudice outcome" fell into a priority 2 category and were approved to proceed. This was on the grounds

that they could be carried out in Musgrave Park Hospital, in lists that had been allocated for fractures but which were unfilled (due to fewer fractures as people were not engaging in usual activities), and also because they did not require HDU post operatively.

403. As time went on, and the number of Belfast Trust patients in the P2 category continued to grow at a rate more quickly than they could be operated on (>1000 July 2020), with the advent of the second surge in October 2020, the P2 category required further refinement to 'absolute priority' ie signfiicant risk to life or limb. Chairs of Division were required to validate these lists to promote transparency, consistency and equity across all specialties.

404. Throughout the pandemic, the surgical prioritisation group continued to seek additional theatre space and asked the Executive Team to consider early phased restoration of elective surgical activity directed towards targeted cohorts, where positive impact will be maximised, such as patients requiring arthroplasty.

405. By November 2020, inequity across the region was very apparent and the Belfast Trust Chief Executive wrote to colleagues in DoH NI and South Eastern HSC Trust asking for support from Lagan Valley Hospital Day Procedure Unit to carry out red flag endoscopies rather than hernia repairs and varicose veins (P4 work). This was to make space for regional cancer and complex surgery that required to be carried out in Belfast Trust. This led to the establishment of the regional prioritisation group, which took over some of the work of the Belfast Trust prioritisation group. As more theatres opened, DoH NI SPPG felt in March 2021 that their role had come to an end, and formally disbanded in April 2021.

406. Whilst considerable effort was made to try to make ethical and fair decisions, in terms of the appropriate use of available surgical capacity during

the pandemic, there can also be no doubt that these decisions were extremely difficult, and often painful, for those involved with them.

A summary of any changes to the provision of maternity services made at the hospital during the relevant period.

407. Changes to maternity services were necessary during the pandemic. The maternity services team worked to adapt the maternity service by implementing a number of service changes to include:

- a multidisciplinary daily maternity situation report meeting (MATSITREP) with social distancing in RJMS lecture theatre. The MATSITREP continuously reviewed evolving published guidance from Royal Colleges and government and advisory bodies. The team developed a three-stage surge plan, providing action cards for each individual ward / department.
- Access to the Maternity Hospital was reduced to essential personnel only. Service adaptations were continuously communicated to the MSLC Chair and service users via various platforms.
- Specialist Midwives were upskilled for clinical redeployment.
- The Midwifery Practice Education Team implemented organised learning simulations and trained all disciplines in PPE donning and doffing.
- Microsoft Teams was used when possible to facilitate meetings and essential contacts.
- A telephone helpline and email address for service user queries was implemented and manned by pregnant and shielded midwives who could no longer be service user facing.
- Joint HR/Maternity podcasts provided information, for pregnant staff within the Belfast Trust and pregnant women using the service, to

promote the helpline and answer queries in relation to visiting, birth partners, midwife-led care, homebirth and water birth.

- Routine antenatal visits were replaced, if safe, with telephone/video conversations. Booking visits were conducted by telephone where feasible.
- Each antenatal clinic was reviewed to ensure face-to-face review was offered only when necessary, and appointment timings were streamlined to ensure 2m spacing. Virtual clinics were created to ensure follow up for diabetic service users.
- Anomaly scanning was maintained as recommended by guidance.
- The service continued to offer medical management of miscarriage, with surgical management reserved for urgent cases. Surgical management was performed by manual vacuum aspiration (MVA) to avoid the need for aerosol generating procedures.
- Criteria for admission to the Antenatal Inpatient area was reviewed and early discharge from ward facilitated.
- Non-urgent cases, induction of labour (IOL), elective caesarean sections, and antenatal clinics were reviewed on a daily basis. Induction of labour (IOL) planning criteria and processes were reviewed and amended.
- The Belfast Trust had already established an IOL out-patient service utilising mechanical balloon for cervical ripening. The criteria for this was reviewed and expanded.
- Self-monitoring of blood pressure for women who met the criteria as recommended by Royal College of Gynacologists (RCOG) was implemented, including the procurement of recommended equipment.
- The standalone and alongside midwifery led units became designated Covid-19 areas, but the senior midwifery team assigned rooms to the Standalone MLU team within the central delivery suite, including one pool room for women on a midwifery led pathway.

- The service worked with a local charity who funded a doula scheme for vulnerable women and those who had no birth partner.
- The home birth service was maintained throughout the pandemic. There was an increased number of requests for home birth with some service users temporarily relocating residency to avail of this service. Home birth rotas were supported by MLU midwives.
- Infant feeding support – breast feeding support initiative was provided via Microsoft teams. A weekly video group meeting for advice, support and social contact was facilitated by the Infant Feeding Lead.

408. Steps were taken to try to support our maternity staff during the pandemic:

- Sleeping areas were identified, if needed.
- Free food and drink was provided for staff.
- Towels, fresh underwear/socks available for staff.
- Clinical psychology team available to support staff.
- Breakout 'wobble' rooms available. These were stocked with water, snacks etc.
- Staff were also invited to contribute food items for provision of hampers to staff experiencing financial difficulties.

409. Impact on Women's Experience. BirthWise carried out a survey of women's experience of maternity services during the pandemic **CH/35 - INQ000471324**

410. Visiting arrangement in Maternity Services were impacted in a similar manner as with all other health care environments. Women were advised as outlined below:

- You and your birthing partner will be asked screening questions on entering the maternity building.

- You must wear **a face covering or face mask** at all times while in the maternity building.
- You must sanitise your hands on entering the maternity building and again on admission to the individual ward or department.
- We expect women admitted to the maternity service to have a Covid-19 test. This helps to ensure that women and staff in the maternity hospital are safe.
- From time to time women may be identified as a Covid-19 contact. You will be contacted if this is relevant to you and advised on the current recommended action required.

411. The following scan and antenatal appointments advice was given to women:
    - One partner may accompany a woman attending the following;
        - Early Pregnancy Unit
        - booking scan
        - anomaly scan
        - fetal medicine scan
        - antenatal appointments
    - We have to adhere to 1-metre social distancing in our outpatient settings and the waiting areas. While you are welcome to bring your partner to all appointments, please be aware that you may be asked to wait outside the building until seating becomes available.
    - We would ask you to consider attending antenatal appointments on your own if you can.
    - Please arrive **no earlier** than 10 minutes prior to your allocated appointment time.
    - If your antenatal appointment is on same day as your GTT, your partner may only accompany you to your antenatal appointment and will be phoned to come in to join you.

- When attending Maternity Assessment Unit, partners will be asked to wait outside the building until the woman is moving into the assessment room.
- We cannot welcome children at this time.

412. Induction of Labour. Birth partners could accompany women for a period of time within the induction of labour area. For privacy reasons, partners could not stay at night.

413. Labour and Birth. Throughout the pandemic, women were limited to one birth partner for labour and delivery, except in exceptional circumstances.

414. Neonatal Unit. Two parents or designated carers were able to provide care for their baby in the Special Care Baby Unit or the Neonatal Intensive Care Unit (PPE was required and provided)

415. Visiting permitted in our inpatient wards. One daily visit from one of three nominated ward visitors was permitted in our inpatient wards. The duration and timing of the visits was decided by the midwife in charge.

An overview of how ambulance handover times changed during the relevant period including whether there were excessive waiting times for ambulances to admit patients to the hospital, and the reasons for this. Describe any steps taken at hospital, Trust, or national level to reduce handover times and whether these steps were effective.

416. During the initial phases of the Covid-19 pandemic, when overall ED attendances decreased, flow from ambulances was not a significant challenge and there were limited delays. However, as attendances began to normalize, and overall flow out of hospitals decreased, there were, at times, significant

delays in offloading ambulances. This was because patients remained in the ambulance until a clinical space was available. The Belfast Trust took a shared care approach with the Northern Ireland Ambulance Service (NIAS), thus ensuring patients were immediately triaged to determine clinical priority and acuity, ensuring personal care, food and hydration.

In relation to escalation of care decision making within the hospital, please set out:

a. ***whether concerns were voiced by clinicians in the hospital regarding the absence of a national decision-making tool for rationing care;***

417. Concerns were voiced by clinicians in the hospital regarding the absence of a national decision-making tool for rationing care; the Faculty of Intensive Care Medicine produced guidelines for this eventuality, but they were never ratified, nor were they required in Northern Ireland.

b. ***whether the hospital had a decision-making tool or checklist to assist clinicians in deciding whether to escalate care, such as admission to the ICU and if so, how and by whom the tool was formulated, and when it was introduced.***

418. The Belfast Trust did have a hospital decision-making tool or checklist to assist clinicians in deciding whether to escalate care, such as admission to the ICU. A tool was formulated to allow collective decision-making regarding escalation. It reflects best practice in normal circumstances and was designed to assist and provide confidence in decision making for referring specialties.

CH/36 - INQ000499443 See goals document.

The clinical decision making tool for escalation to Critical Care was developed during the first phase of the pandemic. It was based on the UK Intensive Care Society's guidance published in May 2020. The rationale for the clinical decision making tool was that it would expedite clinical decision making during times of increased covid admission pressure. To our knowledge the tool was not used clinically as we did not depart from our normal decision making processes.

c. ***whether the hospital's ethics panel or committee was involved in formulating such a tool or policy***

419. The hospital's ethics panel was involved in formulating such a tool or policy.

d. ***any changes to this tool, if implemented, during the relevant period;***

420. The tool was not implemented beyond the first stages, which reflect routine practice.

e. ***whether the criteria for admission of patients to intensive care differed during the pandemic to the criteria in place prior to the pandemic, and if so, how the criteria differed and the reasons for this change***

421. The criteria for admission of patients to intensive care did not change or differ during the pandemic to the criteria in place prior to the pandemic.

f. ***whether the criteria for providing oxygen therapy (including low or high flow oxygen, CPAP, NIV and/or mechanical ventilation) changed during the relevant period, and if so the reasons for this change.***

422. The criteria for providing oxygen therapy (including low or high flow oxygen, CPAP, NIV and/or mechanical ventilation) followed standard practice. With experience in UK centres shared in real time, and clinical trials informing outcomes, practice followed evidence-based UK guidance with regard to high flow, non-invasive and self-proning strategies.

An overview of any concerns or issues in relation to rationing of care (for example, including but not limited to: rationing treatment such as the supply

of oxygen, rationing access to ICU beds, rationing non-invasive ventilation) and the impact this had on both the patient and the decision maker.

423. As indicated, Belfast Trust consists of multiple sites providing aspects of care to both the greater Belfast area and to the region. Patients of the Belfast Trust were, and are, cared for in the most appropriate location within the Trust. This included trying to reduce unnecessary duplication of surgical and medical services across sites during the pandemic crisis, The imperative during the pandemic was to preserve as much time critical and emergency medical and surgical interventions as possible, doing as much good for as many people that could benefit.

424. Admission to critical care is appropriate if the patient can be reasonably expected to survive and receive sustained benefit from the treatments or interventions that can provided in an ICU. Continuation of critical care treatments should be considered in the light of patient response.

425. While numerous scoring systems have been developed to indicate the severity of critical illness, organ dysfunction, and likely outcomes, these are not validated for specific individual outcomes. Scoring systems are not routinely used to determine suitability for admission to critical care in the Belfast Trust.

426. Early modelling predictions suggested that the healthcare system could be overwhelmed by the number of Covid-19 patients at both local and national levels, due to insufficient staff and bed capacity. While each HSC Trust developed their own plan for meeting the increased demand, the Critical Care Network for Northern Ireland (CCaNNi) co-ordinated the HSC Trusts' planning for the pandemic and developed a plan for managing the critical care demand across Northern Ireland. During times of heaviest critical care demand,

CCaNNi produced four hourly updates on critical care bed availability across the province and identified where subsequent critically ill patients should be admitted if there was a lack of bed availability in the admitting hospital. If the inter-hospital transfer of a critically ill patient was required, this was undertaken by the Northern Ireland Specialist Transport and Retrieval service (NISTAR).

427. In an emergency situation, when a system is likely to be overwhelmed by the demand on it, triaging of patients/victims may be required to identify those most likely to benefit from interventions and utilise the available resources most efficiently. There were concerns in the early stages of the pandemic that a triage system would need to be implemented to manage the potential huge demand for critical care. Initial work was undertaken by CCaNNi to develop a triage tool, but this work was ceased as a national tool was being developed. On 25 March 2020 a draft triage tool for patients with Covid-19 infection was circulated. However, the instruction was that this could only be used following signoff by the Chief Medical Officers of the four Home Nations. Ultimately, this triage tool was not endorsed for clinical use.

428. All decisions to admit a patient to critical care were taken by a critical care consultant. In March 2020, a pathway was designed for dealing with (i) disagreement with a referring service about the appropriateness of admission or (ii) concerns about the goals of care for an existing patient. Escalating steps involved in the pathway included discussing the case with a second ICU consultant, seeking an external critical care opinion which could be facilitated by CCaNNi, and then seeking advice from members of the Belfast Trust's Clinical Ethics Committee.

429. A flowchart highlighting how a decision to admit to critical care in the Belfast Trust in the event of a disagreement between a referring clinician and

ICU consultant was produced in January 2021. This was to try to ensure a robust system was in place if such a situation should arise. This flow chart is included as **CH/36 - INQ000499443**

430. Throughout the pandemic, no patients were denied access to critical care if their clinical situation warranted it. There was no modification of the principle highlighted above. At no stage was a triage, or reverse triage, system utilised, or care rationed. In the event of no bed availability in the Belfast Trust, patients were transferred by NISTAR to an available critical care bed elsewhere in Northern Ireland.

431. Clinicians expressed concern on numerous occasions about the wider impact of the downturn of services in order to support critical care, particularly surgery, and the effects to be anticipated in due course as a result of people not being able to access the required healthcare services in a timely manner. The expansion of critical care capacity to meet the Covid-19 demand required the redeployment to critical care of large numbers of operating theatre nursing staff, with the resultant extensive downturn of non-emergency surgery.

Whether the existence of a DNACPR notice, either as part of an Advance Directive or a standalone notice, was taken into account by clinicians when deciding whether to escalate care, for example providing oxygen therapy or admitting the patient to ICU. An explanation of whether clinicians received any guidance from the hospital, Trust, or other bodies, regarding the effect of DNACPR or advance care planning forms on clinical decisions around the escalation of care.

432. A "Do not attempt cardiopulmonary resuscitation"" notice (or DNACPR) is a topic which is covered well by a variety of external bodies, including the General Medical Council (GMC), Royal Colleges, a variety of professional unions (e.g. British Medical Association BMA), and also learning cases and

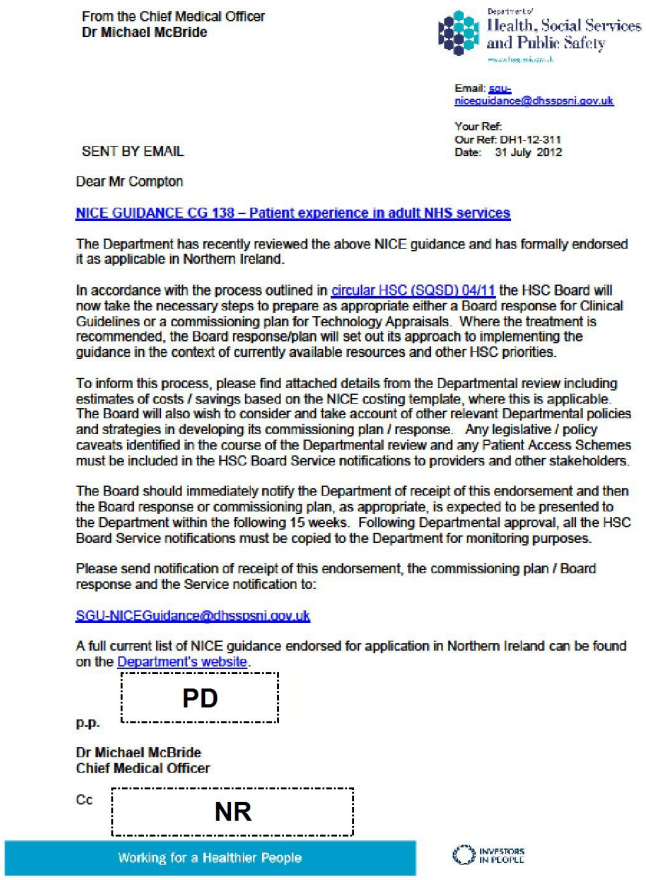
discussions from the indemnity providers. Undergraduate and Postgraduate training through the Deaneries also ensures that this is part of continuing education supported until a Doctor within the hospital assumes either a Consultant role or a SAS contract.

433. The GMC has extensive documentation relating to DNACPR. The GMC's Cardiopulmonary Resuscitation (CPR) – professional standards document outlines the professional standards for all medical professionals within the United Kingdom and covers recommended good clinical practice including communication with the patient, the family members and also in emergency scenarios.

434. The NHS has also produced a reference document dealing with DNACPR decisions. Within this document, it clearly articulates that DNACPR is on an individual basis, and it is unlawful to make a collective decision on a group of patients, or service users, based on shared locality. Within this document it is outlined that the process of decision making of "not for cardio pulmonary resuscitation" is achieved by use of a variety of tools which are used by a variety of clinical staff to communicate with each other about this shared decision making process. It outlines it is not legally binding and therefore, in Northern Ireland, during transitions of care, the DNACPR status has to be reassessed at each stage of transition ie. on entrance to a hospital or discharge from a hospital. Within this document, it also outlines that the decision is not time limited and can alter with clinical condition as appropriate. As such, therefore, a resource dependent audit tool of decisions of revoking or changing DNACPR status is not mandated. As Northern Ireland moves to a digital healthcare record this will be a potential area to be looked at, however during the reporting period of Covid-19, no such robust systematic audit existed in relation to revoking of DNACPR.

435. In 2016 a joint document was published between the British Resuscitation Council and the British Medical Association (BMA) and the Royal College of Nursing (RCN). This was called "Decisions relating to Cardiopulmonary Resuscitation" and was the 3rd edition of what was previously referred to as the "Joint Statement". This multi-professional document, co-produced with experts in the clinical area of resuscitation, also had an extensive consultative process including patient groups, regulators, and charities. This ensured there was Patient Public Involvement. This document also took into consideration judicial decisions on the subject.

436. The National Institute for Clinical Excellence (NICE) is not mandated within Northern Ireland, but its guidance is subject to a local endorsement process by the DOH NI. In 2012, NICE had a clinical guideline called CG:138 "Patient experience in adult NHS services: improving the experience of care for people using adult NHS services". This was endorsed by DoH NI in July 2012 and the communication from the DoH NI to all trusts that followed is set out below:



From the Chief Medical Officer
Dr Michael McBride

Department of Health, Social Services and Public Safety

Email: sgu-nicequidance@dhsspsni.gov.uk

Your Ref:
Our Ref: DH1-12-311
Date: 31 July 2012

SENT BY EMAIL

Dear Mr Compton

NICE GUIDANCE CG 138 – Patient experience in adult NHS services

The Department has recently reviewed the above NICE guidance and has formally endorsed it as applicable in Northern Ireland.

In accordance with the process outlined in circular HSC (SQSD) 04/11 the HSC Board will now take the necessary steps to prepare as appropriate either a Board response for Clinical Guidelines or a commissioning plan for Technology Appraisals. Where the treatment is recommended, the Board response/plan will set out its approach to implementing the guidance in the context of currently available resources and other HSC priorities.

To inform this process, please find attached details from the Departmental review including estimates of costs / savings based on the NICE costing template, where this is applicable. The Board will also wish to consider and take account of other relevant Departmental policies and strategies in developing its commissioning plan / response. Any legislative / policy caveats identified in the course of the Departmental review and any Patient Access Schemes must be included in the HSC Board Service notifications to providers and other stakeholders.

The Board should immediately notify the Department of receipt of this endorsement and then the Board response or commissioning plan, as appropriate, is expected to be presented to the Department within the following 15 weeks. Following Departmental approval, all the HSC Board Service notifications must be copied to the Department for monitoring purposes.

Please send notification of receipt of this endorsement, the commissioning plan / Board response and the Service notification to:

SGU-NICEGuidance@dhsspsni.gov.uk

A full current list of NICE guidance endorsed for application in Northern Ireland can be found on the Department's website.

PD

p.p.

Dr Michael McBride
Chief Medical Officer

Cc **NR**

Working for a Healthier People

INVESTORS IN PEOPLE

437. There is evidence of compliance with this from the current deputy nursing directors and their predecessors. This was then revised in June 2021 to form the wider national guideline called “Shared Decision Making” (NG197). There was extensive consultation performed by NICE in this process, and it included the development of useful tool kits. Although these documents do not solely relate to DNACPR, it is important to ensure the principles of shared care decision making, and the culture to include patients and their families, are understood. NICE also ensured that there is consideration of those patients who may lack mental capacity, and have focused on this aspect in another document produced in 2018 called NG108. It dealt with decision making in the context of mental capacity. This was not specifically endorsed in Northern Ireland, but is a best practice standard.

438. In Feb 2021 the Ethical Committee of the Royal College of Physicians (London) published a document which covered a range of issues. It reminded clinicians of the above important GMC statements and associated guidance. This document was endorsed by a wide range of other royal colleges and also referenced by the Academy of Medical Royal Colleges.

439. During the pandemic there was a requirement for the urgent cascade of information across the 4 nations, within the NHS and HSC, and also therefore within the Belfast Trust. The Belfast Trust achieved this, as I have previously mentioned, through the Covid-19 Oversight Group and a comprehensive communications strategy.

440. By the 20 April 2020, guidance which was evidence based was collated and electronically available in one location so that it could be accessed by all clinical teams within the Belfast Trust. This guidance was reviewed and updated as required, depending on the literature and other relevant external guidance. This suite of material was hosted on the Belfast Trust intra net providing access for all staff, and also on the system that assisted the medical postgraduate trainees. One important document developed related to communication with families:

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Family Member/Agreed Contact Telephone Communication Sheet

Name of Agreed Contact Person (One Contact Only): _____

The preference is to meet or phone agreed contact and update verbally.
This communication sheet should ONLY be used during times of increased work pressures, when medical staff are likely to be unavailable to meet or phone the Agreed Contact.

Doctors Record	Please write **Legibly, Clearly and Succintly,** and **exactly** as you would speak to the named contact if they were present. **Circle** all relevant statements. Free text can be added.	**Support Staff Record** Read doctors record aloud to named contact over phone or in person.
Date:	This is the situation for Mr /Mrs _____ at present: • Conscious/unconscious • Needing Oxygen/medication to ease breathing	**Date:**
Time:	• Ventilator support • IV Antibiotics **Other treatments** (please name):	**Time:**
Written on behalf of (Senior Clinician):	**(Please Circle)** Mr/Mrs _____ is stable/ improving / deteriorating.	**Read to:**
Written by:	**(Please Circle)** There ARE other active treatment options to improve the outlook for this patient. This is the plan for the other treatments :- **OR** Unfortunately there are limits to medicine. Mr/Mrs _____ has had all the treatments available for them, and we are now concerned that they are sick enough that they might die in the coming days / hours.	**Read by:**
If survival unclear or actively dying: Use or score out as appropriate	**(Please Circle)** We will continue with the current treatments and see how things go over the next 24 hours. **OR** All treatment now is focused on comfort care. I'm so sorry to have to say this by telephone. Go to Communication with Family/Named Contact Before and After Death for more details on what to say now.	

Message to be communicated to named contact / family member at every conversation:

We are so sorry this is happening.

We wish to assure you that we are doing **everything we possibly can to help your loved one and to relieve any distress.** And we will continue to do this.

441. Further tools were developed and shared to assist and guide staff through what was an extremely difficult time for families. It assisted with keeping GMC and Belfast Trust principles at the forefront of everyone's minds.

Communication with Family/Named Contact Before and After Death

This communication sheet should be used to help staff find a form of words to explain what is happening and answer common questions

Before Death Conversation

Sadly the doctors are now feeling that the treatment your ….. has been receiving is not going to save his/her life. The team has decided they should now be making him/her as comfortable as possible.

To allow me to care for …… in the best possible way I would like to ask:

- Did they ever mention what would be important to them at the end of their life?
- Is there anything we need to know in order to take care of the patient at this time?
- Are there religious or cultural practices that are important to them? We will try our very best to facilitate these.
- So that everybody is clear, I wonder if you would allow me to ask some questions about your …… rings , medals or other precious possessions as the nurses would have to take them off on the ward if you want them returned. They would be kept in a safe place until we can get them back to you.

  We advise that clothes and blankets etc are disposed of by the hospital – due to the infection risk. (If you wish to take these home we can seal them in a double bag. We will send details by post about this.)
- Would you like us to hold a phone to his/her ear so you can speak to him/her?
  - o Family could phone their loved ones own phone if present and on.
  - o Other devices/phones can be used and cleaned – need to check ward availability before offering.
- We want to do everything possible to help you visit your loved one. It is up to you but we could support one person (by putting special protective clothing on you) for a short visit at an arranged time.
  - o We do not recommend this if you are over 70, or pregnant or have another medical problem
  - o You would need to continue to follow government guidelines regarding general social distancing but no other special precautions after this visit.
  - o but please follow current guidelines eg if visiting not permitted at all at the time

We are so sorry this is happening. We wish to assure you that we are doing **everything we possibly can to help your loved one and to relieve any distress.** And we will continue to do this.

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442. We also ensured that tools were designed to support the communication with families after their loved one had died.

After Death Conversation

I am ringing to let you know that your …….. has just died.

I am so sorry. It must be so difficult to not be here at this time.

Please allow silence and time for the person to hear this news.

- We will follow your instructions about ….. personal possessions.
- You will now need to contact a funeral director - they will make arrangements for you and guide you through this process. They will keep you right about what is possible to do by way of a funeral.
- When someone dies we give family a bereavement pack with bereavement booklets and other information we hope is useful. We will post it out to you as soon as possible in a Belfast Trust marked envelope.

Is there anything you want to ask me?

Is there someone who can be with you now? (If not, there may be a support number you can offer, please check updated guidance at the time.)

We hope to be in touch soon to talk through everything that has happened.

I am so sorry to be making this call to you.

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443. The progression of the pandemic led to the opening of the "Nightingale" Hospital at the Belfast City Hospital. Again guidelines relating to anticipatory care were developed and share:

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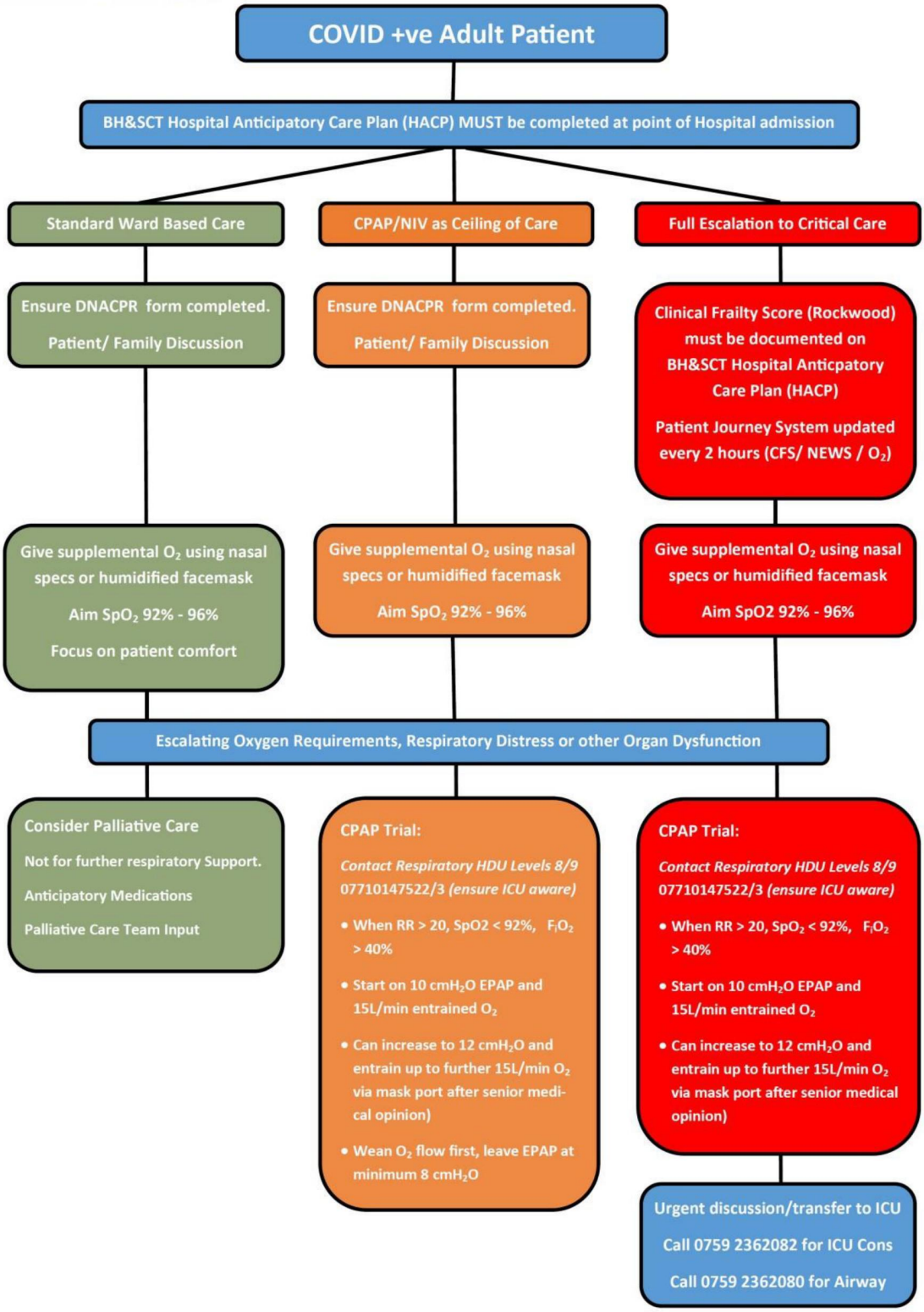
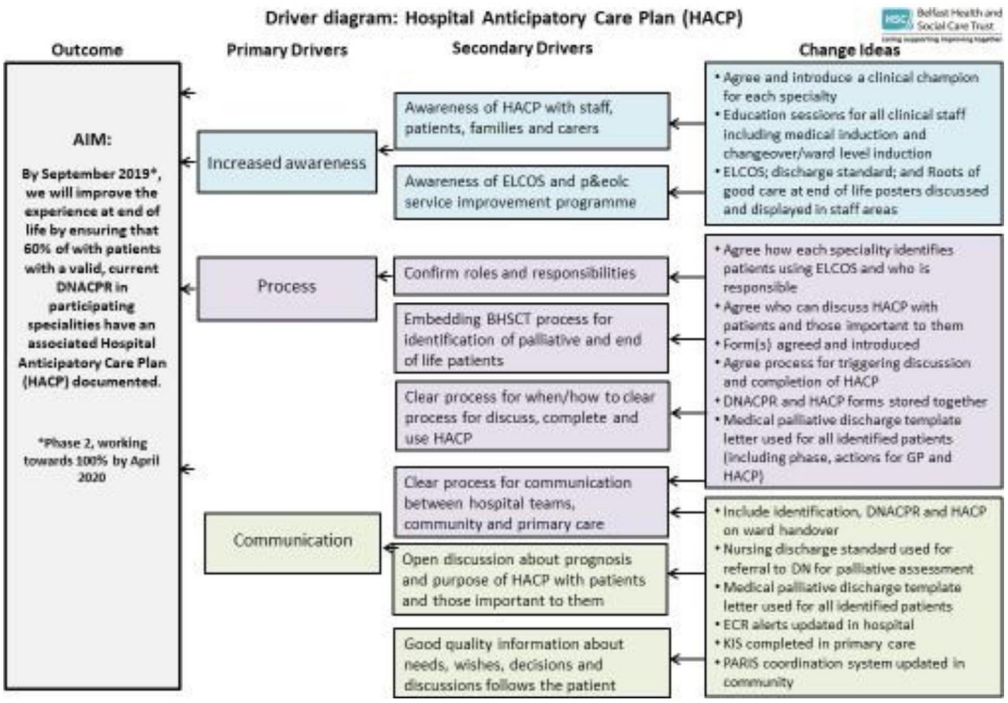
Belfast City Hospital Site COVID-19 Treatment Pathway

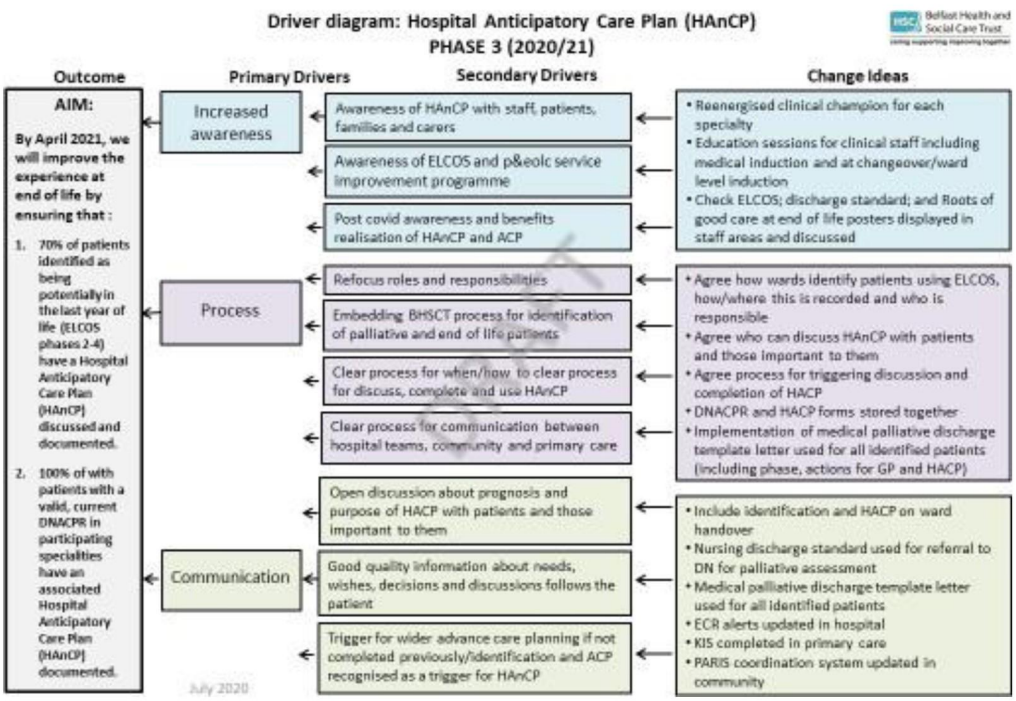


444. The regional Palliative Medicines Group also developed important documents alongside the PHA to address how patients, whilst in hospital, were to be treated with medicines including oxygen. Within the Belfast Trust itself we had a policy relating to DNACPR, and also developed a pathway relating to anticipatory care. Enshrined in both of these documents, from 2017 and 2018, are the principles of inclusion of discussions with the patient and also the family. The latter also includes both acute hospital sites but also important support for similar decision making in the community.

445. The Belfast Trust agreed anticipatory care plan was adopted as the regional standard in 2019 and was to be implemented as such. Using the approach of Quality Improvement this was then endorsed in a spread and scale approach



446. During 2020 and 2021 this was then modified;



447. The final aspects to refer to is the development of the Covid-19 pathway as led by clinical teams to ensure that the decisions made via the anticipatory care and also the DNACPR also were taken into account. This included prompts to clinical colleagues to ensure family and patients were central to all decision-making steps in relationship to decisions relating to not for resuscitation.

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COVID-19 Daily Assessment: Day___

Use addressograph-otherwise write in capitals

Surname:_____

First names: _____

DOB: _____

Health and Care No. _____

Consultant (If present) _____

Dr leading review:_____

Date:_____Time:_____

Day on Respiratory support: _____

Others present: _____

MORNING ROUND- Clinical Progress

Co-morbidities

Examination

NEWS: RR_____ Spo2____ Temp_____ T_{max} 24 hours_____ BP_____ HR_____

I/0 last 24 hours_____

Respiratory Support

☐ **Oxygen**

Nasal cannula flow (L/min)_____

Face mask (FiO2)_____

☐ **NIV** Date/Time commenced_____

IPAP___EPAP___MODE___

NIV past 24h_____

O2 via NIV_____O2 on NIV breaks_____

NIV Prescription complete? ☐

☐ **HFNO** Date/Time commenced_____

Flow setting_____L O2 entrained_____L

Concentration O2_____%

HFNO prescription complete? ☐

Considerations

For escalation? **Yes** ☐ **No** ☐

DNACPR form: **Yes** ☐ **No** ☐

If yes, Hospital Anticipatory Care Plan ☐

Family discussion **Yes** ☐ **Need to plan** ☐

☐ **T**hromboprophylaxis ☐ **A**ntibiotics review

☐ **O**xygen prescribed ☐ **L**ength of stay

☐ **F**luid status ☐ **S**teroids/ supplements

☐ **K**ardex reviewed

☐ ICU discussion ☐ Palliative Care

Current issues	Plan from Morning Round/ICU Input

Completed by:_____ **GMC No:**_____

Blood & investigation results

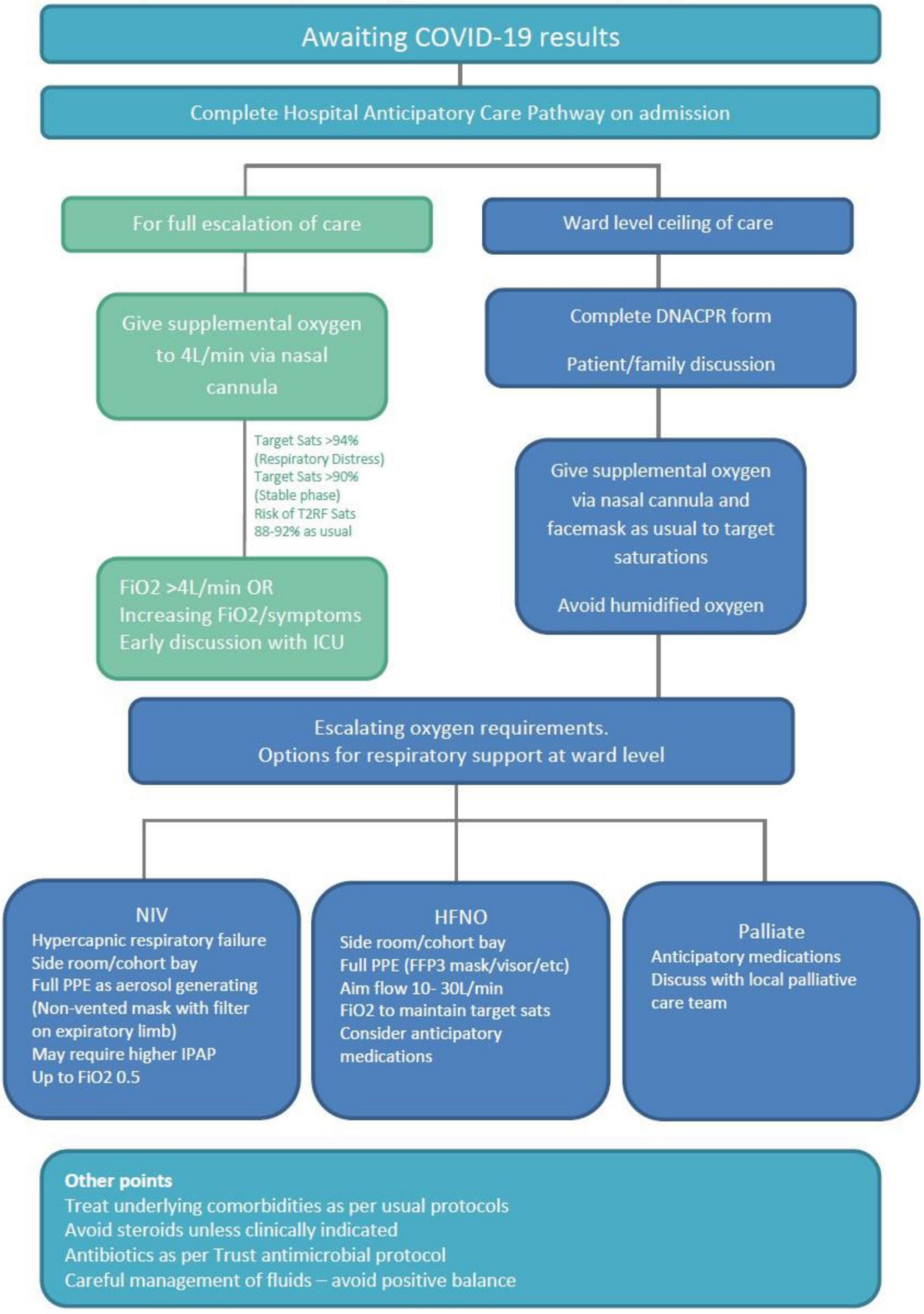
EVENING ROUND

OVERNIGHT PLAN

448. The focus within Belfast Trust was to facilitate rapid access to meaningful documents based on rapidly changing evidence-based medicine. As such, the usual assurance processes of seeking approval at a committee was replaced by approval at the Covid-19 Oversight Group, after relevant clinical MDT expert development had occurred. This led to the development of the below resource for clinical colleagues. It helped clinicians ensure that all patients were following the outlined over-arching principles adopted by the GMC, Royal Colleges, BMA, RCN, NHS, DoH NI and NICE.

Respiratory support algorithm for suspected COVID-19 patients at ward level

*NB. These guidelines are subject to change. Please consult with Respiratory/Medical Consultant



In relation to DNACPR notices, whether:

a. DNACPR notices issued by clinicians in the hospital form part of the patient's electronic record;

449. Within Belfast Trust, with the exception of ICU, the majority of clinical areas do not utilise an electronic record. The majority of the clinical records for inpatients are in the format of handwritten patient notes. DNACPR notices form part of the patient's clinical records, but these are not electronic.

450. In June 2023, as part of a regional project, Belfast Trust moved to the Encompass electronic patient record system. As a consequence, DNACPR will become part of the patient electronic record.

b. any concerns were raised that DNACPR notices appeared to be issued (whether by hospital or external clinicians such as GPs) disproportionately to patients falling within an equality category set out in the Northern Ireland Act 1998, such as patients from ethnic minority backgrounds, patients of a particular age or disabled patients;

451. Those involved with this witness statement were not themselves aware of the type of concerns referred to in the question.

452. In order to answer this question as comprehensively as possible, the Belfast Trust reviewed its incident reporting system, and its complaints system.

453. The Belfast Trust does not have any record of any concerns raised that DNACPR notices appeared to be issued disproportionately or inappropriately to patients falling within an equality category as set out in the Northern Ireland Act 1998, including ethnicity, age or disabled patients.

454. In preparation for this answer, we reviewed our incident reporting system to analyse if the data was any concern. As the data shows below

c. any concerns that patients arriving at the hospital had DNACPR notices which did not appear to be clinically appropriate,

455. Belfast Trust does not routinely collect this specific data, and we are also mindful the DoH NI does not either. However within the Belfast Trust, the tool of DNACPR is used to share information between professional colleagues such as paramedics, nurses and doctors and especially at periods of transition of care. The DNACPR is not of legal standing and therefore the Belfast Trust would have to reassess and re-evaluate and follow the principles as outlined by the GMC and Belfast Trust policy to re-complete a form detailing DNACPR. This would also ensure that further affirmative discussion with next of kin occurred or a reassessment. There have been no concerns escalated within the Belfast Trust of staff encountering DNACPR notices which did not appear to be clinically appropriate.

456. Within the Belfast Trust there is a process in which there is a review of the death of patients who die whilst in the care of the Belfast Trust. During this mortality review, all aspects of care are reviewed and discussed by the team involved with the care of the patient. The below table demonstrate how many patients have been reviewed in this mortality pathway over the years.

year	Number of patients reported via mortality pathway
2019	2140
2020	2061
2021	2104
2022	2368

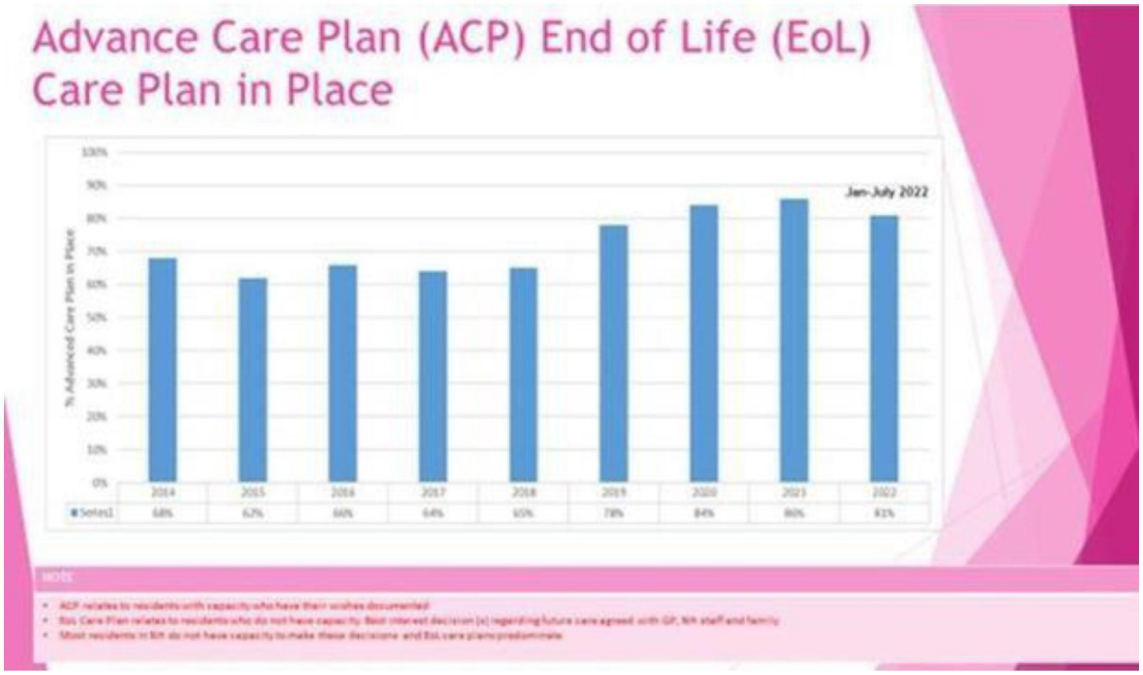
457. The numbers do not appear to show any significant variation of avoidance of hospital or change in pattern of death occurring. Our mortality figures also are compared via a variety of statistical methods (Risk Adjusted Mortality

Index (RAMI) and Standardised Hospital Mortality Index (SHMI)). If there had been any inappropriate use of DNACPR this would potentially have increased our mortality over these time year periods. Review of these deaths indicate no significant comments relating to inappropriate DNACPR decision making.

d. the hospital noticed any increase in the number of patients arriving at the hospital with a DNACPR notice on their notes;

458. We do not routinely collect this type of data. However, we do have data in respect of Advanced Care Plans (ACP) for frail elderly patients in care home facilities. The Belfast Trust Care Home Support Team (CHST) during Covid-19 provided support to care homes and reviewed which residents had an ACP in place and ensured this was well communicated within the care facility. For those who did not have an ACP in place, advice was provided to consider beginning conversations with the resident, family and GP to ascertain their wishes should the resident develop Covid-19 and potentially deteriorate. Routine CHST clinical visits were undertaken to review residents receiving palliative care, which included a review of residents' wishes and best interests' decisions. This enabled patients in these clinical settings to be supported in the community, and it helped ensure that patients and their families and primary care general practitioners were experiencing best practice.

459. Audit of the relevant data in relation to patients shows that the use of Advanced Care Plans/ End of Life plans had already increased in 2019, and there was no significant increase in use of Advanced Care Plans in our nursing homes during the period under examination, 2020 to 2022.



e. the hospital issued guidance to clinical staff regarding how to communicate and explain DNACPR decisions to patients and their families, carers, and loved ones, and if so, a brief outline of this guidance.

460. As mentioned in the answer to question 41, Belfast Trust has several policies and pathways developed which assist in guiding our staff to communicate with patients and their families in relation to DNACPR. This includes the Belfast Trust policy, the anticipatory care pathway which led onto a regional standard, the development of a Covid-19 pathway which drew on the overarching policies and good clinical practice. We also ensured, through our divisional structures, the provision of support to those areas in which we were aware of patients of age, mental health and learning disability and

engaged and support them to ensure the principles of good clinical practice were followed.

Impact on Hospital Staff

A summary of the impact of the pandemic on staff morale and on their physical health and mental wellbeing, including:

a. A description of any practical steps taken by the hospital or Trust to minimise the impact of the pandemic on staff members:

i. physical health

461. Dealing with Covid-19 inevitably had a serious impact on the staff of the Belfast Trust. This is something we were both cogniscant of, and did what we could to manage.

462. Our bWell Here4U free activities were delivered virtually to staff including Pilates, yoga and HIIT classes. In addition, we adapted the NHS Fit For The Fight initiative, which provided staff with a comprehensive, free resource of a wide range of virtual, physical activities.

463. The Belfast Trust supported front line staff in the provision of accommodation to enable them to remain in work, and minimise the impact for those staff who had high-risk/vulnerable/shielded family at home. Accommodation requests were considered for both short and longer- term periods, depending on requirements and criteria established by the Belfast Trust. A summary of the position is as follows:

- Over 300 requests for accommodation
- Approx. 2000 nights booked in Hotel
- Approx. 100 staff moved to longer-term accommodation (Apartments/Houses)

ii. mental wellbeing including those staff suffering from moral distress and/ or moral injury;

464. The Occupational Health Advice Line was operational 7 days per week and provided advice to 45,765 staff. Advice line operators also followed up on calls with individuals who were unwell and made 11,095 wellness calls. A psychological support line was also operational for staff as required.

465. The Belfast Trust developed a range of initiatives to enhance staff engagement and increase communication with staff. A number of guides for staff and managers were developed in partnership with HR, Trade Unions, Occupational Health and Service Managers, and these were designed and presented in a user-friendly manner using "Page Tiger" to convey key facts and signpost to additional information sources. We developed the following specific virtual resources;

- Supporting our staff and their families during Covid-19
- Wellbeing Support
- Video – facing Covid-19 and managing fear & anxiety
- Pre and post shift checklists on psychological wellbeing for staff
- Posters

466. Belfast Trust Psychology Team and the Occupational Health department developed a comprehensive range of multi-media materials designed to support staff maintain resilience and good emotional mental health and wellbeing during Covid-19.

467. The Belfast Recovery College delivered a range of on-line support courses throughout Covid-19. This included:

- Anxiety and Covid-19
- Compassion, self-care and resilience
- Introduction to psychological therapies

468. Chaplaincy and Bereavement Services developed a staff support framework for our staff enabling us to provide tailored, compassionate and practical support through difficult and challenging times for our staff and their families.

469. A central HR Support email address: *Ask HRCOVID-19* was developed as a single point of contact for resolving employment issues for staff and managers. This proved effective in streamlining information for staff and ensuring that all queries were replied to in a timely, consistent manner.

470. The Belfast Trust provided childcare support for staff. In April to June 2020 places were fully funded, and from July 2020 to February 2021 places were subsidised. This resulted in 1,165 sessions of care for staff Trust-wide being established within those day care providers already under contract with Belfast Trust Social Services.

471. During Surge 1 in March 2020, the Belfast Trust provided interim, emergency childcare on a no-cost basis in the first instance, which commenced 1 April 2020 and ended on 30 June 2020.

472. From July 2020, childcare costs were then subsidized, whereby staff could claim the additional childcare costs associated with the Covid-19 Pandemic and which enabled them to remain in work. Staff were required to provide evidence of the additional childcare costs, which included up to fully funded where staff were able to evidence they had no pre-Covid-19 childcare costs.

473. A total of 213 staff accessed emergency childcare. This scheme was open to all key worker parents employed in the HSC who experienced increased registered childcare costs as a result of supporting the response to Covid-19 during the period 1 April to 30 June 2020, or whose childcare arrangements were stood down during the first lockdown.

474. For the period of April to July 2020 only, Belfast Trust, as an employer, was granted the authority by HMRC to pay the resulting tax and National Insurance contributions on this taxable benefit on a staff member's behalf. However, Belfast Trust did not have the authority to pay taxes and national insurance contributions beyond that period. 130 staff availed of the scheme beyond the period (ie. 1 July 2020 onwards) for which the PAYE Settlement Agreement with DoH NI and HMRC was applicable. This resulted in the generation of a P11D ie. this was a benefit in kind and HMRC were notified accordingly. The childcare scheme ended overall in February 2021.

475. Home working was enabled and implemented Trust wide. HR and ICT worked in partnership to support non-patient facing staff to work from home, ensure safe and effective service delivery and enable staff to work safely in

accordance with DoH NI and UK Government guidelines. One of the most positive outcomes from Covid-19, which was identified by both staff and service users, was the rapid move to digitalisation. In particular, the widespread roll-out of MS Teams supported key aspects of Belfast Trust's business.

476. Virtual meeting, training and conferencing was deployed. A large number of staff embraced this new way of working, with teams from every directorate and division holding virtual team meetings. Many staff commented on how helpful this had been, and how they had really benefited from this. However, it is noted that this change to usual practice resulted in some staff experiencing feelings of isolation, virtual fatigue, and stress/anxiety around having to learn or adapt to new forms of technology.

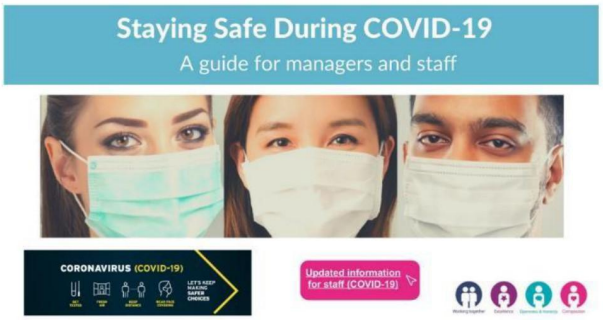
477. Staff were supported by the Belfast Trust with free meals from the Belfast Trust canteens for the period April to July 2020.

478. Shower Facilities were provided for staff enabling them to minimise the risk of cross infection at the end of each shift.

479. In May 2020 a working group was formed called 'Working safely through Covid-19.' It was chaired by a senior manager in HR and membership included representatives from;

- Trade unions
- Health and Safety
- Occupational Health
- Estates
- IT
- Corporate Comms

480. The remit of the group was to mitigate the risk of working during Covid-19 through the application of a series of control measures based around the principles of the Hierarchy of Controls. An interactive publication created and hosted on "Page Tiger" ensured real-time updates in accordance with the latest government guidance as well as compatibility with mobile devices for staff working on site and remotely increasing its accessibility. The document set out the 'Safe Working' framework below. It was based on the hierarchy of controls principles, and guided managers through the various steps needed to ensure work was as safe for employees as possible. The document has received a range of positive feedback from staff and managers across the organisation and received over 26,000 visits.



https://belfasttrust.pagetiger.com/ccbllgx/

'how to guide' for managers- safe working -

b. Whether any initiatives, advanced by the Department of Health, were helpful and of practical assistance;

481. 'Thrive' initiative. In response to the impact of Covid-19 on the psychological health and well-being of health and social care staff, the DoH NI commissioned the Belfast Trust to pilot an early-evidenced based intervention for ICU staff from 24 May 2021 to 31 March 2022. 169 staff self-referred to the "Thrive" initiative with very good outcomes.

c. Whether NHS England initiatives, such as "wellbeing Wednesdays" and the mental health hotlines, were helpful and of practical assistance;

482. Belfast Trust adopted and shared the NHS Fit for The Fight Initiative (now known as "Doing Our Bit") that enabled staff to avail of a wide range of free, virtual fitness activities for all ranges of abilities including yoga, HiiT and Pilates.

d. (and e) The use and practical efficacy of safe spaces / wellbeing spaces and virtual common rooms;

483. In some facilities, 'Wobble rooms' were set up as quiet spaces for staff to visit if they felt overwhelmed and needed to take a moment for themselves. Resources were also made available online to support staff health and wellbeing (see above).

f. ***Support for staff with long Covid***;

484. The Belfast Trust Occupational Health Service has been providing support and guidance to staff who are experiencing symptoms of long Covid in line with NICE guidelines, since March 2021. The service is supported by a dedicated multi-disciplinary team including occupational therapists, nurses, clinical psychology, respiratory physiotherapist and an occupational health physician.

485. Staff absent due to Covid-19 were supported by the provision of full pay until 1 October 2022 when the DoH NI confirmed the temporary arrangements associated with Covid absence would be withdrawn.

Details of any concerns brought to the attention of the hospital regarding Covid-19 risk assessments for staff, including the time taken to introduce the national risk assessment tool, and any challenges encountered by the hospital in ensuring that all staff were appropriately risk-assessed. Please comment on whether the introduction of staff risk assessments affected staff capacity or deployment.

486. At the beginning of the pandemic, a regional approach was taken to develop frequently asked questions (FAQs) for HSC staff. These were posted on the Public Health Agency website and kept under review throughout the pandemic. A regional group was quickly formed and consisted of regional Human Resources staff, Public Health Agency and Occupational Health representatives. The Occupational Health representative liaised with the DoH NI medical cell whenever necessary. The group met weekly initially and reviewed all relevant guidance, updating resources to support staff and managers and ensuring consistency across HSC. The group engaged with

Trade Union representatives ensuring they had sight of all guidance and the opportunity to provide feedback where appropriate.

487. A regional risk assessment was established, in line with Covid-19 guidance for those staff who were identified as vulnerable and clinically extremely vulnerable. The regional FAQs provided guidance to managers and staff on the completion of the risk assessment and informed risk-based decisions regarding where staff could work.

488. Within Belfast Trust, the link to the FAQs on the Public Health website was circulated via an HR Notice. An HR Notice is all user email issued alerting all staff to important information. This information was also accessible through the Belfast Trust Intranet known as the Hub. There were weekly meetings with local trade union representatives and senior managers throughout the organisation, ensuring regular engagement and a partnership approach in dealing with queries. The Senior Executives had a daily Safety Huddle, where updates on guidance and measures taken within the Belfast Trust were discussed on a regular basis.

489. The Covid-19 helpline set up by Occupational Health also supported staff and managers to work through the risk assessment to ensure staff and patient safety throughout the pandemic. The Occupational Health Service continued to provide fitness to work assessments during the pandemic.

490. The risk assessment for vulnerable and extremely vulnerable staff did result in some staff, considered as high or medium risk, not being able to work in clinical settings. Not all roles were suitable for home working and alternative working arrangements and duties did, on occasion take time to arrange. No

data was collected for this centrally to confirm the numbers of staff this affected.

For those staff who were required to shield, there was no alternative other than to remain at home. Access to ICT equipment also had to be facilitated where homeworking was required. This undoubtedly had an impact on workforce capacity, resulting from staff shielding, undertaking alternative duties/redeployment and homeworking. Guidance for vulnerable and clinically vulnerable staff was updated throughout the pandemic and as such the risk assessment content had to be reviewed and communicated on a regular basis. The guidance for those identified as Clinically Extremely Vulnerable changed from 12 April 2021. Staff who remained at home, and unable to work from home, were able to return to the work place provided a HSCNI Covid-19 Risk Assessment had been completed and appropriate actions had been taken to ensure their safety, including safe travel to work which allowed for social distancing. The risk assessment did facilitate staff to return to work and that did have a positive impact on workforce capacity. The guidance issued had to be translated into a risk assessment that was clear, easy to understand and easy to complete, ensuring compliance with regulations throughout the pandemic.

Details of any issues identified concerning any potential unequal impact on patients of measures adopted by the hospital in response to the Covid-19 pandemic (whether related to an equality category under the Northern Ireland Act 1998, literacy or language difficulties, socioeconomic background or otherwise). This may include the way(s) in which PPE may have inhibited communication with deaf people, or the impact of visiting restrictions on patients with limited English.

In relation to Equality Impact Assessments ("EIAs") that the hospital conducted in respect of any hospital specific IPC guidance, fit testing or risk assessments:

- ***a. summaries of those EIAs undertaken during the relevant period and how, if at all, this was this different to before the pandemic; and***
- ***b. if EIAs were not carried out, the reason for this, for how long this continued and whether this decision remained under review.***

Any issues the hospital identified concerning any unequal impact of measures adopted by the hospital in response to the Covid-19 pandemic on hospital staff (whether related to an equality category under the Northern Ireland Act 1998, literacy or language difficulties, socioeconomic background or otherwise). This may include PPE that was unsuitable for certain groups of staff and the impact on those with caring responsibilities etc.

491. The DoH NI introduced the Health Protection (Coronavirus Restrictions) Regulations 2020 (the Regulations) in response to the serious and imminent threat to public health posed by the incidence and spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Northern Ireland. It was considered that the restrictions and requirements imposed by these Regulations were proportionate to the legitimate aim of saving lives, reducing mortality rates and controlling the Covid-19 transmission rates in Northern Ireland.

492. Belfast Trust prepared its strategic approach in accordance with these Regulations and, as previously discussed, implemented a robust command and control structure through the Covid-19 Oversight Group. The Covid-19 pandemic resulted in the Belfast Trust having to adopt new ways of working to balance the challenges of securing the health and wellbeing of the most vulnerable people in our community, with ensuring that high quality and safe patient/client services were provided. Belfast Trust service areas had to focus solely on essential work to maximize the number of staff available to deal with the emergency situation and to maintain safe effective and compassionate clinical care.

493. The Belfast Trust prepared a surge plan for the month of June 2020 to reconfigure services and duly postponed all non-urgent elective appointments in order to free staff up for additional training.

494. The Rebuilding Strategic Framework published by the DoH NI committed to the development of HSC Trust incremental service plans and set out the approach to restoring services as quickly as possible, taking into account examples of innovative approaches to service delivery, developed in response to the pandemic. Over the course of the pandemic, the Belfast Trust produced quarterly reports to either stand down or rebuild services in response to the prevalence of Covid-19.

Plans

Surge Plan	
Phase 1 Rebuild Plan	June 2020
Phase 2 Rebuild Plan	July – September 2020
Phase 3 Surge Plan	October - December 2020
Phase 4	Due to the severe impact of the pandemic, no rebuild plans were published for January – March 2021
Phase 5 Rebuild Plan	April – June 2021
Phase 6 Service Delivery Plan	July – August 2021
Phase 7 delivery plan	October – December 2021
Phase 8 Winter Service Delivery Plan	January- March 2022
Phase 9 Service Delivery Plan	April – June 2022

495. In accordance with the Belfast Trust's statutory equality duties, under Section 75 of the Northern Ireland Act 1998, each of the plans was subject to a comprehensive equality screening to assess the potential impact on any of the 9 protected groups – age, disability, men and women generally, race, religion, political opinion, marital status, sexual orientation, and caring responsibilities. The Belfast Trust also assessed these plans in terms of human rights. In assessing the potential impact, the Belfast Trust was then required to consider and implement necessary mitigating measures or adopt an alternative policy to better promote equality of opportunity.

496. In normal times, the Belfast Trust would have subjected proposals of this magnitude to an equality impact assessment process, which incorporated a full

12 week public consultation. However, due to the severity of the situation, the state of clinical emergency, the exceptional context of the imminent risk to life, and the immediate need to implement these measures to protect public health, it was not possible to publicly consult on the plans and the Belfast Trust instead adopted a pragmatic and prudent approach to their Section 75 duties by publishing and proactively sharing this completed screening template with all of our stakeholders to demonstrate an ongoing focus on the dual statutory responsibilities.

Table of screenings for plans

Phase 1 Rebuild Plan Equality Screening	June 2020
Phase 2 Rebuild Plan Equality Screening	July – September 2020
Phase 3 Surge Plan Equality Screening	October - December 2020
Phase 4 Rebuild Plan Equality Screening	Due to the severe impact of the pandemic, no rebuild plans were published for January – March 2021, therefore no Equality Screening was carried out.
Phase 5 Rebuild Plan Equality Screening	April – June 2021
Phase 6 Service Delivery Plan Equality Screening	July – August 2021
Phase 7 Delivery Plan Equality Screening *(See Phase 8)*	October – December 2021
Phase 8 Winter Service Delivery Plan Equality Screening *(Includes Phase 7)*	January- March 2022
Phase 9 Service Delivery Plan Equality Screening	April – June 2022

497. In addition to these plans and equality screenings, the Belfast Trust also undertook a number of equality screenings to assess the potential impact of other specific measures undertaken during the Covid-19 pandemic and the ensuring periods. The table below contains the list of these screenings and which question in the overall request to which these pertain.

Equality Screenings Carried out	Associated Question
ACOPS Day Care Recovery Equality Screening 2020	46 Equality Impact Assessment in terms of risk assessment
LD Day Centre Recovery Phase 1 Screening	46 Equality Impact Assessment in terms of risk assessment
Phlebotomy Centre at Musgrave Park Hospital (MPH) screening	36- Patient Treatment and Care
Covid-19 vaccine medicines management policy screening	18- Medicines
Changes to Adult Yearly Reviews within the Regional Auditory Implant Centre due to Covid 19 screening	36- Patient treatment and Care
Changes to Eye Casualty service re Covid screening	36- Patient treatment and Care
Virtual Consultations Equality Screening April 2021 screening	50. Approach to virtual care and impact on population
Visiting policy Covid 19 Screening	33-35 visiting guidance
Guidance for continuous subcutaneous infusion screening	18- Medicines
Lithium and COVID19 screening	18- Medicines
Missed or delayed doses of Depot screening	18- Medicines
Prescribing of potassium lowering agents in reduced frequency haemodialysis during Covid screening	18- Medicines
Thromboembolism and Anticoagulant Therapy during Covid 19 screening	18- Medicines
Treatments for non-hospitalised patients with COVID-19 screening	36 Patient treatment and care
Casirivimab and Imdevimab for patients hospitalised due to Covid-19 or with hospital onset Covid-19 screening	26 Infection Prevention Control
Antivirals and Neutralising monoclonal antibodies screening	26 Infection Prevention Control
Clozapine and COVID19 screening	36- Patient treatment and Care

Other plans

Plan	Type of Document/Associated Question
BHSCT COVID19 SUMMARY PLAN – PATIENT & SITE FLOW AND SURGE CAPACITY	Plan
BHSCT Orthopaedic Rebuild plan January 2022	36- Patient treatment and care
Critical care	18- Medicines
Time Critical Surgery OCT 21	15/16- ICU

Learning from Covid 19

Name of Document	Associated Question
Overview of Covid19 learning and recommendations	51- Recommendations
Learning From Covid	51- Recommendations

The Inquiry is keen to understand the relationship between the hospital and Belfast Health & Social Care Trust, and national bodies or other decision-makers within the healthcare system. Please provide details of:

a. whether channels of communication from frontline staff to hospital management and the Trust (whether from the bottom up or from the top down)were effective;

498. As previously described, the Belfast Trust tried to ensure there was excellent two-way communication between front line staff and the executive team throughout the pandemic. This was primarily achieved through:

- daily safety huddles utilising the Charles Vincent framework that allowed ward level issues to be escalated to the Chief Executive by 11am Monday to Friday, or the Director on call at weekends.
- The Covid-19 Oversight Group formally meeting all Divisional teams with their Director twice weekly to address concerns or operational issues, with availability for immediate “ad hoc” meetings should the need arise.

- An Operational Director was present on all main hospital sites ensuring visible leadership.
- Communication Strategy that ensured daily staff briefings were issued on the Trust's Hub.

b. the responsiveness of national decision-makers to feedback from the hospitals or Trusts;

499. The Belfast Trust was in regular two-way communication with PHA, HSCB/ SPPG and DoH NI via bronze/silver/gold command structure, with daily sitreps and regular meetings. In general, this worked very well and was responsive. It must be remembered that these were exceptional times and decision makers were doing their best to manage rapidly evolving situations often with limited or estimated information based often on worst case scenarios, especially during 2020 pre-Covid 19 vaccination availability.

c. whether national guidance appeared to be formulated with an awareness of the feasibility and realities of implementation;

500. I believe that national guidance did intend to take account of the realities of implementation, and the Belfast trust worked hard to operationalise the guidance provided. National guidance changed by necessity to meet the evolving situation and as our understanding of the behaviour of the virus (and its variants) improved. I absolutely accept that the pace of change of guidance was at times difficult to keep up with, but looking back with hindsight, I welcome this, as it allowed us as a senior leadership team to deliver the best possible outcomes for our patients and keep our staff safe.

d. whether there was sufficient support for hospital staff and management from national bodies or decision-makers such as the Department of Health, the medical royal colleges and the Public Health Agency?

501. As above, I think that the entire HSC, including DoH, PHA and HSC Trusts in Northern Ireland pulled together collectively in a manner that exemplified how

staff were able to work collaboratively to achieve the best possible outcomes for patients.

502. I think the surgical colleges contributed significantly in providing guidance in respect of surgical prioritisation which was enormously helpful in determining how best to use our scant theatre resources. I was able to maintain direct contact with the authors during the pandemic which allowed me to best understand how decisions were made and also to bring some influence. Similarly, the Intensive Care Society and Royal College of Physicians were great sources of up-to-date guidance for clinical teams.

503. I do think that the UK Government avoided providing guidance on some difficult discussions in respect of issues such as reverse triage of patients should our hospitals become overwhelmed or how Trusts were to prioritise Covid-19 vs non-Covid-19 patients. This should not have defaulted to HSC Trusts and front line clinical teams to make these decisions because those in policy making positions appeared unwilling to do so.

An overview of the direct and indirect impact the Trust's designation of the Mater hospital site (as a Covid-19 Regional Respiratory Centre) had upon the hospital, its staff and their patients during the relevant period.

504. We expanded medical beds on the Mater Site from 130 to 173 beds for Covid-19 positive patients, which was achieved by transferring the BCH respiratory team to the Mater Site and transferring Surgical Heptato Pancreatico Biliary (HPB) surgical services from the Mater to the RVH/BCH. We also downturned the BCH Cardiology services and opened additional Cardiology beds in Ward F in the Mater. All ICU beds in the Mater were eventually closed as previously described, with a protocol to transfer deteriorating patients to either the RVH or BCH ICUs. The Mater Midwifery led Maternity unit and Gynaecology Services were also stopped during Covid-19.

The Mater ED did not permit walk in patients, accepting only known or potential Covid-19 patients, while non-Covid-19 patients in the Belfast Trust catchment area were directed to the RVH ED.

505. At the peak of the Covid-19 surges, the MIH had over 35 patients on CPAP which had significant implications for staffing numbers. During this time, medical staff from downturned elective surgery services, such as Ophthalmology Services, were redeployed to the Mater Site to help support the respiratory team with ward duties and contacting relatives.

The hospital's approach to creating and implementing virtual care during the relevant period and the impact that virtual care had on the patient population. Please describe whether any patient groups experienced difficulties with virtual care and, if so, what was done to resolve or lessen those difficulties.

506. Belfast Trust did run a virtual care pilot during the relevant period. The Virtual Hospital, albeit at low patient numbers during wave 3 (e.g. 7 cases daily), had been providing clinical care to Covid-19 patients, and we had hoped to expand this. A detailed Standard Operating Procedure was prepared, to identify cases that needed to be admitted to physical hospital, facilitate early discharge of Covid-19 cases where safe, and support patients who were worried (but physiologically safe to be at home). ED staff had been managing patients with confirmed Covid-19 sent home from ED, and the CNIR (OPAT) team followed up ward discharges from the RVH and MIH. We also had input from respiratory community physiotherapy. We estimated the virtual ward service could deliver a phone call support service for 20 cases at any one time, which could have been scaled up with more dedicated nursing time.

Recommendations

a. hospitals respond to a future pandemic;

507. It would be my view that as a region, Northern Ireland responded well to the pandemic and the outcome for Covid-19 related illness in Belfast Trust compared favourably, both regionally and nationally, but at the expense of non-Covid-19 related illness. I therefore think, in a future similar pandemic, more effort should be made to identify "red" and "green" hospital sites that are designated at a Regional rather than Trust level, in order to protect elective work. Potentially this could mean that all those patients with the infection could be managed by one Trust, with other Trusts maintaining normal work. Obviously, the surge plan would have to be such that if case numbers rose, other Trusts would begin to accept patients with infection.

508. It would also be beneficial if employees had regional HSC contracts in order that they can move easily between hospital and other HSC sites, as there was a reluctance from staff moving between organisations.

b. national decision-makers for the healthcare system respond to a future pandemic.

509. PPE – there must be a single agreed standard for PPE and not multiple masks that require re-fit testing, as this created a logistical challenge and was stressful for staff. This is one of the single most important pieces of learning.

510. Utilitarian Ethics – the "best for the most" in a pandemic must be the overriding principle, which includes potentially prioritising those for treatment without the infection. One issue that caused concern for ICU colleagues was the possibility of "reverse triage", should the ICU become overwhelmed. Thankfully, this situation never arose, but DoH NI and the regulators need to provide clear guidance, with public engagement, on this matter, and not default the decision to frontline clinical staff who will justifiably feel very exposed should their decision making be examined in a coroner's court.

511. DoH NI/ PHE/ PHA guidance – the volume of guidance produced made keeping up with it, at times, difficult. What would help would be if guidance originated from 1 UK source, and that, when possible, the guidance was distributed earlier in the week and not approaching weekends.

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.

PD

Signed: _____

28/07/2024

Dated: _____

Annex 1

High level chronology of Belfast Trust Covid-19 response in 2020

17 November 2019	Likely first Covid-19 case China
21 December 2019	Cluster of cases of pneumonia in Wuhan China
31 December 2019	New coronavirus identified
2 January 2020	Central Hospital Wuhan bans hospital staff discussing disease
8 January 2020	WHO team go to China to assist research
11 January 2020	First death reported in China
20 January 2020	First cases outside China in Japan, South Korea and Thailand
21 January 2020	Covid-19 epidemic declared in China
22 January 2020	PHE moves risk level from very-low to low
23 January 2020	Wuhan placed in lockdown and work begins on specialist hospital
27 January 2020	**Covid-19 pandemic oversight group established in Belfast Trust**
29 January 2020	First 2 UK cases in York
30 January 2020	**First meeting of Belfast Trust pandemic planning group**
	WHO declares global Health Emergency
2 February 2020	First death outside China
7 February 2020	**First local testing in Belfast**
11 February 2020	1,113 deaths in China and 44,653 cases

14 February 2020 **Belfast Trust Covid-19 operational plan published**

26 February 2020 **First positive test in Norther Ireland – due to be transferred to HCID unit UK – admitted 7A RVH**

6 March 2020 **Covid-19 Oversight Group established with responsibility for surge planning and business continuity – daily sit-rep, HSC silver submissions, daily update to Executive Team, twice weekly meetings with all divisions. Surge phase 2 Mater Hospital identified as main Covid-19 site for Belfast Trust. Mater will have 96 ward beds and 14 to 16 ICU beds.**

11 March 2020 WHO declares Pandemic.

First Covid-19 patients admitted to Mater

12 March 2020 UK moves to delay phase

13 March 2020 **BBC carry story of Mater Covid-19 Hospital on Local and National News**

16 March 2020 **Routine non-urgent procedures, diagnostics, and outpatients cease to ensure staff trained and FIT tested. Fracture surgery moves to MPH. Outpatient clinics, where possible, should be telephone or skype. HPB surgery to move from Mater site, and Mater ED to close to walk in admissions with plan for ambulance divert with Covid-19 suspected patients.**

18 March 2020 **Instructed to establish 4 Covid-19 centres for primary care by beginning of week commencing 23 March 2020**

19 March 2020 **Surge phase 3 – BCH tower identified as next Covid-19 hospital with capacity up to 275 patients.**

22 March 2020	Mater Respiratory staff "stay at home" video goes international
23 March 2020	Begin to clear floors 1-9 of BCH tower preserving nephrology, haematology and cancer centre. Oxygen vaporisers upgraded on BCH and MIH sites
30 March 2020	First GP Covid-19 centre opened at Beech Hall
	BCH tower ready to accept ICU and ward level patients
	Possible field hospital for critical care considered not viable
	NI modelling paper released with 3 scenarios
31 March 2020	BCHST updated surge plan published
1 April 2020	689 positive tests / 30 deaths / 6450 tests Northern Ireland
2 April 2020	BCH Tower designated as Northern Ireland "Nightingale" hospital with ventilator capacity for 230 patients
3 April 2020	NISTAR transfers 3 patients in convoy to BCH ICU
5 April 2020	Ramada Hotel in Belfast prepared to accept 150 step-down Covid-19 patients
5 April 2020	Belfast Trust led discussion between DoH/Trusts/advisors around staffing and models for critical care. 2 extremes between closing regional DGH ICUs to maximising capacity in DGH regional ICUs. Meeting with DoH NI on 7 April 2020 advising middle road between both models as proposed by Belfast Trust

12 April 2020	**IS contract renegotiated with HSCB/RQIA/DoH NI/ DLS/Trusts as original stated that Belfast Trust responsible for acts and omissions of non HSCB staff**
13 April 2020	**MOT centre opens for testing**