Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CHRIS MATTHEWS

UK COVID-19 PUBLIC INQUIRY
MODULE 5 RULE 9 REQUEST – REFERENCE M5/DoHNI/01
DEPARTMENT OF HEALTH (NI)

Contents

I, Chris Matthews, Deputy Secretary Resource & Corporate Management Group, will say as follows: -

I was appointed to the role of Deputy Secretary for Resources and Corporate Management on 25 April 2022. I therefore have limited first-hand knowledge of the events and issues set out. In preparing this statement, I have relied on my staff who have carried out a thorough review of the documentary evidence held by the Department. I have also discussed the substance of this statement with senior colleagues, who had first-hand experience of the matters described. I am signing this statement on the basis that I am the Executive Board Member with sponsorship responsibilities for BSO.

GENERAL

Background to the Health and Social Care system in Northern Ireland

1. The Department of Health is responsible for health and social care legislation and policy in Northern Ireland. The Department of Health, until April 2022, had 17 Arm's Length Bodies, which aid in achieving the Department's objectives through functions delegated to them by the Department. On 31 March 2022, one of those Arm's Length Bodies – the Health and Social Care Board – was dissolved and responsibility for the majority of its functions were transferred to the Department of Health. Those functions now reside within the Strategic Planning and Performance Group in the Department. The functions of the Department of Health and its Arm's Length Bodies are often referred to by the umbrella term "Health and Social Care and to the Arm's Length Bodies as "Health and Social Care bodies". These are colloquialisms and "Health and Social Care" is used as shorthand for the health system as a whole in Northern Ireland. There does not exist, and never has existed, an organisation called "Health and Social Care Northern Ireland".

2. The structures in Northern Ireland, as established by the Health and Social Care (Reform) Act (Northern Ireland) 2009, retained commissioning like England (with a central commissioning body – the Health and Social Care

Board), but also place specific emphasis on public health. The normal governance arrangements for Health and Social Care in Northern Ireland are set out in the Health and Social Care Framework Document [CM/001 - INQ000188742], published by the Department in September 2011, to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the Department, its Health and Social Care Arm's Length Bodies and the systems that govern their relationships with each other and the Department. The Health and Social Care Act (NI) 2022 saw the closure of the Health and Social Care Board on 31 March 2022 and the formation of the Strategic Planning and Performance Group within the Department as part of the process of reform currently underway.

3. The system here is believed to be too small to support a fully-fledged "market" and the emphasis has been on commissioning as a means of developing and promoting reform and modernisation. The private sector in healthcare is tiny compared to England and, to date, there has been no demand or expectation that it should grow.

The Integrated Care System

4. Health and social care services in Northern Ireland were integrated in 1973. Since then, there have been numerous restructuring exercises which follow broad patterns established across the United Kingdom. The Health and Social Care (Reform) Act (Northern Ireland) 2009 reinforced in statute the Department's responsibility to promote an integrated system of health and social care in Northern Ireland. It also provided for a single Health and Social Care Board, working in conjunction with a Public Health Agency, which commissioned services to meet assessed need and promote general health and wellbeing. A full range of health and social care services are provided by five Health and Social Care Trusts, with a sixth Trust providing ambulance services for the region. These structures are unique to Northern Ireland because in England, Scotland and Wales provision of social services remain the responsibility of Local Authorities.

5. In addition to supporting the commissioning process, the Public Health Agency is also charged with promoting health protection; service improvement; and

improvements in the general health and wellbeing of the people of Northern Ireland. The Public Health Agency works closely with other public services such as health, education and local government in a local community planning process..

6. Integration provides the opportunity for comprehensive assessment of both health and social care needs and allows the Department to plan services based on Programmes of Care. A single budget has also promoted the coherent development of objectives within a unified strategic planning process, which spans acute and community-based care.

7. On 4 November 2015 the then Minister of Health announced his intention to close the Health and Social Care Board with the aim of reducing bureaucracy and complexity within the system and enhancing the Department's strategic leadership and control of the system. The decision was re-affirmed following public consultation in March 2016, and further confirmed with the launch of Health & Wellbeing 2026: Delivering Together in October 2016. Minister Swann further reaffirmed the decision to close the Health and Social Care Board in early 2020.

8. Work was undertaken to give operational effect to this decision, and legislation progressed leading to the Health and Social Care Act (Northern Ireland) 2022. The 2022 Act provisions took effect on 1 April 2022 and provided for the following:

- The closure of the Health and Social Care Board and the transfer of its legislative functions to the Department except for Social Care and Children's functions. Responsibility for these was placed directly upon Health and Social Care trusts. The Health and Social Care Act (Northern Ireland) 2022 inserted a new Article 10A of the Health and Personal Social Services (Northern Ireland) Order 1991 which provides a definition of Social Care and Children's functions;
- Responsibility for the exercise of prescribed Social Care and Children functions are now placed directly upon Health and Social Care Trusts, and the Department has responsibility for the oversight of the exercise of these functions; and

- Local Commissioning Groups which were Committees of the Health and Social Care Board, remain in place beyond the closure of the Health and Social Care Board. They remain in place until such times as the Department makes regulations via the draft affirmative process to establish local area bodies (Area Integrated Partnership Boards) as part of the development of an Integrated Care System for Northern Ireland.

9. Since 1 April 2022 the newly established Strategic Planning and Performance Group in the Department has undertaken the former functions of the Health and Social Care Board, as prescribed in the Health and Social Care Act (Northern Ireland) 2022. The former Health and Social Care Board staff continue to carry out their previous roles within the Department's Strategic Planning and Performance Group although they are employed by the Business Services Organisation under a hosting arrangement, retaining their status as public servants with the same terms and conditions as before.

10. The closure of the Health and Social Care Board has provided the system with an opportunity to transform how the Department plans, manages and delivers services in line with the vision set out in Health and Wellbeing 2026: Delivering Together. It articulates the need to empower local providers and communities to plan integrated continuous care based on the needs of their population, with specialised and regional services planned, managed and delivered regionally.

11. In line with this vision, Minister Swann approved a programme of work in October 2020 on the development of an Integrated Care System model in Northern Ireland. To support the model, a Draft Framework has been developed which provides a blueprint for the future of planning and managing health and social care services in Northern Ireland. The model will promote and enable improved integration, partnership working and collaboration both within and outside traditional Health and Social Care boundaries [CM/002 - INQ000114846]. This will allow the Department to tackle wider determinants of health and wellbeing and will deliver care on a population health-based needs approach, which places the individual at the centre of the model.

Minister of Health

12. Minister Swann was appointed Northern Ireland Minister of Health on 11 January 2020, a few weeks before the start of the pandemic and his term in office ended on 27 October 2022. There was no Minister of health between 2 March 2017 and 11 January 2020.

13. In his/her ministerial role, a minister will exercise the functions assigned to the ministerial office that they hold and have full executive authority within any broad programme agreed to by the Northern Ireland Executive and endorsed by the Northern Ireland Assembly, and they are expected to act in accordance with the Northern Ireland Executive Ministerial Code [CM/003 - INQ000262764]. The functions of a department are at all times exercised subject to the minister's direction and control as per Article 4 of the Department's (Northern Ireland) Order 1999. Ministers are accountable to the Northern Ireland Assembly for the decisions and actions of their departments and agencies, including the stewardship of public funds and the extent to which key performance targets and objectives have been met. Under paragraph 2.4 of the Ministerial Code, ministers are required to bring matters deemed to be crosscutting, significant or controversial to the Northern Ireland Executive..

14. The Minister of Health, along with all ministers, is supported by a Special Adviser. According to the Code of Conduct for Special Advisers [CM/004 - INQ000400121] Special Advisers are an additional resource for the Minister, who can provide advice from a more political viewpoint than a civil servant. While Special Advisers work closely with civil servants, they are not civil servants. Special Advisers can act on behalf of their Minister; they can convey their Minister's views, instructions and priorities to officials including on issues of presentation. In doing so they must take account of any priorities that their Minister has set. For example, Special Advisers can request officials to prepare and provide information and data for Ministers, including internal analyses and papers and they can review and comment on – but not change, suppress or supplant – advice submitted to Ministers by civil servants.

Structure and Organisation

15. The diagram provided at [CM/005 - INQ000137413] sets out the Department's organisational structure at policy group level, its senior leaders, and their respective group areas of responsibility as at 1 January 2020. The senior

officials and professional officers identified in the diagram comprise the Department's Top Management Group and the Departmental Board. The Top Management Group and the Departmental Board have responsibility for the overall corporate governance of the Department and ensuring that the Minister's policies and priorities are implemented in compliance with all statutory, regulatory and financial management requirements to which Northern Ireland Executive departments adhere. Both the Top Management Group and the Departmental Board are chaired by the Department's Permanent Secretary who is the Department's Accounting Officer. The Permanent Secretary is also the Accounting Officer for the statutory-based health and social care bodies in Northern Ireland reporting to the Minister. The Top Management Group's respective roles and responsibilities both before and during the pandemic are set out in the document exhibited at [CM/006 - INQ000137414] and are:

- Richard Pengelly- DoH Permanent Secretary
- Prof. Sir Michael McBride – Chief Medical Officer
- Charlotte McArdle – Chief Nursing officer – Grade 5
- Deborah McNeilly – Deputy Secretary Resources & Corporate Management group – Grade 3
- Jackie Johnston – Deputy Secretary Healthcare Policy Group - Grade 3
- Sean Holland – Deputy Secretary Social Services Policy Group and Chief Social Worker – Grade 3
- Sharon Gallagher – Deputy Secretary Strategic Planning & Performance Group – Grade 3
- Dan West – Chief Digital Information Officer – Grade 3
- David Gordon – Director of Communications – Grade 5

16. The Top Management Group (now known as the Senior Leadership Team) has regular weekly meetings. The Departmental Board, which also has two Non-Executive Directors among its membership, meets every two months. The Top Management Group is the main vehicle for managing the Department on a day-to-day basis whereas the Departmental Board has oversight for monitoring the effective discharge of corporate governance. Whilst not formally stood down during the pandemic, the frequency of Departmental Board meetings was reduced. This meant that only two meetings were held in 2020 and three meetings were held in 2021. This reduction in meetings was to permit the

Department to focus on the additional workload arising from the pandemic. The Top Management Group weekly meetings were also paused from 19 March 2020 to 18 May 2020 as the Department's senior team was fully engaged in leading the emergency response.

Rebuilding Management Board

17. During the period April to May 2020 the Department's Top Management Group had recognised that a new temporary governance model would be needed to oversee the Health and Social Care system during the period of the ongoing pandemic. This required striking a balance between the emergency governance arrangements introduced to mitigate the impact of Covid-19 on the Health and Social Care system, allowing these to be escalated and de-escalated in line with the projected trajectory of the pandemic; and modifying the normal governance arrangements for the oversight of Health and Social Care routine service delivery.

18. In June 2020 these considerations led to the Minister agreeing to temporary changes to the Health and Social Care Framework Document, which established a new Rebuilding Management Board [CM/007 - INQ000137399]. This was announced in the NI Assembly on 9 June through a Ministerial Statement. The purpose of this temporary change was to provide clear direction to the Health and Social Care Board, the Public Health Agency, the Health and Social Care Trusts and the Business Services Organisation. This was in the context of rebuilding health and social care services coming out of the first COVID-19 wave and effectively managing further COVID-19 surges.

19. The DoH Framework Document describes the roles and responsibilities of the main Health and Social Care public bodies, including the Department of Health. The temporary change was subject to a public consultation, which launched on 14 September 2020. The consultation closed on 4 December 2020 and the consultation response was agreed by the Minister on 19 March 2021 [HE1/21/172815]. The public consultation response was subsequently published on 23 March 2021 on the Departments website. Rebuild Management Board was a temporary structure reflective of the need to respond to the pandemic and rebuild services, it was formally stood down at the end of the 2 year operating period as originally envisaged. The framework

documentation was amended accordingly and reverted to original arrangements.

Covid-19 Gold Command Group

20. Arrangements for managing the COVID-19 pandemic were also revised. This involved taking a business continuity approach to managing future COVID-19 waves, as opposed to the emergency management approach adopted during the first COVID-19 wave. The revised arrangements were set out in a letter issued by the then Permanent Secretary Richard Pengelly on 22 October 2020 [CM/008 - INQ000137358]. The primary purpose of these arrangements was to effectively manage future COVID-19 waves by avoiding duplication of effort, simplifying the decision-making process and ensuring sustainable working arrangements.

21. The new arrangements involved the establishment of an integrated COVID-19 Gold Command Group, consisting of senior Department of Health officials, alongside senior Health and Social Care Board and Public Health Agency officials. This COVID-19 Gold Command Group was chaired by the Permanent Secretary. To support the management of these structures 21 integrated cells were also stood up. The number and membership of these cells were kept under review to adopt an agile approach. Furthermore, as part of these business continuity arrangements, a DoH COVID-19 Operations Centre was established to be operational during limited business hours Monday to Friday. Also, a proportionate Sitrep process to ensure information flow was put in place. The Gold Command Group met for this first time on 29 October 2020 [CM/009 - INQ000276293] and held its last meeting on 4 March 2022 [CM/010 INQ000276294].

22. The following paragraphs provide details of the posts and personnel with key responsibilities and oversight within the Department, with particular focus on the role of those in the Chief Medical Officer's Group as well as the Permanent Secretary and Chief Nursing Officer. Exhibits [as referred to in paragraph 15] [CM/005 - INQ000137413 and CM/006 INQ000137414] provide detail on senior officials in other Departmental groups.

Permanent Secretary

23. Richard Pengelly was Permanent Secretary from 2014 until 3 April 2022. Peter May has been in post from 4 April 2022.

24. The Permanent Secretary acts as the senior adviser to the Minister of Health, and to the Northern Ireland Executive via the Northern Ireland Civil Service Board, on the working of Department of Health on a daily and weekly basis, including developing and delivering on policy, leading and managing people and business, delivering outcomes and innovation and driving better public services.

25. As Principal Accounting officer for the Department, the Permanent Secretary is accountable to the Northern Ireland Assembly (through the Public Accounts Committee) for the sound management of risk and public funds. In addition to this, the Permanent Secretary is responsible for the direction and oversight of Health and Social Care organisations which plan and deliver health and social care services for Northern Ireland's population.

Chief Medical Officer (CMO)

26. Professor Sir Michael McBride has been the Chief Medical Officer (CMO) for Northern Ireland since September 2006. As CMO, located within the Department of Health and a member of the Department's Top Management Group (TMG), he has a wide range of roles which cut across his professional, executive and leadership responsibilities within the Department and in relation to its direction and oversight of HSC organisations, which plan and deliver services for the population of Northern Ireland. CMO unlike other UK counterparts does not have a separate office and is an integral part of the DOH. He also liaises with his Chief Medical Officer colleagues across the UK and the Republic of Ireland on a collaborative basis concerning public health issues. The CMO is accountable to the Minister of Health and the Permanent Secretary in the Department. His role is to provide independent professional advice to the Minister of Health. Although the Department has been undergoing a reorganisation since August 2023, which includes a restructuring of the CMO role, both prior to, during and after the pandemic CMO Group had responsibility for emergency planning, all domains of public health policy including health

protection and health improvement, as well as policy responsibility for a range of healthcare quality, safety and improvement issues.

27. Separately from these responsibilities, the CMO has policy responsibility for Health and Social Care Research policy working closely with the Chief Scientific Advisor (CSA). The CMO also provides professional leadership to the medical profession in NI. With his CMO colleagues in England, Scotland and Wales, they provide collective leadership and guidance to the profession across the United Kingdom on a range of clinical and professional matters.

28. As the principal healthcare professional advisor to the Minister of Health and to other policy groups within the Department, the CMO leads a small team of doctors who provide professional medical advice. This group includes two Deputy Chief Medical Officers, Dr Lourda Geoghegan and Dr Naresh Chada, together with several medical advisors. Both Deputy Chief Medical Officers have specific policy responsibilities within the Chief Medical Officer Group alongside their role as professional advisors. They did not have any specific role with regards to the scope of Module 5.

29. The CMO Group also includes the policy and professional responsibilities of the Chief Pharmaceutical Officer, the Chief Dental Officer, and Chief Environmental Health Officer, all of whom reported directly to the CMO. Only the Chief Pharmaceutical Officer had a role with regards to the scope of Module 5.

Chief Pharmaceutical Officer (CPO)

30. Professor Cathy Harrison has been the Department's Chief Pharmaceutical Officer since January 2019. The Chief Pharmaceutical Officer (CPO) is the most senior professional adviser on medicines and pharmaceutical matters. The Chief Pharmaceutical Officer is accountable to the Minister of Health and Permanent Secretary and she reports to the Chief Medical Officer. The Chief Pharmaceutical Officer role is also the head of the pharmacy profession in Northern Ireland, responsible for strategic leadership, planning and decision making to deliver the optimal contribution of pharmacy professional practice to the population's health.

31. The Chief Pharmaceutical Officer leads and advises on all areas of medicines and pharmaceutical policy and related legislation, and also on the modernisation and development of professional pharmacy practice in all sectors (Hospital Trusts, General Practices and Community Pharmacies), related standards, education, workforce planning and professional regulation and leadership.

32. During the Covid-19 pandemic the Chief Pharmaceutical Officer worked collectively with senior leaders from across the Health and Social Care as a member of the Gold command structure/ Health Gold command. The Chief Pharmaceutical Officer led the medical supplies cell and provided professional advice relating to the response to the Covid-19 pandemic which included the Covid-19 vaccination programme, Covid-19 therapeutic treatments and maintenance of access for the public to essential pharmaceutical care and medication supplies and business continuity arrangements. The Chief Pharmaceutical Officer represented Northern Ireland's interests at a national level in areas including the United Kingdom Medicines Supply programme, which oversees all aspects of medicines continuity and involves direct working with senior officials of the Medicines and Healthcare Regulatory Agency and the UK Department of Health and Social Care (DHSC) and the Devolved Administrations. This collaboration ensured that there was a United Kingdom wide approach to the use of medicines and vaccines during the pandemic. The sharing of information between the four countries also helped inform local decisions in Northern Ireland relating to the deployment of countermeasures including vaccines and antivirals.

33. The Chief Pharmaceutical Officer led the provision of professional pharmaceutical advice for emergency planning, including responsibility as the named person on the Department's Wholesale Dealers Licence for the maintenance of medicines stockpiles. During the pandemic the Chief Pharmaceutical Officer also led the Department's response to European Union transition, responsible for advising Minister on Executive matters relating to European Union medical supplies. She was the Senior Responsible Officer for a Northern Ireland Protocol Programme to mitigate risk across a range of areas.

34. Actions were also taken by the Chief Pharmaceutical Officer to bolster community pharmacy services in Northern Ireland to maintain access to

medicines, including home deliveries for vulnerable patients, and provide reliable access to the advice of pharmacists across the country. This included consideration of the implications of European Union Exit plans.

Chief Scientific Advisor (CSA)

35. Professor Ian Young has been the Department's Chief Scientific Advisor (CSA) since November 2015. The CSA reports directly to the CMO and provided key leadership and support during the pandemic. His role in the Department is a part time one (equivalent to three days per week although this increased by necessity to full time during the pandemic) and has three main aspects:

a. Chief Scientific Advisor – this involves providing scientific advice as required in the Department, and it was in this capacity that he was mainly acting during Covid-19;
b. Director of Research and Development for HSC with overall responsibility for issues related to Research (including funding) in the HSC; and
c. Head of profession for the Healthcare Science workforce in the HSC (Chief Scientific Officer), a role similar to that of other Heads of Profession (CMO, CNO, CPO, CSWO, CAHPO).

36. The Chief Scientific Adviser chaired both the Department's Strategic Intelligence Group and Modelling group and liaised with officials in other Government Departments, The Executive Office, and other parts of the Health and Social Care system as required. He provided advice to the Department's Minister and attended Northern Ireland Executive meetings and meetings with individual Ministers as required to provide scientific advice. The Chief Scientific Adviser also attended meetings with officials from the Republic of Ireland, and represented Northern Ireland at the Scientific Advisory Group for Emergencies, relevant subgroups and other United Kingdom wide groups.

Chief Nursing Officer (CNO)

37. Charlotte McArdle was Chief Nursing Officer from April 2013 to October 2021, Linda Kelly was interim post holder from 2021 to 2022 and Maria McIlgorm has been in post from 2022 to present.

38. The Chief Nursing Officer is a member of the Department's Top Management Group, and by extension, was also a member of Health Gold Command and the Strategic Cell. The Chief Nursing Officer provided nursing leadership and advice, working alongside the Chief Medical Officer, Deputy Secretary (Healthcare Policy Group) and the Covid-19 Strategic Surge Planning Director as a leadership group, within the Strategic Cell, to coordinate the Department's policy input to surge planning for the health service. This leadership group worked closely with the Health and Social Care Board Director of Commissioning to ensure that the development of the Department's policy was responsive to the evolving situation within Health and Social Care Trusts and fully informed by expert medical advice provided by The Health and Social Care Board and Public Health Agency.

39. Charlotte McArdle was the Senior Responsible Officer for the planning and implementation of the Nightingale Hospitals at the outset of the pandemic response. The escalation in capacity involved significant staff redeployment and reconfiguration of clinical space in hospitals. The Chief Nursing Officer led the nursing care response and worked closely with the Directors of Nursing and the Critical Care Network Northern Ireland within the various Health and Social Care Trusts to agree staff training, redeployment, skill mix and patient care ratios.

40. Charlotte McArdle was also responsible for developing the Department's policy guidance, which was subsequently issued and distributed to all healthcare settings to allow safe and compassionate visiting arrangements to be put in place for patients, residents and others. This guidance was developed to apply equally in nursing and residential Care Homes and other community settings.

Individuals providing the witness statement.

41. Chris Matthews, Deputy Secretary Resource & Corporate Management Group is signing the Departments Corporate M5 statement in absence of a suitable alternative and in his role as sponsor for the Business Services Organisation (BSO) within the Departments Top Management Group (TMG). Chris Matthews has limited first-hand knowledge of the events and issues set out. The Inquiry may call other Departmental staff with direct experience of specific elements of the statement if required.

Director COVID-19 Response Directorate

42. Kieran McAteer the Director of the COVID-19 Response Directorate (the Director) formally took up post when the Directorate was established on 1 October 2020 (had been temporarily promoted into the role effective from 8 September 2020 to lead the creation of the new Directorate).

43. The Director had delegated policy responsibility for COVID-19 Testing and Contact Tracing and reported to Dr Lourda Geoghegan (Deputy Chief Medical Officer). To inform policy options and advice, the Director worked closely with and secured appropriate inputs from a range of colleagues including in particular senior professional colleagues including CMO, DCMOs and CSA.

44. In line with the Department and CMOG's general role in relation to procurement, the Director had no direct role in procurement matters. The Director and his team prepared submissions for consideration by the Chief Medical Officer, Permanent Secretary and Minister.

45. The Director attended the UK-wide, DHSC/ UKHSA led Investment Board along with the Chair of the Department's Expert Advisory Group (Dr Brid Farrell, previously PHA now retired).

Chief Medical Officers role during pandemic

46. The Chief Medical Officers (CMO's) role, in response to any emergency (including a pandemic), is described in detail in the Department's Emergency Response Plan (ERP) [CM/011 - INQ000215533] which was last updated in 2019 prior to the pandemic and was further updated to take account of lessons identified during the first wave in 2024. The full range of individual roles, structures, systems, and processes to be enacted in an emergency are defined in the ERP. The ERP describes the roles and responsibilities of Senior Officers and business areas within the Department as well as the roles of various organisations which are expected to play a role in a response to an emergency.

47. The CMO's role during the initial phase of the response was to lead the coordination of the health response to the impending public health emergency

recognising the significant work and contribution from many others. The Department's Emergency Operations Centre (The EOC) was activated on 27 January 2020 in response to the emerging threat of what came to be known as the Covid-19 pandemic. The Strategic Cell, met formally for the first time on 9 March 2020 [CM/012 - INQ000103632] in response to the growing threat to NI from the virus and was c. Chaired by the CMO or a deputy from the Department's Top Management Group. The meetings were conducted on the basis of a set agenda. The membership of the Strategic Cell included Top Management Group senior officials and the Department's professional officers from the medical, nursing and social care disciplines. It had regular meetings and operated for the first four months of the pandemic during the initial emergency response phase of the pandemic. It held its last meeting on 16 June 2020.

48. The Strategic Cell is a strategic decision-making group that provided strategic health and social care policy advice to the Minister. It also provided health, social care and public safety advice, direction and leadership to HSC organisations and to other departments/organisations. Due to the unprecedented nature of the pandemic, the complexity of the response and the number of workstreams required, it was felt that it would be useful to draft a Modus Operandi document to set out the structures involved in the Department's response [CM/013 - INQ000103635]. The structure in keeping with the principle of subsidiarity, matters were only escalated to the Strategic Cell if they were particularly complex or had significant policy implications. This was the 'Emergency' phase of the pandemic which is one of the scenarios which the ERP was developed to address. The CMO's role involved overseeing and seeking assurance on what in effect was the formation and foundation of the various programmes of work, many of which were delivered by key professional and policy leads throughout the pandemic. The CMO had no direct role in procurement issues and was not a key decision maker in respect of the issues outlined in the Scope for module 5. As Chair of Health Gold Command CMO was aware of procurement but did not approve or make decisions in relation to them.

49. These emergency response arrangements, during which Health Gold Command, the Strategic Cell and the EOC were operating, lasted until June 2020. The EOC formally stood down on 12 August 2020. The work of the

Emergency response structures was replaced by the newly established Rebuilding Management Board for rebuilding HSC Services, along with a newly stood up Covid 19 Gold Command, which was Chaired by the Permanent Secretary and of which the CMO was a member and attended subject to his other commitments. Background on the Rebuilding Management Board is set out in earlier paragraphs [see paragraphs 17 to 19].

50. The CPO was the head of the medical supplies cell at the start of the pandemic but had no direct role in procurement issues and was not a key decision maker in respect of the issues outlined in the Scope for module 5.

DoH Structures

51. The committees, working groups and other bodies relevant to the Module 5 scope with the Department are set out below.

PPE Strategic Supply Cell

52. Given the significant and intensified demand for PPE across all health and social care settings at a time when the global supply chain was experiencing extreme pressure, a decision was taken on 23 March 2020, by Health Gold Command [CM/014 - INQ000417487], to establish a distinct Personal Protective Equipment Strategic Supply Cell within the Department. At the time the PPE Strategic Supply Cell was established, issues were being escalated to the Department around the supply and availability of personal protective equipment within Health and Social Care Trusts and within parts of the health and social care system which would not normally use personal protective equipment daily, for example, Community Pharmacies or those who would normally source their own supplies, such as General Practices and dentists and the Independent Sector (Care Homes).

53. The aim of the PPE Strategic Supply Cell was to prioritise the supply and distribution of personal protective equipment for the health and social care system and to improve the robustness of the decision-making at the appropriate level.

54. Whilst the Health and Social Care procurement lead, the Business Services Organisation, had ultimate responsibility for procuring personal protective equipment, their efforts were supported by the Personal Protective Equipment Strategic Supply Cell and the Construction and Procurement Delivery Division of the Department of Finance (responsible for leading on the procurement of personal protective equipment for the non-health sector). The three parties engaged on a near daily basis during this period to ensure efforts were co-ordinated and that opportunities were explored to source personal protective equipment locally and internationally.

55. In the context of this role, the PPE Strategic Supply Cell did not have operational procurement or buying workstreams nor did it contain personnel with expertise in in supply chains, logistics and procurement. The PPE Strategic Supply Cell was led by the Deputy Secretary (Grade 3) of Strategic Planning & Performance Group, Sharon Gallager with a deputy lead Grade 5 Martina Moore from 24 March 2020 until 20 September 2020 when it stood down.

56. The role of the PPE Strategic Supply Cell included monitoring of the stock position and supporting BSO in their exploration of potential avenues of supply;.

57. In relation to distribution, the PPE Strategic Supply Cell oversaw the implementation of the revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List and undertook a monitoring role with regards the distribution of PPE from Trusts to the Independent Sector. The PPE Strategic Supply Cell also supported the progression of actions across the HSC to strengthen the system's ability to respond effectively to meeting PPE needs within what was a new challenging operating environment. This included oversight of the implementation of the recommendations of the Rapid Review Report of PPE including bringing forward proposals that required both Departmental and Ministerial approval, such as the BSO's development of a Dynamic Purchasing System [see BSO Dynamic Purchasing System heading at paragraphs 205 – 208].

Covid-19 Response Directorate – Test & Trace

58. The DOH Covid-19 Response Directorate was established in October 2020 to oversee all aspects of Covid-19 testing and contact tracing policy, including

liaison with the National Testing Programme led by the UK Department of Health and Social Care (DHSC). The Directorate provided a dedicated resource, which grew incrementally, to oversee policy in relation to Covid-19 testing and contact tracing. The remit of the Directorate was to provide policy direction and oversight for: the Covid-19 testing policy for NI, including working closely with the PHA, the interface with the National Testing Programme led by the DHSC; and, for the Test, Trace, Protect Strategy which detailed the approach to contact tracing in NI.

59. To inform policy options, the Directorate worked extremely closely with and secured inputs from senior professional colleagues (including CMO, DCMOs and CSA), Departmental policy officials, and a range of other key stakeholders and partners including principally the Department's Expert Advisory Group on Testing, the Test Trace Protect (TTP) Strategic Oversight Board and public health professionals from the PHA.

Expert Advisory Group on Testing (EAG-T)

60. The Expert Advisory Group on Testing (EAG-T) was a Departmental Group led by an Associate Director within the Public Health Agency (PHA); Dr Brid Farrell now retired. A key function of this group was to advise on implementation of Covid-19 testing in Northern Ireland (NI) and to provide expert advice which was then considered by policy leads to inform advice to CMO and the Minister.

61. The group also played a significant role in advising on and in delivering the expansion of testing capacity in hospital and community services as quickly as possible, exploring all available options including increasing laboratory testing capacity within the NI Health and Social Care laboratory network (known as Pillar 1); and advising as required regarding local operational delivery and implementation of the national testing programme, known as Pillar 2 testing, which was procured and contract managed nationally on behalf of UK nations by the Department of Health and Social Care (DHSC) London, and latterly by the UK Health Security Agency (UKHSA).

62. Members of the Department's EAG-T had open communication and engagement with the National Testing Programme led by the Department for Health and Social Care in England. Operational delivery of the testing

programme, including overseeing local implementation of the National Testing Programme, was overseen by the Public Health Agency working closely with the Department's officials. Colleagues in the PHA worked closely where required with DHSC on local operational delivery of Pillar 2 testing. The EAG-T also supported the development of a local NI Covid-19 Testing Scientific Advisory Consortium comprising Queen's University Belfast, University of Ulster, Western HSC Trust's Clinical Translational Research and Innovation Centre, the Agri-Food and Biosciences Institute (AFBI) laboratory and the Almac Group.

63. EAGT had no direct role in procurement decisions but it did at times provide advice to inform procurement opt-in / out decisions. One example is the UKHSA request to the Devolved Administrations to extend the workplace Covid-19 LFD testing programme, part of the National Testing Programme, to 31 March 2022. The request was considered by the EAG-T in the context of the ongoing need for regular asymptomatic testing in NI at that point. The EAG-T advised it was content to approve the proposed extension [CM/015 - INQ000437677] and this informed the subsequent advice to the CMO and the Minister.

64. Procurements in relation to testing which NI benefitted from during the pandemic were undertaken on a UK wide basis as part of the National Testing Programme. All procurement and supporting legal, commercial, VfM and contract management activities etc as part of the National Testing Programme were undertaken by DHSC (and latterly UKHSA) on behalf of Devolved Administrations in the M5 relevant period.

65. Similarly, the vast majority of all aspects related to Distribution and to Standards of PCR and LFDs test kits were managed by DHSC/ UKHSA as part of the National Testing Programme (NTP); excepting some minor elements which included, for example, the role of BSO in distributing test kits to pharmacies later in the pandemic.

NI SMART Programme Board

66. With the agreement of the Minister a separate NI SMART (Systematic, Meaningful, Asymptomatic, Repeated Testing) Programme Board, chaired by

CMO, was established in March 2021 to rapidly expand asymptomatic testing using LFDs for Covid-19 in Northern Ireland. This testing was undertaken as part of the UK-wide National testing Programme.

67. The NI SMART Programme Board and its small supporting team had no direct role in procurement.

68. The Board initially focused on coordinating and advising on availability of asymptomatic testing through workplace schemes. Its role also included oversight of population level testing for example working with a range of stakeholder to coordinate making tests available to the general public in Northern Ireland through the Home Channel, Pharmacy Collect and a range of local collect sites. This work was all undertaken under the auspices of contracts managed by the National Testing Programme.

NI Pathology Network

69. The NI Pathology Network (hosted by SPPG, DoH) set up a regional group to enable planning and coordination of the expansion of SARS-CoV-2 PCR testing in HSC Laboratories (Pillar 1), working with and reporting to EAG-T. This group included leadership from a number of Network stakeholders, in particular the Microbiology & Virology and Point of Care Speciality Fora, commissioners, public health leads, BSO Information Technology Services (ITS) and Belfast Health & Social Care Trust (BHSCT) Lab IT leads who supported work on data and connectivity, and BSO Procurement & Logistics Service (PaLS) who provided critical input on contracting, procurement and logistics.

DHSC/ UKHSA Investment Board

70. Delivery of the National Testing Programme in Northern Ireland was underpinned by a Memorandum of Understanding [CM/016 - INQ000467330] between the Department of Health and the Health Secretary acting through the Department of Health & Social Care [DHSC], England. Each Devolved Administration Health Minister signed the same MoU with only minor adjustments to take account of local issues where relevant.

71. To support the financial arrangements underpinning the National Testing Programme MoU, officials in Northern Ireland and the other DAs worked with DHSC colleagues (and then with UKHSA from 1 October 2021) on a four-nation basis to agree Devolved Administrations Financial Guidance. This was aimed at ensuring transparency and accuracy around processes for ensuring that appropriate Barnett consequentials from procurements were identified and made available to the DAs; and that the supporting detailed financial reconciliations - led and overseen by DHSC/ UKHSA to take account of the financial impacts of DAs opt-in/ out procurement decisions - were transparent.

72. Under the terms of the MoU, from April 2021, Devolved Administrations had an option to opt-in or out of significant procurements defined as a value of £25 million or above, for new testing technologies (for example LFDs). Where a DA choose to opt-out, it was to receive instead its population share financial consequential of the initial contract and of any future contracts. As set out in the Financial Guidance, DAs did not have the option to opt-out of NTP supporting contracts for example to provide warehousing, inbound logistics, outbound logistics and kitting services (not exhaustive). These costs were incurred in support of the Pillar 2 services offered across the UK, and as such were considered part of the UK-wide NTP. As provided for in the MoU, DAs received a population share of NTP capacity enabled by these contracts.

73. Prior to that date, in line with the agreed MoU and supporting Devolved Administrations Funding Guidance, all spend through the National Testing Programme was considered UK-wide with DAs receiving a Barnett share allocation of capacity procured.

74. Decisions in relation to procurement were taken by the UKHSA Investment Board. Devolved Administration attended the Investment Board from March 2021. Devolved Administrations opt-in/out decisions were typically reported at or shortly after Investment Board meetings.

75. The role of the DHSC/ UKHSA Investment Board is set out in the MoU as:

24.1 The Investment Board provides overall oversight of Test & Trace (T&T) Commercial spend, aligning to overall T&T programme strategy,

flagging any risks and issues, and reporting to ExCo DHSC, Cabinet Office and HM Treasury as required.

24.2 Devolved Administrations are members of the Investment Board which meets on a weekly basis. Terms of Reference are available on request.

76. Detailed Devolved Administrations Financial Guidance [CM/017 - INQ000503801] was agreed on a four-nation basis to support the MoU.

77. The guidance described DAs role at Investment Board as:
"The primary role of DAs in considering Business Justification Templates (BJTs) is not to challenge or scrutinise VFM and contractual process, this is the role of others involved in the contracts development process and others at Investment Board (IB) (for example commercial; procurement and legal experts, and DHSC and UKHSA finance, and HM Treasury); rather the primary role of DAs is to consider whether procurement aligns with policy intent in each DA in order to inform opt- out decision where relevant. In the wider interest of achieving VFM, DAs may offer input on VFM at IB discussion should there be points they wish to raise"

78. NI representatives at the DHSC/ UKHSA led Investment Board were, ordinarily, the Department's Director of COVID-19 Response (Test & Trace) and the Chair of the Department's Expert Advisory Group (previously PHA, now retired). Opt in/out decisions at Investment Board were taken by the COVID-19 Response Director and the Chair of the Department's Expert Advisory Group on Testing (EAG-T) based on the extant NI testing policy position, and reported to Investment Board secretariat, usually each week. As such, NI opt in/out decisions reported at Investment Board were taken to enable and support delivery of Northern Ireland testing policy (which in turn was anchored in public health advice and taking account of the evolving pandemic). For example whether NI was availing of and likely to continue to avail of a particular testing technology such as Northern Ireland opted-in to UK-wide procurements of LumiraDX (which NI used in Emergency Departments and other clinical settings based on assessment by EAG-T) but opted-out of UK procurements for ABBOT ID-NOW as this was not a testing technology used in NI (again, based on assessment by EAG-T).

79. An amended MoU underpinning the NTP was signed by Minister Swann on 12 October 2022 [CM/018 - INQ000503802, CM/019 - INQ000503803, CM/020 - INQ000503807, CM021 - INQ000503808]. One key change in the updated MoU was to reflect revised financial funding arrangements, effective from financial year 2022/23, between the Devolved Administrations' Departments of Health, including NI, and UKHSA in relation to the National Testing Programme. In summary, rather than Northern Ireland and the other Devolved Administrations receiving a Barnett (population based) share of testing capacity procured by UKHSA as part of a UK-wide programme, DAs including NI advised UKHSA of specific requirements. The cost of such services - beyond those which were funded on a UK-wide basis (one example funded on a UK-wide basis was the decommissioning of Pillar 2 tests sites) - were then reimbursed by the Northern Ireland Department of Health directly to UKHSA; with the reimbursement amount calculated by UKHSA based on its financial reconciliation processes. There was no change to procurement and contract management of services, all of which continued under the National Testing Programme to be undertaken by UKHSA in the same manner as before.

80. One example of a NI specific requirement under these new arrangements, was when DoH NI requested that UKHSA extend the Pillar 2 contract with the local Lighthouse Laboratory contractor on behalf of NI; initially for 1 April 2022 – 30 June 2022. At the end of March 2022, the future pandemic trajectory remained uncertain, and NI opted to retain access to this Pillar 2 capacity for this period as the preferred contingency option should prevalence increase and increased PCR testing be required the period. The contract extension was on a 'minimum volume' basis and, as demand for PCR was uncertain, this structure posed a clear element of financial risk should demand for testing not meet those minimum contacted volumes. As it transpired, during the extension period testing demand did not meet the minimum thresholds set out in the contract which meant that some of that financial risk exposure was realized. The Department monitored PCR usage and therefore subsequently opted to terminate the contact early during this period which limited the exposure somewhat. The Department intends that this issue will be set out in greater detail in Module 7 which will consider, amongst other things, how Test & Trace policy and supporting arrangements transitioned at the end of the pandemic across each UK nation. All contract negotiation and oversight of laboratory services direct with the Lighthouse Laboratory contractor in relation to this

extension period continued under the National Testing Programme to be undertaken by UKHSA in the same manner as before, acting on behalf of DoH NI.

Documents and chronologies relevant to DoH structures

81. Documents relating to key decisions, actions, policies, guidance, minutes etc. are exhibited throughout this statement at the appropriate text to assist location of them.

Background to NI Procurement Policy (NIPPP)

82. At its meeting on 16 May 2002, the NI Executive agreed to a public procurement policy for NI departments, agencies, non-departmental public bodies and public corporations. The Northern Ireland Public Procurement Policy (NIPPP) (Version 11) [CM/022 - INQ000494692] (issued in August 2014) sets out the policies adopted by the Executive.

83. Under NIPPP responsibility for public procurement policy lies with the Procurement Board, chaired by the Finance Minister. All policies agreed by the board must comply with relevant procurement legislation.

84. The Department of Finance, Construction & Procurement Delivery (CPD) supports the Procurement Board, liaising with the Cabinet Office on UK wide legislative matters, helping in the development of new policies, and monitoring their implementation.

Centres of Procurement Expertise (CoPEs)

85. There are a number of centres with specialist procurement expertise across the NI public sector. Each of these CoPEs undertake procurement activities which are heavily interlinked with the area of responsibility which they support and they include Business Services Organisation, Procurement and Logistics Service (BSO PaLS). NI Public Procurement Policy requires Departments, their Agencies, NDPBs and public corporations to carry out their procurement activities by means of documented Service Level Agreements with CPD or a

relevant CoPE. NI Public Procurement Policy also requires the competency of CoPEs to be reviewed by the Procurement Board on a periodic basis.

DoH Procurement Role

86. The Department of Health has overall responsibility and legal competence for the procurement of all goods and services within its remit. The Department, however, delegates operational procurement to an appropriate CoPE in accordance with NI Public Procurement Policy. The CoPEs used by DoH are:

- BSO PaLS (part of the Business Services Organisation, which is an Arm's Length Body (ALB) of the Department of Health) - For healthcare equipment and supplies.
- DoF CPD Health Projects Division (on 1st April 2023 became DoH Health Estates Directorate) - For capital construction works and services.
- DoF CPD Supplies & Services Division - For office supplies used by DoH itself.

87. DoH therefore generally undertakes no operational procurement and has delegated its operational procurement role for healthcare equipment and supplies to BSO PaLS. BSO PaLS continued to maintain their direct operational responsibility for procurement of key healthcare equipment and supplies including PPE throughout the Covid-19 pandemic for NI's HSC system.

88. On behalf of the Department DoH Investment Directorate undertakes promulgation of NI Public Procurement Policy and CPD procurement guidance to relevant DoH staff and Arm's Length Bodies.

89. The Department leads on the arrangements for storage, management, cycling and distribution of the NI held countermeasures (including PIPP PPE). The Department has an arrangement with BSO PaLS for the storage and distribution of PIPP stockpile.

90. The DoH Head of Emergency Planning managed the revenue and capital budgets to support Pandemic and Civil Contingencies preparedness, including NI's contribution to UK wide procurement exercises for NI's share of stocks,

and storage costs where appropriate. The outturn on emergency preparedness has fluctuated annually to reflect the expiry profile of the PIPP stockpile and cost of replenishment to agreed targets, as well as one-off costs.

Funding of the Department of Health

91. The general means of funding provided to the Department is through the Department of Finance in Northern Ireland. The Department is provided with an opening budget and any easements are declared or additional funding requirements are bid for through "Monitoring Rounds" in-year (June, October and January). Transfers of funding both between other NI departments and from other UK departments (via HM Treasury) are also processed through the Department of Finance at a Monitoring Round.

92. The pandemic covered a number of financial years, and the impact of the pandemic is still ongoing. Covid-19 commenced in the 2019/20 financial year, and the main impact of Covid-19 was within the 2020/21 and 2021/22 financial years.

93. During the financial years 2019/20, 2020/21 & 2021/22, additional funding exercises were commissioned by the Department of Finance to determine requirements and redistribute ring fenced Covid-19 funding in addition to and/or alongside Monitoring Rounds. The Department also received a Budget Cover Transfer (BCT) directly from the Department of Health and Social Care (DHSC) for Covid-19 Testing during the pandemic. This Budget Cover Transfer supplemented the general funding arrangements underpinning the National Testing Programme across the four UK nations whereby, in summary, Northern Ireland and the other Devolved Administrations received a Barnett (population-based) share of National Testing Programme capacity in lieu of the consequential funding they would otherwise have received from health spending in England. Outputs funded under the National Testing Programme, managed centrally by DHSC, included for example delivery of the public facing COVID-19 PCR testing sites and the supporting laboratory processing capacity, and procurement of new COVID-19 test technologies (for example Lateral Flow Devices).

94. While Covid-19 commenced in 2019/20 and some Covid-19 related costs materialised in that year, these costs were contained within existing budgets. In 2020/21 the Department received £989m of additional resource Covid-19 Funding. However, final spending on Covid-19 exceeded this budget by £11.1m, with the overspend authorised by the Department of Finance. In 2021/22 the Department received £610m of additional resource Covid-19 Funding, including a Budget Cover Transfer of £49m in relation to Covid-19 Testing, and the underspend against this was £3.3m. As part of financial reconciliations undertaken by UKHSA which underpinned the National Testing Programme funding across the UK, BCTs were calculated by UKHSA and transfers made as required in relation to each relevant financial year (in addition to the £49m for 2021/22, BCTs were made for 2022/23 (circa £5m by DoH to DHSC) and 2023/24 (circa £26.7m by DHSC to DoH)). Resource spending included: support for the health and social care workforce, including a one-off acknowledgement payment for service during the pandemic; support for additional service delivery, including testing and contact tracing; support for independent providers of health and social care; purchase and consumption of PPE; revenue costs associated with capital works; and additional support costs including increased cleaning.

95. Capital funding of £70 million was provided in 2020/21, with an underspend of £2.43 million declared at year end. This underspend relates to £1.65 million being held as unallocated Covid capital funds at end year with a further underspend of £782,000 reported by Health organisations in their final end year spend returns. The underspend relates primarily to equipment, IT and capital works.

96. In 2021/22 the Department received an additional £15.7 million of capital in relation to Covid-19, reporting an underspend of £1.5 million at year end. This underspend, relating to capital works schemes and IT related schemes, was £370,000 being held as unallocated funds at year end with a further £1.1 million reported by Health organisations in their final year spend returns. Capital spending included purchase of medical equipment including oxygen generators, capital works to provide necessary adaptations to facilities, ICT to support homeworking and other IT infrastructure developed as part of the Covid-19 response, such as the Track, Trace & Protect Contact Management System.

Business Services Organisation, Procurement & Logistics Service (BSO PaLS)

97. BSO PaLs is a part of the Business Services Organisation, which is an Arm's Length Body (ALB) of the Department of Health and therefore ultimately accountable to the Department. A Management Statement and Financial Memorandum (MS/FM) [CM/023 - INQ000503810] has been drawn up, and updated in June 2020, by the Department of Health in consultation with the Business services Organisation (BSO) and sets out the broad framework within which the BSO will operate, including the BSO's overall aims, objectives and targets in support of the Sponsor Department's wider strategic aims; the rules and guidelines relevant to the exercise of the BSO's functions, duties and powers; the conditions under which any public funds are paid to the BSO; how the BSO is to be held to account for its performance.

98. As stated in the Northern Ireland Public Procurement Policy Version 11 (NIPPP) [CM/022 - INQ000494692] issued August 2014 the competency of CoPEs should be reviewed by the NICS Procurement Board on a periodic basis. The competency of BSO as a CoPE is therefore established by the NICS Procurement Board. Senior Departmental officials hold biannual Ground Clearing meetings with the BSO. The purpose of these meetings is to discuss the BSO's overall performance, its current and future activities, any policy developments relevant to those activities safety and quality, financial performance and corporate control / risk management performance, and other issues as prescribed by the Department. Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues will be escalated for discussion to the biannual Accounting Officer Accountability meeting with the Chair and Chief Executive of the BSO. These meetings are supplemented by documentary requirements and provision of information as detailed in Appendix 1 of the MS/FM [CM/023 - INQ000503810].

99. These monitoring arrangements were paused when the Department activated its Business Continuity Plan [CM/024 - INQ000325157 & CM/025 - INQ000325162] on 23 March 2020. During the remainder of 2020 into the early months of 2021, due to the pressures on staffing, the Department paused much of its core business to manage the response to the pandemic. The attached Departmental Audit and Risk Assurance Committee paper [CM/026 -

INQ000360970] details governance activities that were paused. From April 2020 to March 2022 the Department paused its formal sponsorship activities related to the governance of its 17 ALBs, including BSO.

100. BSO is funded in part through Grant in Aid from the Department but mainly through charging for the services it provides to other Health ALBs via Service Level Agreements (SLAs). BSO PaLS is funded via the SLAs. As part of its financial planning the Department works with the BSO to ensure that an appropriate level of funding is provided for the services it delivers through core funding. There is also a clear expectation that BSO will engage with its customers to ensure that the services it provides to them is appropriate and providing Value for Money (VfM).

101. The BSO Accounting Officer appointment letter sets out the responsibilities for the ALB Accounting Officer as stipulated in Managing Public Money Northern Ireland (MPMNI), including safeguarding public funds in their charge and ensuring that they are applied only to the purposes for which they were voted and, more generally, for efficient and economical administration. The Accounting Officer appointment letter also notes their responsibility to ensure value for money: ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, good value and avoidance of error and other waste, judged for the public sector as a whole, not just for the Accounting Officer's organisation.

102. The Department chairs the regional Procurement and Supply Chain Partnership Board (PSCPB) (formerly the Regional Procurement Board) that has representation from BSO PaLs and HSC Trusts, to collectively discuss procurement developments, at a national level, within the NI Public Sector and in HSC. This group also agrees an annual Procurement Plan which sets priorities on HSC procurement matters and monitors progress towards achievement of Procurement Plan objectives. The Department promotes collaborative procurement activities across Northern Ireland Health and Social Care Trusts to optimise productivity and efficiency, but ultimately the Department does not provide detailed instructions to BSO on what medical equipment and supplies or what volumes should be purchased on behalf of its customers.

BSO / DoH Interaction during the Pandemic

103. BSO was represented by Myles O'Hagan its Divisional Head of Procurement on the Department's Expert Advisory Group on Testing (EAG-T). While the BSO role – in line with other members – is not defined in EAG-T terms of reference, the general role of BSO colleagues on EAG-T might be summarised at a high level as contributing to discussion regarding, testing supply, capacity planning and resilience issues across the regional Pillar 1 laboratory network. EAG-T had no role in operational procurement.

PRIOR TO THE COVID-19 PANDEMIC

DoH Procurement role prior to the pandemic

104. This section provides an overview of the general position on Procurement prior to the Pandemic, with a specific focus on the business of the DoH

105. The overall role of the Department for procurement has been described above. In summary, prior to the pandemic the Department of Health had overall responsibility for the procurement of all goods and services within its remit. As set out in paragraph 86 above the department, however, delegated operational procurement to an appropriate CoPE in accordance with NI Public Procurement Policy. DoH therefore generally undertook no operational procurement and delegated its operational procurement role for healthcare equipment and supplies to BSO PaLS.

106. DoH did not put any frameworks in place for key medical equipment or supplies including PPE. Frameworks and other procurements were put in place and operated by BSO PaLS to supply healthcare equipment and supplies. BSO PaLS were responsible for the supply chains to meet its procurement requirements including HSC equipment supply chain and procurement activity on behalf of HSC Trusts.

107. As set out in paragraph 90 above, as part of the UK Pandemic Influenza Preparedness Programme (PIPP), the Department's Emergency Planning Branch owns and manages PIPP stockpiles for use in an emergency, which act as a buffer to the HSC normal supply chain. These stockpiles include PPE including gloves, aprons, gowns, facemasks, visors and eye protection. The procurement of all items for the PIPP stockpile was led by PHE and then UKHSA.

Rationale for and operation of BSO PaLS

108. In Northern Ireland, responsibility for public procurement policy lies with the Procurement Board, chaired by the Finance Minister. All policies agreed by the board must comply with relevant procurement legislation.

109. Construction & Procurement Delivery (CPD) supports the Procurement Board, liaising with the Cabinet Office on legislative matters, helping in the development of new policies, and monitoring their implementation. Construction & Procurement Delivery (CPD) provides a central procurement function for central government in Northern Ireland, however there are also seven additional Centres of Procurement Expertise (CoPEs) providing professional procurement services.

110. Procurement and Logistics Service, commonly known as PaLS / BSO PaLS, is the sole provider of professional procurement and logistics services to all public Health and Social Care (HSC) organisations in Northern Ireland (NI). It is a recognised Centre of Procurement Expertise (CoPE) established under the Northern Ireland Public Procurement Policy, as approved by the Northern Ireland Executive. Competency of CoPEs is established by the NICS Procurement Board.

111. BSO PaLs is a part of the Business Services Organisation, which is an Arm's Length Body (ALB) of the Department of Health and therefore ultimately accountable to the Department. A Management Statement and Financial Memorandum (MS/FM) has been drawn up by the Department of Health in consultation with the Business services Organisation (BSO) and sets out the broad framework within which the BSO will operate, including the BSO's overall aims, objectives and targets in support of the Sponsor Department's wider

strategic aims; the rules and guidelines relevant to the exercise of the BSO's functions, duties and powers; the conditions under which any public funds are paid to the BSO; how the BSO is to be held to account for its performance.

Direct Award Contracts

112. The process for awarding contracts via direct award prior to the pandemic was as documented in the *DoF Revised Procurement Guidance Note 03/11 – Direct Award Contracts* [CM/027 - INQ000503811] and applied to any direct award contracts for PPE destined for the HSC. The Department supplements DoF DAC guidance with HSC specific instructions on when to seek approval from the Department, approval delegations and HSC DAC application forms [CM/028 - INQ000503812].

113. Prior to the pandemic the process for awarding contracts via direct award was as follows:

- A DAC request was raised by the relevant ALB officer using the agreed proforma [CM/029 - INQ000503813];
- This request detailed the nature of the required DAC, its proposed value and the justification;
- Approval to process the DAC request was then sought from the relevant HSC Asst Director / Co-Director;
- For supplies and equipment, DACs applications over £30k were sent to BSO PaLS for procurement advice and risk assessment;
- When returned to the ALB, the application was subject to approval by the relevant HSC Chief Executive (accounting Officer); and
- The circumstances in which approval for DACs from ALBs must be sought from the Departmental Accounting Officer are where the value of the procurement is above the EU threshold, currently £139,688 (including VAT) for goods and services, and BSO Procurement and Logistic Service (PaLS) as BSO PaLs has risk-rated the DAC risk as Red.
- Following Acounting Officer approval, a contract was awarded subject to HSC contract terms and conditions.
- The contracting authority was the relevant HSC ALB and the awarding authority was BSO PaLS.

114. The circumstances in which approval for DACs from ALBs must be sought from the Departmental Accounting Officer are where the value of the procurement is above the EU threshold, currently £139,688 (including VAT) for goods and services, and BSO Procurement and Logistic Service (PaLS) as the relevant procurement body has RAG-rated the DAC risk as Red.

115. The Department does not have a record of any PPE direct award contracts being sent to the Departmental Accounting Officer for approval prior to the pandemic.

Technical and regulatory compliance of supplies

116. BSO PaLS held operational procurement responsibility for NI's HSC system both prior to and throughout the Covid-19 pandemic. BSO PaLS is responsible for ensuring the technical/regulatory specification compliance of the supplies it sources. Details of compliance processes and checks would be held by BSO PaLS.

117. PIPP product specifications were stipulated by Public Health England. PHE also completed necessary checks on receipt of goods for use within the PIPP stockpile prior to distribution to Devolved Administrations stockpiles.

DoH Counter Fraud Measures

118. As set out in the Departmental Anti-Fraud Policy [CM/030 - INQ000503814], the Department endorses a zero tolerance to fraud. Every staff member must complete mandatory fraud training on an annual basis and managers are responsible for ensuring that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively to deter, prevent, detect and investigate fraud. Guidance is circulated both within the Department and its ALBs.

119. Were fraud to be suspected either in the Department' or in one of its ALBs, preliminary enquiries are carried out and cases are reported to BSO Counter Fraud and Probity Services (CFPS) and, if necessary, also referred for further investigation, including onward referral to the PSNI. Probity checks and

reporting requirements would also be carried out by CFPS in line with policies and procedures.

120. [CM/031 – INQ000503815] and [CM/032 - INQ000503817] (both issued 03/04/2020) set out specific guidance on fraud controls during the Covid-19 pandemic. [CM/033 - INQ000503818, CM/034 – INQ000503819 and CM/035 - INQ000503820] communicated the NI Audit Office guidance on procurement fraud and the need to consider additional fraud risks due to COVID-19.

DoH Delegated Limits / Spending Controls

121. If expenditure exceeds the relevant delegated limit, a business case must be submitted to the Department for approval prior to the expenditure being incurred. [CM/036 - INQ000503821] (updated in February 2022 by [CM/037 – INQ000503822]) set out the delegated limits for the Department, for HSC bodies and for Northern Ireland Fire & Rescue Service (NIFRS). Table A in the circular summarises the main financial delegated limits where the Department gave delegated authority to HSC and NIFRS to spend within those limits.

122. Except in specified circumstances (e.g. External Consultancy, IT spend), Revenue Business Cases were fully delegated to the Department and to HSC Bodies, with a limit of £250,000 set for NIFRS Revenue Business cases. No departmental approval was therefore required for revenue business cases except for NIFRS cases above £250k.

123. [CM/038 - INQ000503823], issued in September 2020 provided updated guidance, including delegated limits, for Covid-19 specific funding. All proposed expenditure which was expected to exceed the relevant delegated limits had to receive the appropriate prior approval from the Department or DoF as required before commitment to spend.

Integrated Care System Model (ICS NI)

124. Integrated Care System Model (ICS NI) will be the new framework for planning health and social care services in Northern Ireland. It is a single planning system that aims to improve the health and wellbeing of our population by placing a focus on prevention, early intervention and community health and

wellbeing; and ensuring we are maximising the resources we have available to best effect. The objective is to improve health and wellbeing outcomes and reduce health inequalities through collaboration and partnership working.

125. There are 2 key elements to the model:

- The first is how we integrate and collaborate within health and social care to ensure we are planning, managing, and delivering health and care to best effect and that is removing duplication, addressing unwarranted variation and developing integrated pathways that not only make more efficient use of our resource but provide a better outcome and experience for the service user.
- The second is how we work at both a local and regional level with others to focus in on prevention, early intervention and community health and wellbeing. We are creating partnerships at both levels that will seek to improve population outcomes through more effective use of the collective assets available within that geography.

126. A phased roll-out schedule for implementation of the ICS NI model has been developed and it will commence in Autum 2024 and complete in Spring 2025. The ICS NI framework does not impact on the existing structure of HSC in Northern Ireland but does create partnerships at a local and regional level to collaborate on improving health and care outcomes within those specific geographies. In essence ICS NI framework is a way of working which will foster greater collaboration and integration both within Health and Social Care but also with wider partners who have an impact on the health and well-being of the population.

Just in Time Procurement Model

127. As BSO PaLS held operational procurement responsibility for NI's HSC system prior to the Covid-19 pandemic it was responsible for ensuring the appropriate procurement and stock management strategy. Details of specific procurement strategies adopted would be held by BSO PaLS. For information 'Just in Time' procurements are where an organisation keeps minimal stocks and relies on its supply chain to provide supplies when they are needed. This saves on storage costs and reduces capital tied up but obviously carries greater supply risk in the short term.

128. In response to a specific action in the Rapid Review of Covid-19 Personal Protective Equipment (PPE) [see paragraphs 221 to 227 for details] that stated "*BSO should manage the risk and take mitigating action in relation to interruption of supply of PPE, utilising external support or expertise as required*", BSO developed a Stock Management Strategy. Under the Global Just in Time (procurement and logistics) supply chains, BSO had procured and maintained stock levels based on usage over a four-week period. The unprecedented demand for PPE and the volatility of the supply chain had now rendered this previously reliable strategy untenable in providing the mitigation required to meet the needs of the system in this new operating environment.

129. As a result, BSO developed a stock management strategy centred on the building and maintaining of a Just In Case stock level based on usage for a 12 week period. Whilst this would incur additional costs for example on storage, BSO deemed it necessary to provide the required mitigation against the risk of unstable supply chains.

130. In relation to the PIPP stockpiles they were not intended as a replacement for the normal HSC supply chain and were only ever meant to tide the Department and HSC Trusts over in an emergency, until such time as normal supplies could be replenished or resume. Pre pandemic the volumes of PIPP PPE stock held represented the "Just in Case" (JIC) element of the PIPP stockpile, with PHE/UKHSA maintaining arrangements for further provision of stock on a 'Just In Time' (JIT) basis. Prior to the pandemic DoH was content with this approach.

131. The Department is not aware of any concerns being raised with it regarding 'Just in Time' procurement strategies.

PANDEMIC PREPAREDNESS

Dealing with supply chain disruption

132. As BSO PaLS held operational procurement responsibility for NI's HSC system prior to the Covid-19 pandemic it was responsible for ensuring the appropriate

procurement strategy resilience in relation to supply chain disruption. Details of specific procurement strategies would be held by BSO PaLS.

Effect of absence of a Minister

133. The restoration of the NI Executive on 11 January 2020 involved the appointment of a new Minister to the Department just before the start of the emergency. This followed a hiatus of three years when the Department had operated without a Minister, due to the collapse of the previous Executive. The Department has not undertaken any analysis or other exercise to determine the impact on our pandemic response caused by the absence of the Executive. While the absence of Ministers did create certain constraints on decision making generally, our assessment at this stage is that it did not have any significant bearing on decision making in the Department during the response to the pandemic, including during the early stages of the emergency, as Ministers had taken up their post and were therefore able to exercise their powers. In the period leading up to the pandemic, the powers of the Department to exercise its functions were set out in Section 3 of the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018, as exercised in line with guidance published by HMG. Once in force, the Act and supporting guidance established the framework for decision making in NI Departments during suspension. There were a range of general consequences for the Department arising from the limitations on powers which could be exercised by the Department and from the fact that there was no Minister in place. The consequences included: the limited ability to take decisions; the policy and financial uncertainty and constraints on opportunities to act on cross-cutting issues. Our general assessment at this stage, based on experience, is that there were no longer term consequences for the pandemic response in NI flowing from the period of suspension. Although there has been no formal analysis of this, we have been unable to identify any examples where difficulties flowing from the period of suspension led to challenges in sustaining our response to the pandemic.

DoH Involvement in Emergency Plans

134. As outlined at paragraph 107 above, as part of the UK Pandemic Influenza Preparedness Programme (PIPP), the Department's Emergency Planning

Branch holds and manages PIPP stockpiles for use in an emergency, which act as a buffer to the HSC normal supply chain. The stockpile was intended for health and social care workers and not contractors or independent sector. At the time of a pandemic or emergency the Department would then make decisions on how the stock would be distributed to best respond to pressures.

135. At the start of the pandemic PPE held within the PIPP stockpile was released to GP Practices, Community Pharmacies, Dentists, Optometrists and BSO PaLS to supplement stock.

DoH Designation as Lead Department

136. In its role as a potential 'Lead Government Department' ('LGD'), DoH is required to maintain a state of readiness and build resilience to allow it to effectively lead the response to health and social care emergencies where they affect, or have the potential to affect, Northern Ireland. These principles have been endorsed by the Head of the Northern Ireland Civil Service in 'A Guide to Emergency Planning Arrangements in Northern Ireland', published by the Executive Office 2011 [CM/039 - INQ000188750]. This document has since been rescinded by TEO in the redraft of the NI Civil Contingencies Framework (2011) published on the 1 August 2021.

137. The Northern Ireland Civil Contingencies Framework (September 2011), which was the extant strategy in place during the Covid 19 response, addresses the Northern Ireland- wide picture, but mainly refers to 'Lead Organisation' rather than 'Lead Government Department'. The Framework covers a broad range of contingencies from local, limited matters to worldwide, catastrophic emergencies. The Framework documents are high-level and reflect the fact that the events which can require an emergency response cannot be fully anticipated. To this end it is apposite to note the assertion in the NICC Framework 2011 which provides that:

> *"Civil Contingencies is a huge field … It is neither possible nor helpful for an organisation to try to plan separately for all possible scenarios and responses."*

138. When an emergency occurs, the lead organisation co-ordinates the multi-agency response at the appropriate level or provides input to the Northern

Ireland Central Crisis Management Arrangements (NICCMA) for Level 2 and 3 emergencies. The purpose of NICCMA, when activated by the Executive Office, is to provide strategic co-ordination of the response and/or recovery across the Northern Ireland departments and other responders, and to provide an interface at strategic level with other emergency co-ordination bodies in Northern Ireland, GB and Ireland. The role and authority of a Lead Organisation or LGD is not to take over and direct the actions of other departments, rather as stated in the CCG(NI) NICMMA Protocol:

"Cross—departmental co-ordination and support will be provided by TEO through the activation of NICCMA."

139. Also relevant to the question of LGD is the legally binding Ministerial Code, which was introduced by the St Andrews Agreement 2006. The Ministerial Code was in part, designed to limit departmental freedom, and to ensure more control at the centre of government. In this context, a definition of LGD which may be suitable for central government in Westminster could be viewed as inapposite for the Northern Ireland system, wherein each department operates independently, with no concept of collective responsibility of government.

DoH Responsibilities as Lead Department

140. In August 2012, the Department defined its LGD role in line with Cabinet Office guidance and best practice as responding to the health consequences of emergencies arising from:

- chemical, biological, radiological and nuclear incidents (CBRN);
- disruptions to the medical supply chain;
- human infectious diseases; and
- mass casualties.

141. In January 2019, DoH revised and published a new ERP in January 2019, which incorporated the lessons learned from Exercise Cygnus (2016). The revised ERP rescinded DoH's "Role of the DHSSPS as a Lead Government Department - AUG 12 Document" [CM/040 - INQ000188749] as it set out the ERP and the LGD role in a single document. The ERP 2019 set out how DoH would effectively carry out the responsibilities and functions associated with its role as LGD. It described the key processes and disciplines necessary in

planning for and responding to a crisis for which DoH was either the nominated lead or had key responsibilities to act during the progress of the crisis. The ERP is based on the principle that preparation, response and recovery will enable an effective joint response to and recovery from any emergency. It explains how DoH will deploy and operate an effective and resilient response for any emergency in respect of which it has been designated the LGD, as well as providing strategic health and social care policy advice or direction in support of others where another department is designated LGD.

142. Paragraph 2.1 of the ERP defines the Department's area of responsibility as *"DoH is responsible for leading and co-ordinating the health response when an emergency has been categorised as serious or catastrophic and requires a cross-departmental or cross-governmental response. The severity and complexity of an emergency will dictate the level of involvement of the Department in the health response to it…"*

143. When an emergency arises, for which it has been nominated as the LGD, DoH takes strategic control of the health response by engaging with its multi-agency partners to facilitate a shared situational awareness and ensure a collaborative response to the emergency. It is important to note that DoH does not have the power to direct the response or commit other departments' resources in dealing with an emergency. DoH's only role in respect of other departments' response efforts is to provide strategic health and social care policy advice or direction including that of its ALBs.

144. DoH's role and authority as a LGD is set out specifically in the ERP 2019 (internal pages 8 –10) which provides that:

1.4 In order to ensure a seamless service to the public during an emergency, DoH may if appropriate, activate its Health Gold Command and will also be required to collaborate with key members of other partner and stakeholder organisations.

1.8 The ERP sets out how the Department will … deploy and operate an effective and resilient response for any emergency that it has been designated LGD; and provide strategic health and social care policy advice or direction in support of the efforts of others, where another Department or its Arm's Length Body (ALB) is in the lead.

1.9 *The Department will deploy and operate an effective and resilient response and recovery for any emergency for which it is designated the LGD arising from an emergency in the following scenarios:* [as those identified at paragraph 140 above].

145. The Department will move into action immediately an emergency arises in the areas for which it has policy responsibility and will provide strategic health and social care advice and support other LGDs where it can assist the emergency response.

146. If DoH had 'led' other departments' response to the threat of Covid-19, in terms of directing what they should do, this would have contravened the constitutional arrangements wherein each department is a separate legal entity, headed by its own Minister. A LGD cannot activate 'Northern Ireland Central Crisis Management Arrangements' ('NICCMA') in Northern Ireland. The CCG(NI) Protocol for the Northern Ireland Central Crisis Management Arrangements (September 2016) (CCG(NI) Protocol) sets out the provisions for NICCMA as follows:

"The First Minister and deputy First Minister or TEO may activate NICCMA following a request to do so from the Executive; the Lead Government Department; a senior representative from the NIO Briefing Room (NIOBR); a senior member of PSNI involved in the Police led multi agency GOLD group; the local level co-ordinator; or in the absence of any such requests, whenever TEO judges it appropriate to do so."

PIPP STOCKPILE

DoH Involvement in PIPP Stockpile

147. The UK Pandemic Influenza Preparedness Programme (PIPP) was established in 2007 and is a DHSC-led programme for managing pandemic preparedness, involving pandemic preparedness leads from Scotland, Wales and Northern Ireland. Clinical countermeasures were, and still are, a key part of the strategic approach to managing a pandemic. Each UK country is responsible for maintaining its own stockpiles and distribution arrangements for countermeasures which included PPE.

148. The Clinical Countermeasures Management Board (CCMB) was chaired by UKHSA (was PHE until 1 October 2021) with membership from the Devolved Administrations (attended by the Head and Deputy head of EPB from the Department). This Board oversaw the procurement, management and storage of clinical countermeasures required to respond to a pandemic via a range of contracts. CCMB's procurement strategy was informed by expert scientific advice provided by groups such as New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), Advisory Committee on Dangerous Pathogens (ACDP) and Joint Committee on Vaccination and Immunisation (JCVI).

149. PIPP Stockpile products pre pandemic were purchased via 4 Nations procurements led by PHE. Product specifications were stipulated by PHE who also undertook the procurement of all items for the PIPP stockpile in line with its specifications. PHE also completed necessary checks on receipt of goods for use within PIPP prior to distribution to Devolved Administrations stockpiles. BSO PaLS stored and delivered the NI PIPP stockpile on behalf of DoH who managed it.

150. CCMB identifies the PIPP stockpile products and required volumes to be held based on expert and scientific advice provided by groups such as NERVTAG, ACDP, and JCVI. DHSC commissioned Reasonable Worst Case Scenario (RWCS) modelling to identify the UK volume of stock required to respond to a pandemic. The NI volume of the PIPP stockpile was calculated based on the Barnett formula. The Department participated in CCMB meetings and provided the necessary approvals and funding for the NI contribution to costs to ensure PIPP stockpiles were held in line with expert advice.

151. UK PIPP stockpile levels had been determined on a four Nations approach following detailed modelling based on RWCS and expert advice. As previously indicated in paragraph 130, the PIPP stockpiles were not intended as a replacement for the normal HSC supply chain and were only ever meant to tide the Department and HSC Trusts over in an emergency, until such time as normal supplies could be replenished or resume.

152. Pre pandemic the volumes of PIPP PPE stock held represented the "Just in Case" (JIC) element of the PIPP stockpile, with PHE/UKHSA maintaining arrangements for further provision of stock on a 'Just in Time' (JIT) basis. Outside of these arrangements DoH had no further plans in place to replenish stock.

Deployment of the NI PIPP Stockpile

153. The DoH Emergency Planning Branch retained overall responsibility for the release of PIPP stocks with requests for release being considered by the head of Emergency Planning Branch, the Director of Population Health and the DCMO before final approval by CMO.

154. During the pandemic it was necessary to release a significant amount of our PIPP stocks to BSO PaLS to enable it to supply the needs of HSC Trusts, as well as to support the PPE needs of adult social care homes, domiciliary care providers, GPs, community pharmacists, and urgent dental services given the policy decision by the Health Minister to support these health and social care providers. As such PIPP stock was released following careful consideration of need and existing stock levels. All PIPP releases have been recorded in the PIPP Decision Log [CM/041 - INQ000503824] with the first release of PIPP stock being made on 3rd March 2020.

155. Prior to the pandemic the PIPP PPE stockpile was stored in two BSO PaLS warehouses within NI in line with arrangements agreed with the Department for storage and distribution of stockpile items during an emergency.

156. BSO PaLS was responsible for the operational distribution and delivery of healthcare equipment and supplies on behalf of the Department. BSO will have information on logistics plans for emergencies.

157. BSO PaLS will have information on any access or delay issues in relation to the PIPP stockpile but the Department is not aware of any such issues.

158. The demand and supply chain replenishment differed for each PPE product leading to greater demand for PIPP PPE items. As a result the demand and requests for release of PIPP PPE products varied with stock of aprons, gowns,

gloves and Type 11R stock facemasks lasting however eye protection was exhausted by 11th May 2020 and FFP3 masks by 29th October 2020.

159. From 2 April 2020 BSO provided the PPE Strategic Supply Cell with a daily Surge Forecast v Demand report. [CM/042 - INQ000503825]. As time went on this process was refined with the inclusion of additional information [CM/043 - INQ000503826]. These reports assisted the monitoring of the supply and distribution position. From 7 July 2020 BSO reverted to twice weekly reporting of these figures until 4 February 2021 where it went to weekly until 25 November 2021. From 25 November 2021 then returns turned to monthly until they eventually stopped on 28 September 2023. It should be noted that from September 2020 the reports continued to issue to DoH after the PPE Strategic Supply Cell had stepped down and the PPE Liaison role had commenced until September 2023.

160. From 14 April 2020 to 30 June 2020 the Department's PPE Strategic Supply Cell reported daily to the DHSC England on Health and Social Care Northern Ireland personal protective equipment demand and supply data based on information provided by Business Services Organisation [CM/044 - INQ000417496]. This assisted the monitoring of stock levels across the four nations to help inform procurement and distribution plans.

161. Prior to the pandemic DoH, Emergency Planning Branch had responsibility for management and maintenance of the PIPP stockpile which it retained during and after the pandemic.

162. This entailed participation in CCMB meetings to agree PIPP products, volumes held and approvals/funding to ensure replenishment of stock as necessary to achieve agreed target volumes. In addition, DoH had arrangements in place with BSO PaLS for the storage and distribution of PIPP products.

Expiry of PIPP stock

163. DoH is not aware of any expired PIPP stock being deployed.

164. A number of 3M face masks held within the stockpile had date expired however they were not distributed until testing was completed and their life extended.

Response to the Initial Outbreak of Covid-19

165. From around 15 January 2020, the Chief Medical Officer began to brief the Health Minister on the emerging Novel Coronavirus in China, with a first formal written submission [CM/045 - INQ000103626] sent to the Health Minister on 22 January 2020. The Chief Medical Officer met with the Health Minister on 23 January to brief him on this submission. On 24 January 2020 the Minister sent an Urgent Written Statement [CM/046 - INQ000103599] to the Assembly on the response to Coronavirus, stating that:
"my Department along with the PHA are in contact with the relevant authorities across the UK to ensure that we have a fully coordinated and effective response to the management of Coronavirus. I have also been in contact with my fellow Health Ministers to discuss our approach."

166. In the early months of 2020 the First Minister (FM), deputy First Minister (dFM) and the Health Minister met with their UK, Scottish and Welsh counterparts at COBR meetings and other four nation meetings. The political leadership of the four administrations discussed the response to Covid-19. This included guidance for the general public and options for non-pharmaceutical interventions which were implemented across the whole of the UK in March and April 2020.

167. From 24 January there were also regular 4 UK CMO calls to discuss Covid-19 and there was full and appropriate information sharing and discussion on key emerging information, including from SAGE, at these meetings.

168. On 24 January 2020, the Deputy Chief Medical Officer joined a call and was later copied into the readout [CM/047 - INQ000103627] from a "National Co-ordination Call" chaired by the Department of Health and Social Care (DHSC), on the Wuhan Novel Coronavirus Incident. This was a 4 nations UK call in relation to the developing situation to ensure awareness of strategic risk and ensure coordinated action. The Department of Health and Social Care in

England had convened daily 4-nation teleconferences which officials within CMOG were dialling into, while the Public Health Agency had organised a regional teleconference involving the HSC Trusts to discuss preparation for dealing with suspected cases in NI. On 27 January 2020, a meeting of this group gave an update on international diagnosed cases and reported an action which required all UK Devolved Authorities to "*send their figures direct to DHSC (copying to Public Health England) by 12 noon daily*" [CM/048 - INQ000103628].

169. In early January 2020, DoH monitored developments concerning the situation in Wuhan. When it was clear that the situation was worsening and had the potential to impact the health of the Northern Ireland population, on 27 January 2020, in line with Section 1.5 ERP 2019, [CM/049 - INQ000137322 and CM/050 - INQ000137323]. In line with Section 3.4 of the Emergency Response Plan 2019, the activation was approved by the Director of Population Health and the Deputy Chief Medical Officer [CM/051 - INQ000103629]. DoH stood up the Department's EOC order to keep the Health Minister and DoH Arm's Length Bodies (ALBs) properly briefed on the emerging situation. This was done so, a calendar month ahead of a case of Covid-19 being identified in Northern Ireland, and three days ahead of the World Health Organisation on 31 January declaring the Covid-19 outbreak as being a Public Health Emergency of International Concern. During this period Departmental officials worked closely with Emergency Preparedness Resilience Response partners in the other DAs, including DHSC, who provided daily Sitreps as the situation evolved.

170. HSC Silver (Tactical Command) Structures, as outlined in their Joint Response Emergency Plan [CM/052 - INQ000102841], were implemented by the Public Health Agency, Health and Social Care Board (HSCB), since 1 April 2022 DoH Strategic Performance and Planning Group (SPPG) and Business Services Organisation, and were formally stood up on 22 January 2020.

171. WHO announced that the outbreak of novel coronavirus was a Public Health Emergency of International concern on the 30 January 2020. The CMO and then the CSA attended SAGE meetings from 11 February 2020 onwards.

172. From 31 January 2020, DoH required Health Silver to provide daily SitReps on multi-agency co-ordination at a tactical level. In addition to this, DoH's EOC

gathered detailed information across local, national and international levels to advise and inform health providers of the latest developments, and to help coordinate resources across HSC. This information was gathered from a variety of sources, including daily calls with DHSC, HSC Silver and NIFRS, which provided the basis for the Northern Ireland Common Recognised Information Picture (CRIP) which was available to all key stakeholders and clearly displayed in the EOC.

173. As the emergency worsened, DoH's coordination role developed significantly: it had daily calls with UK policy teams; during which time the PHA were also having daily calls with PHE. DoH worked with NIDirect to manage a public helpline. DoH officials worked alongside colleagues from NHS, DHSC, PHA and the MoD on transfer arrangement protocols for the first possible cases in Northern Ireland. During this period DoH developed and assisted the NICS in establishing guidance and information for professional staff and the public on managing the effects of Covid-19.

174. In collaboration with TEO, DHSC and the Cabinet Office, DoH coordinated the introduction of the Emergency Powers Coronavirus Act 2020.

175. There were also regular meetings between Health Gold/HSC Silver. These meetings facilitated decision making opportunities and the sharing of information between Health Gold, HSC Silver and HSC organisations, and enabled key issues to be discussed and actions agreed.

176. The EOC also established a Generic Information Management System to support a daily 'Reporting Rhythm' and a 'Key Issues and Actions information Board', it was responsible for managing information flows; producing situation reports (SitReps) and maintaining a watching brief of the incident particularly through monitoring SitReps from Health Silver and the NIFRS. This enabled DoH to take informed decisions across health and to coordinate the sharing of accurate and timely information, including communications and public messaging on situational awareness. which helped to inform key stakeholders at a local and national level.

177. The above are all examples of how DoH fulfilled its role as LGD, and in coordinating the health emergency to inform a cross departmental response to the threat of Covid-19.

Working Groups & Committees Activated

178. The decision was made to activate the Department's Emergency Response Plan (ERP) in January 2020. In simple terms this involved the activation of the Emergency Operations Centre (EOC). This activation included the establishment of multiple subject-specific Cells (Groups) focusing on specific areas of response to the pandemic. The principle of subsidiarity applied within each cell, with the cell being responsible for preparing for, monitoring and responding to the impact of the pandemic in its specified service delivery and or policy area and in addressing matters raised by Health Silver. As such each of the Cell leads [CM/053 - INQ000137324] provided key leadership to areas of the response and support to the CMO as Chair of the Strategic Cell. All of this required the ability to respond to new and complex emergent issues through the development of new processes, guidance or policy. Where necessary such matters were escalated to Health Gold Strategic Cell. The CMO would not have had sight of documentation generated by some of these cells unless the issue had been escalated to the strategic cell for action or decision.

179. In response to the continuing work demands placed on the CMO Group staff, a Covid-19 Response Directorate was established in September 2020 [see paragraphs 58 and 59 for details of remit]. The following year, in June 2021, a Covid-19 Strategy Directorate was established. The primary role of the Covid-19 Response Directorate was to oversee policy in relation to Testing and Contact Tracing. The role of the Covid-19 Strategy Directorate was to oversee a range of new evolving responsibilities including Waste Water (WW) Surveillance, coordination of the relationship with the then soon to be established United Kingdom Health Security Agency (UKHSA); support for the International Travel Programme.

180. The CMO also established or approved the establishment of several other key Northern Ireland groups which also generated information and advice for the same purposes. They included:

a. The Expert Advisory Group on Testing (EAG-T) [see paragraphs 60 to 65 for information on EAG-T]. The EAG-T was not responsible for the sourcing, procurement or distribution of PPE and key medical equipment.
b. Testing in Care Homes – Task and Finish Group [CM/054 - INQ000137355]. This Departmental group was established at the request of the CMO on the 8 May 2020 to provide direction and guidance to support the development and implementation of Covid-19 testing arrangements within care homes. It also more generally provided advice on testing to social care policy leads within the Department, and included active participation from the policy leads in Social Services Policy Group (SSPG), Public Health Agency and Regulation and Quality Improvement Authority. The Testing in Care Homes Task and Finish Group was not responsible for the sourcing, procurement or distribution of PPE and key medical equipment.
c. The NI Modelling Group [CM/055 - INQ000137356] which was Chaired by the CSA, Professor Ian Young, was a Departmental group. The role of the group was to undertake population level modelling work and to estimate the value of 'R' in Northern Ireland. The group considered information and modelling generated from across the UK and within Northern Ireland to inform their work and this was submitted to the Executive and published on the Departments website. Trust level modelling for the purposes of operational surge planning was commissioned by the HSCB now SPPG within the Department. The NI Modelling Group was not responsible for the sourcing, procurement or distribution of PPE and key medical equipment.
d. The Nosocomial Support Cell (NSC) was a regional group established by the CMO in December 2020, as part of the Department's approach to supporting Trusts to address the challenges arising from Covid-19 in healthcare settings [CM/056 - INQ000137357]. The role of the group was to provide additional support and did not replace the primary role and responsibility of Trusts to prevent and control Covid-19 in healthcare settings supported by expert advice provided as required by the Public Health Agency (PHA). The key objective of the NSC was to provide multidisciplinary support to the region and HSC Trusts experiencing clusters or sustained complex outbreaks of healthcare associated Covid-19 infections in acute settings. The work programme for the NSC included development and introduction of a regional nosocomial dashboard, completion of a programme of learning visits to acute hospitals with a focus on sharing learning, development of a region-wide approach to reviewing and learning

from deaths associated with hospital-acquired Covid-19. The NSC was not responsible for the sourcing, procurement or distribution of PPE and key medical equipment.

e. During the summer of 2021, having completed its planned programme of work, the NSC transitioned into a Regional Health Care Acquired Infections (HCAI) Working Group, also referred to as the 'HCAI, Regular Testing and Outbreak Group'. This nosocomial dashboard, developed by the NSC, is an important information management tool which continues to be utilised by all relevant HSC organisations to support the oversight and operational management of Covid-19 incidents and outbreaks.

181. By June/July 2020, the Department's response to the pandemic was no longer being managed under ERP structures. The pandemic was by this stage being managed under more business continuity arrangements with the Health Service (including Covid-19) aspects being overseen by a Rebuilding Management Board (RMB) chaired by the Permanent Secretary. The subject-specific cells were revisited and renewed in October 2020 under the overall auspices of the RMB.

182. Also, in October 2020 the Department established a Covid-19 Gold Command Group (CGCG) linked to the RMB. This group acted as a forum for resolving issues and actions escalated by subject-specific cells or the HSC in relation to Covid-19 responses during the second and third Wave of the pandemic. Although the CMO was a member of both groups and attended when other commitments allowed, his focus over the following 18 months was on the ongoing and developing public health response to Covid-19, which he oversaw through a number of key oversight groups which he established. These were:

a. The NI SMART (Systematic, Meaningful, Asymptomatic, Repeated Testing) [CM/057 - INQ000137362] Programme Board. The CMO chaired this Programme Board which was established in March 2021 to rapidly expand asymptomatic testing for Covid-19 in Northern Ireland. The NI SMART Programme Board had no responsibility for the sourcing or procurement of PPE and key medical equipment;

b. Test, Trace, Isolate, Protect Strategic Oversight Board [CM/058 - INQ000137363]: the CMO established and chaired this Board in May 2020. The Board's role was to provide oversight of both the contact tracing and testing programmes. This included the sharing of intelligence on clusters

and outbreaks and providing advice in terms of policy implementation and its effectiveness. In April 2022 the Board's Terms of Reference were updated to oversee implementation of the Covid-19 Test, Trace and Protect Transition Plan [CM/059 - INQ000137364] but it did not have responsibilities for the sourcing, procurement or distribution of PPE and key medical equipment;

c. Covid-19 Vaccination Programme Oversight Board [CM/060 - INQ000276631]: the CMO established and chaired this Board in July 2020 to oversee the end-to-end deployment of Covid-19 vaccine including storage, distribution, and administration. The Oversight Board included key stakeholders from the Department, HSCB (now SPPG) and the PHA and set the direction for the Covid-19 vaccination programme, oversaw the progress of the development and implementation of the programme as well as managed the strategic interfaces between the expanded 2020/21 seasonal flu vaccination programme and the Covid-19 programme. The Oversight Board had no responsibility for the sourcing, procurement and distribution of PPE or other key medical equipment covered in the scope of this module; and

d. Department Covid-19 Therapeutics Oversight Board [CM/061 - INQ000137366]: The CMO established and co-chaired with the Chief Pharmaceutical Officer this Board in December 2021 to set the overall strategic direction for deployment of novel Covid-19 therapeutics in Northern Ireland and oversee the development and implementation of a coordinated system-wide approach to deployment. The operational delivery of the treatment of non-hospitalised eligible people was provided by the five HSC Trusts with regional coordination by the Health and Social Care Board (now SPPG) and who chaired the Covid-19 Therapeutics Operational Group.

183. A PPE Strategic Supply Cell was stood up by DoH Health Gold Command between 24 March 2020 and 20 September 2020 [see paragraphs 52 – 57 for details of PPE Strategic Supply Cell].

Responsibility for Procurement

184. While the Department of Health has overall responsibility for the procurement of all goods and services within its remit it delegates operational procurement for healthcare equipment and supplies to BSO PaLS in accordance with NI

Public Procurement Policy. DoH therefore generally undertakes no operational procurement as it has delegated its operational procurement role for healthcare equipment and supplies to BSO PaLS.

PPE

185. During the pandemic BSO PaLS continued to lead on procurement of PPE, including sourcing and distribution to HSC Trusts. The HSC Trusts provided access to PPE for the care sector. The Departments PPE Strategic Supply Cell did not have responsibility for sourcing or the procurement and distribution of PPE. The role of the DoH, therefore, was largely unchanged during the pandemic.

Ventilators

186. The process of ordering, distributing and monitoring demand for ventilator stock across Northern Ireland's critical care units was led by the Critical Care Network Northern Ireland (CCaNNI) in conjunction with the Procurement and Logistics Service (PaLS), which is a part of the Health and Social Care Business Services Organisation (BSO) and is the Centre of Procurement Expertise (CoPE) for the Health and Social Care system. The Department of Health had a role in approving expenditure on ventilators and other vital equipment, in line with Covid funding approval procedures.

187. The HSCB (DoH SPPG since 1 April 2022) worked through BSO in ensuring the procurement of critical care equipment, such as ventilators and oxygen supply. CCaNNI was accountable to the HSCB and is now accountable to the Department through the Strategic Planning and Performance Group (SPPG) of the Department.

188. The HSCB (now SPPG) through the Critical Care Network supported the distribution of equipment received from UK national stock allocation and facilitated the distribution to Trusts and provided updates to DOH on which equipment could be returned for use elsewhere.

Tests

189. The Department did not have any responsibilities for sourcing and procurement of PCRs or LFDs.

190. The significant majority of actual distribution and delivery of test kits was managed and delivered through the DHSC/ UKHSA National Testing Programme and supporting parcel delivery contracts. In relation to LFD kits,

this was assisted by BSO storage and distribution under its existing contracts and service delivery models. The small NI SMART support team worked closely with DHSC/ UKHSA who lead the National Testing Programme and with BSO and a range of local delivery partners - including the Department for Communities, local government, other public sector agencies, and a range of business sectors – to assist at times with coordinating distribution of LFD tests to sites across NI. As such the NI SMART support team had an advice and administration role in relation to some aspects of distribution.

191. While the NI SMART support team did not undertake any significant distribution itself, it did manage a small LFD Collect site for Department of Health staff. The team worked with Local Government and a number of third sector organisations to help establish local LFD collection sites in leisure centres and community centres across Northern Ireland. Again, these sites were under the NTP MoU and were managed by delivery partners – not by the Department. The NI SMART Programme Board and its supporting team had no direct role in procurement.

PROCUREMENT OF PPE

Concerns on ability to procure PPE

192. The Departments PPE Strategic Supply Cell was aware of the issues around the ability to procure PPE through its daily engagement with BSO. These concerns centred around the fact that there was a significant and intensified demand for PPE across all health and social care settings at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a significant decline in the export of personal protective equipment by China, a leading global provider.

193. In response, the Departments PPE Strategic Supply Cell supported BSO in their exploration of potential avenues of supply, facilitating engagement with other Departments and jurisdictions and providing the necessary authority, decision-making and financial support where these matters were outwith the

control of the BSO and /or required an expedient response [see paragraph 57 for further details].

Support provided to PaLS

PPE

194. PPE Strategic Supply Cell supported BSO in recognition of the challenging environment in which BSO was operating and the critical need for PPE.

195. From late March 2020 an approach was taken to explore every viable channel both locally and internationally to procure personal protective equipment. The Departments PPE Strategic Supply Cell supported BSO through facilitating engagement with the CPD Supplies & Services Division in the Department of Finance (responsible for leading on the procurement of personal protective equipment for the non-health sector).

196. The three parties engaged on a near daily basis during this period to ensure efforts were coordinated and that opportunities were explored to source personal protective equipment locally and internationally. This included the Department of Health, the Department of Finance and the Business Services Organisation working in collaboration with The Executive Office (TEO) to successfully purchase significant stock direct from China through a company (China Resources Pharmaceutical Commercial Group International Trading Co. Ltd) which was identified by the TEO Northern Ireland Bureau and Invest NI in China and who had been approved by the Chinese government to export personal protective equipment [see paragraphs 265 to 271 for details of the contract].

197. By April 2020 the Chief Pharmaceutical Officer had commissioned the Medicines Optimisation Innovation Centre (MOIC) to develop a process, working in partnership with BSO PaLS and regional IPC leads, that utilised pharmacist skills to undertake a technical assessment of all PPE items procured for use within the HSC to ensure that they were fit for use.

198. Following due diligence checks undertaken by BSO PaLS, MOIC reviewed and validated all technical documentation associated with each PPE product to ensure that items procured were genuine, fit for purpose, and compliant with

relevant legislation e.g. EU Regulation 2016/425, and guidance e.g. PHE guidance on types of PPE for use in clinical settings.

199. The physical design of the product was desktop assessed by regional IPC leads to confirm user acceptability and product performance. This process identified that many items offered for purchase were identified as sub-standard e.g. due to documentation deficiencies or misleading labelling, and that procurement of only safe and effective products was progressed to ensure the safety of HSC staff and patients.

200. From 21 September 2020 DoH continued support to BSO PaLS through a new PPE Liaison role [see paragraph 257 for details of role].

Ventilators

201. BSO PaLS contacted suppliers around critical care requirements through normal procurement ordering processes. HSCB (now SPPG) through Critical Care Network Northern Ireland (CCaNNI) worked closely with BSO and Trusts to support ordering of the appropriate equipment via BSO procurement processes [see paragraph 356 to 376 for procurement of ventilators].

Tests

202. BSO provided logistical support (storage and transportation) for LFD stock (all procurement of LFD stock was managed by UKHSA) linking with the Department's NI SMART team and with DHSC DoH and DHSC logistics/ supplies teams. A key role of NI SMART team was to work with UKHSA to agree supply and drawdown requirements (from stock procured, held and managed centrally by UKHSA on behalf of NI) in line with testing policy/ projected demand in NI; and to discuss with UKHSA as required regarding logistics of bringing LFD stock in to NI (all contracts to support logistics and distribution from UK to NI continued to be managed by DHSC/ UKHSA). These discussions regarding logistics were also assisted by BSO pertaining to stock being received into their logistical network.

203. BSO also undertook distribution of LFDs to HSC Trusts to support testing by Trusts. This included replenishing stock levels when Trusts reported to BSO that they required more stock and, later in the pandemic (from April 2022), to support distribution to pharmacies (when the NTP Pharmacy Collect contract was removed). The NI SMART team assisted with general co-ordination

around this. The distribution was done using existing BSO contracts and HSC delivery networks/ models.

Oxygen

204. The Chief Pharmaceutical Officer led the medical supplies and medicines cell reporting to Health Gold. The scope of this work included oxygen supply availability, oxygen system delivery capacities and related consumables. Modelling undertaken in March 2020 to inform the first Covid-19 surge plan [HE1-20-580389] indicated that large numbers of patients would require high intensity treatments including oxygen therapy. In addition, it was anticipated that levels of cylinder and concentrator oxygen use in domiciliary settings would also increase. A number of interlinked work-streams were progressed, and two regional groups were established to consider the likely acute hospital and community clinical demands. Coupled with this, mathematical modelling was used to establish the oxygen system capacity across Northern Ireland. The Department working with the HSC Trusts and the regional oxygen supplier, British Oxygen Company (BOC), coordinated and authorised a prioritised work plan to enhance the Trusts' infrastructure and capacity for oxygen supplies. Oxygen concentrator installations and removals in the community setting were managed by BOC. Practice changes were implemented, which meant that respiratory specialists were provided with the authority to sign the Hospital Oxygen Order Form (HOOF) and on 10 April 2020 BOC was commissioned to install concentrators into nursing homes on a named patient basis.

BSO Dynamic Purchasing System

205. On 21 May 2020 BSO made representation to the Departments PPE Strategic Supply Cell that the introduction of a Dynamic Purchasing System would expedite the process of PPE procurement. A Dynamic Purchasing System is an electronic system, set up under Regulation 34 of the Public Contract Regulations 2015, that lists suppliers who are available for contracts for works, services, and goods commonly available on the market and that have been assessed as meeting a minimum required standard from which a body or bodies can then invite procurement tenders.

206. Unlike framework agreements, opportunities competed for through mini competitions by those listed on the DPS enables an organisation (in this instance BSO) to work with suppliers with much more agility and speed as it

was designed to allow the Health and Social Care system access to a pool of checked and pre-qualified suppliers, thereby greatly reducing avoidable delay

207. Following a submission to the Minister of Health by the PPE Strategic Supply Cell permission was granted on 12 June 2020 in recognition of the significant increase in demand encountered in the first wave of Covid 19 and was considered an opportunity to mitigate against further supply chain risks and an unprecedented demand position. This was particularly relevant at that time in the context of a potential second and further waves of Covid 19.

208. BSO as both the lead for procurement and distribution of PPE and the manager of the Dynamic Purchasing System, would be able to provide an assessment of its impact on the availability of PPE. During the period of the PPE Liaison role in DoH, the department was informally advised that the DPS had been used however the extent of this use was minimal given the level of stocks BSO PaLS were holding. BSO is best placed to provide the detail on impact of the DPS on PPE supplies from its implementation during the remaining period of the pandemic.

Direct DoH procurement

209. DoH did not carry out direct procurements of medical equipment or supplies including PPE as BSO PaLS continued its procurement responsibility for NI's HSC system throughout the Covid-19 pandemic.

Direct Award Contracts

210. During the pandemic, 132 DACs, with a combined value of some £92m, were sent to the Department for approval. A number of the DACs were requested to provide services specifically in relation to the HSC's response to the pandemic. e.g. face mask fitting services, architectural services in relation to the Nightingale Hospital and Public Health Communications in relation to Covid. None of these DACs related to the provision of PPE. The Department has not identified any Direct Award contracts for key medical equipment and supplies which it made. [see paragraphs 112 to115 for pre pandemic DACs and paragraphs 266 to 271 for details of the China contract]

211. An annual report is sent to the Department's Audit and Risk Committee on volumes / values of Direct Award Contracts by all the Department's ALBs over the financial year but does not split these out in a level of detail to identify those that related specifically to medical equipment and supplies. From 1st April 2020 to 31st March 2021, a total of 1,195 DACs were awarded at a cost of £785m in 2020/21, compared to 927 DACs at a value of £100m for 2019/20. Adjusting for Pharmacy DACs which typically relate to patent-protected drugs and / or continuity of care, results in an increase in the number of DACs from the previous year of 47% (2019/20: 779, 2020/21: 1,144) and a considerable increase in the value of 954% (2019/20: £70.3m; 2020/21: £741m).

212. Over the following year, from 1st April 2021 to 31st March 2022, as the HSC continued in its journey of recovery from the peak of the COVID-19 emergency, there was a significant drop in numbers and value of DACs compared to 2020/21. A total of 909 DACs were awarded at a cost of £208m in 2021/22. Adjusting for Pharmacy DACs resulted in a decrease in the number of DACs from 2020/21 of 32% (2020/21: 1,144, 2021/22: 782) and a considerable decrease in the value of 633% (2020/21: £741m, 2021/22: £117m).

213. This reduction in the value and volume of Direct award contracts continued into 2022/23 where the comparative totals were 413 direct award contracts, with a value of £65.5m.

214. According to the Single Tender Award and Direct Award Contract database, there were 26 Direct Award Contracts relevant to Critical Care Services and were approved by the HSCB (now SPPG) during the pandemic.

215. In order to bolster testing capacity in Norther Ireland, the Department, during March 2020, established a NI Covid-19 Testing Scientific Advisory Consortium comprising Queen's University Belfast, University of Ulster, Western HSC Trust's Clinical Translational Research and Innovation Centre, the Department of Agriculture, Environment and Rural Affairs Agri-Food and Biosciences Institute (AFBI) laboratory and a commercial partner the Almac Group.

216. While the Department did not undertake any direct procurement, funding to support discrete areas of Pillar 1 PCR testing at AfBI and at ALMAC, and to

support whole genome sequencing (WGS) at Queens University Belfast was secured in line with extant Departmental arrangements.

217. In these instances, the role of CMOG was supporting the business case for funding for consideration and approval by the Permanent Secretary and/or the Minister and did not involve any procurement, distribution or standards – all of which were subject to standard contracting and Service Level Agreement procedures and governance by the BHSCT involving BSO and DLS as relevant.

218. Contract management/ monitoring of laboratory performance and standards and invoice payment was overseen and managed by BHSCT in line with separate Service Level Agreements (SLAs) put in place by BHSCT with ALMAC and Queens University Belfast; keeping EAG-T informed and for support/ discussion as needed under the auspice of the Academic Consortium work.

219. The contracts / SLAs with ALMAC and Queens University (the latter was initially funded as part of a National Testing Programme, under the COVID-19 Genomics UK (COG-UK) program) were put in place by BHSCT under instruction by the Department, out of necessity to rapidly scale up and then to retain PCR and WGS capacity. There was no competitive tendering undertaken by BHSCT and the contract with ALMAC was a Direct Award Contract approved in line with HSC arrangements.

220. Prior to instructing BHSCT to enter into a Direct Award Contract with ALMAC in relation to rapidly scaling up and retaining Pillar 1 testing, the Department lead on a reasonableness assessment of the value for money offered by a potential ALMAC contract for PCR test capacity. All supporting documentation related to this exercise, and to related approvals, has been retained. [CM/062 - INQ000503827, CM/063 - INQ000503828, CM/064 - INQ000503829, CM/065 - INQ000503827, CM/066 - INQ000503831, CM/067 - INQ000503832, CM/068 - INQ000503846, CM/069 - INQ000503847, CM/070 - INQ000503855, CM/071 - INQ000503857, CM/072 - INQ000503858, CM/073 - INQ000503859, CM/074 - INQ000503860, CM/075 - INQ000503861, CM/076 - INQ000429598]. This assessment secured input from BSO, BHSCT Regional Virus Laboratory and EAG-T and concluded the proposed per unit/ test cost offered by ALMAC was

similar to other market alternatives - both public and private sector. This assessment was used to underpin the business case that was subsequently approved by the Department's Permanent Secretary and was the cost basis for a subsequent Direct Award Contract and an SLA between BHSCT and ALMAC.

Rapid Review of PPE

221. On 15 April 2020 the Minister commissioned [CM/077 - INQ000120712, CM/078 - INQ000120813 & CM/079 - INQ000120814] a rapid review of personal protective equipment to focus on the appropriate receipt, storage, distribution, and use of personal protective equipment across the health and social care system. The terms of reference also included an assessment of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the health and social care system.

222. The final report *Rapid Review of Covid-19 Personal Protective Equipment (PPE)* was dated 12 May 2020 and submitted to the Minister on 14 May 2020. The report highlighted a number of areas that required attention to prepare for any further waves and made specific recommendations for the short-term improvement of the personal protective equipment position, in the following areas:

- demand management and use of PPE;
- modelling;
- stock management and management of supplies across the system;
- resilience of supply chains;
- PIPP release mechanisms; and
- supporting staff.

223. The accompanying exhibits detail the final report and supporting documentation such as a submission with the background information, Ministerial comments and approval and action plan for the recommendations:

- [CM/080 - INQ000137351] Rapid Review Report of PPE - 12 May 2020;
- [CM/081 - INQ000130338] Email confirming Minister had noted the Rapid Review Report of PPE;

- [CM/082 - INQ000120815] Cover Sheet from Private Office iro Rapid Review Report of PPE noting 2 questions asked by Minister Swann;
- [CM/083 - INQ000120816] Email from Minister Swann to Departmental Officials noting clarification received on question he asked about removal of the word "transparency" from Rapid Reivew of PPE Audit Recommendation Action 2;
- [CM/084 - INQ000120817] Email from Departmental official to Minister Swann responding to points of clarification he required on a number of Rapid Review of PPE Audit Recommendations;
- [CM/085 - INQ000120820] PPE Review Action Plan v2.0;
- [CM/086 - INQ000120821] Attachment to support response to Minister Swann's questions: Annex A - EU Exit Response Period: Design, Build, Test and Stand Up: Lessons Identified;
- [CM/087 - INQ000120822] Email from Minister Swann to Departmental Official asking for clarification on the removal of the word "transparency" from Rapid Review of PPE Audit Recommendation Action 2.

224. The Review made 19 recommendations for the short-term improvement of the personal protective equipment position, which was in preparation for a second wave of Covid-19. Seventeen associated actions were identified to implement the 19 recommendations with a lead official identified against each action on 15 June 2020. [CM/088 - INQ000120714]. Twelve of the actions were assessed as Critical (to be completed within 2-4 weeks) with the remaining five as Essential (to be completed within 4-8 weeks). Progress on the actions was monitored by the PPE Strategic Supply Cell and whilst some of the actions were completed in a relatively timely manner, the initial timeframe for completion proved challenging given the nature of some of the actions.

225. Of the actions deemed critical, three were closed by mid-July 2020, five by the end of July2020, two by the start of August and one at the end of August 2020. The remaining action was not closed until mid-December 2020. Of the actions deemed essential, three were closed by end of June 2020, one mid-July 2020 and the other action at the end of October 2020.

226. The two actions which took longer to close were in relation to the appropriateness of the reuse of personal protective equipment in a period of

critical shortage in line with expert scientific advice (Essential) and the development of systems to enable feedback from end users around the quality of personal protective equipment across all the health and social care system and independent sector which could be used to better inform procurement (Critical). Both actions required the lead owner, the Public Health Agency, to engage with key stakeholders and develop supporting products which impacted on the overall timeline. The Department sought regular updates from the PHA lead on progress of the actions required.

227. No other reports into the procurement and distribution of PPE were commissioned by DoH during the pandemic.

228. Following a request from DoH, a task and finish group was established on 22 April 2020, under the direction of Rodney Morton, Executive Director of Nursing, Midwifery and Allied Health Professions in the Public Health Agency (PHA) and Chair of the Infection Prevention Control Cell (COVID-19), to undertake a rapid review into the effective utilisation of PPE and the reuse of PPE.

229. The following terms of reference were agreed:

- To interpret Public Health England PPE guidance on the most effective utilisation of PPE and develop a framework to support its use across settings (to provide direction and/or clarification to HSCNI);
- Consider all relevant literature available in relation to the effective utilisation of PPE and reuse of PPE;
- Consider the current evidence re: potential decontamination options in addition to emerging technologies designed to meet this requirement;
- Consider how to optimise the use of PPE with regards to sessional use across all settings;
- Consider how risk assessment approaches, social distancing and modifying work patterns can be maximised to ensure the most efficient use of PPE;
- Identify the key PPE products and their attributes that can be considered for reuse/recycling during the COVID-19 pandemic;
- Consider what a specification for reusable products needs to contain for future tendering and contract arrangements.

230. The findings were outlined under three headings:

- Optimise usage of PPE
- Define and encourage the safe sessional use of PPE across all HSC settings
- Reprocessing/Decontamination of PPE for repeated use in times of shortage or crisis.

231. The final draft *Rapid review into the effective utilisation of personal protective equipment (PPE) and the reuse of PPE* dated 19 May 2020 was submitted to the Minister on 3 July 2020 [CM/089 - INQ000325800]

LIAISON WITH OTHER BODIES

Other bodies worked with

232. The Department's Emergency Planning Branch participated in calls on a UK four nation basis to discuss stock levels and planned procurement volumes and approvals.

233. At a UK level, there was engagement with the other jurisdictions through a range of fora. The Department collaborated closely with them on all aspects of the UK-wide PPE Action Plan which was published on 10 April 2020 [CM/090 - INQ000050008]. The plan was set around three strands; guidance, distribution, and future supply, which was aimed at ensuring that everyone got the PPE they needed. This engagement allowed for a collaborative working arrangement which included mutual aid, whilst enabling each nation to continue with its own procurement plans.

234. The Department's PPE Strategic Supply Cell engaged on a near daily basis with both the Business Services Organisation and Construction and Procurement Delivery Division of the Department of Finance (responsible for leading on the procurement of personal protective equipment for the non-health sector). This was to ensure efforts were coordinated and that opportunities were explored to source personal protective equipment locally and internationally.

235. The Department's Covid-19 Response Directorate established 1 October 2020 to oversee testing and contact tracing policy, worked, together with the PHA and EAG-T, with the following bodies:

- National Testing Programme (Pillar 2) procurement; distribution & standards: Worked with DHSC London/ latterly UKHSA
- Pillar 1 Testing: Department provided funding to support testing arrangements managed by BHSCT for PCR testing at AfBI and ALMAC, and WGS at QUB
- Worked with BSO under its existing contracts coordinating aspects of storage and distribution of LFD test kits.

236. HSCB (now SPPG) through the NI Pathology Network worked closely with the DHSC/UKHSA Reagents and Operational Supplies Team on the issue of availability and distribution of PCR testing kits. The Network set up a regional group, from HSC Trusts and BSO, to enable planning and coordination of the expansion of SARS-CoV-2 PCR testing in HSC Laboratories (Pillar 1), reporting to EAG-T.

237. BSO procured required critical care equipment with input from HSC Trusts in relation to specifications and in support of distribution, coordinated by HSCB (now SPPG).

Representative Bodies' Views

238. The Department established an Infection Prevention and Control (IPC) Cell located at the PHA. It was clear, through initial reports on mainstream and social media, as well as discussions at TMG, Gold/Silver structures and concerns being raised by staff, that PPE was either not available to all staff in a timely fashion, or that there were concerns around how the requisite PPE was being managed and shared around those who needed it. The CNO supported the PHA Executive Director of Nursing, Midwifery and Allied Health Professions in his role as a member of the IPC Cell if called upon, and ensured the identified needs of nurses and midwives were highlighted.

239. The mechanisms for becoming aware of issues were mainly managed via Bronze, Silver, and Gold structures as and when matters arose. A second

mechanism was through the daily huddle meetings which CNO held with HSCT Directors of Nursing. Matters of concern regarding PPE were raised in both these forums and the IPC Cell was present at Gold Command so the cell would be made aware of the issue at the same time. Where information came from the huddle, CNO used the opportunity at Gold to raise this to IPC Cell. In addition, CNO communicated to the Director of Nursing PHA who further raised the issues at the IPC Cell. The same process was used to alert the PPE Strategic Supply Cell to take steps to work with supplies teams to find alternative products.

Health & Care Staff Concerns

240. As a result of concerns raised in the media and elsewhere regarding PPE a product review group was established by the IPC Cell to clinically review products before they were introduced to the clinical environment.

241. The Department was aware through initial reports on mainstream and social media, as well as discussions at the Department's TMG meetings, about concerns being raised by staff that PPE was either not available to all staff in a timely fashion, or that there were concerns around how it was being managed and shared around those who needed it.

242. Reacting to this concern, on Friday 17 April 2020, CNO met with Minister Swann to discuss how a suitable solution could be identified, or at least a means by which issues could be raised and addressed. Following that discussion, a PPE mailbox was established that day by the Department to allow concerned members of staff across the Health & Social Care workforce as well as other interested stakeholders to raise issues of concern over the supply, quality, and usage of Personal Protective Equipment. Minister announced the detail of the mailbox arrangements shortly thereafter.

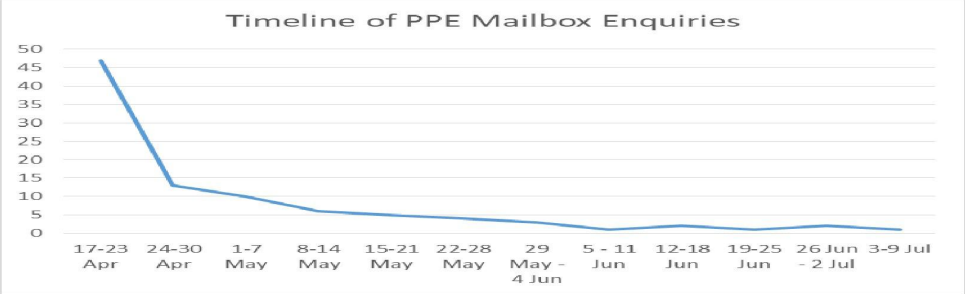
Management of PPE mailbox

243. A small team in the Chief Nursing Officer's Group (CNOG), (then known as the Nursing, Midwifery and Allied Professionals Directorate) was charged with the management of the PPE mailbox which allowed concerned members of staff across the Health & Social Care workforce as well as other interested

stakeholders to raise issues of concern over the supply, quality, and usage of Personal Protective Equipment. A procedure was put in place to ensure it was kept under regular review during working hours. A team of 5-6 civil servants was led by a Deputy Principal civil servant who directed the response to queries received with input as necessary from a Departmental Nursing Officer working under the command of the Chief Nursing Officer. Those CNOG staff members considered all the requests received, referring correspondents to the relevant guidance/support or referring them to the relevant operational lead/service within the HSC system. The role of the PPE mailbox was principally to provide a single point of contact for queries which were forwarded to the Supply Cell, Trusts, the IPC Cell to consider and address, or direction given to published PPE guidance.

PPE Mailbox Use

244. The queries were mainly received over the initial few weeks/months that the mailbox was open, and as the wider issues were dealt with on a structural level, mailbox usage diminished by the autumn of 2020 as shown in chart below.



245. As of 31 December 2020, this mailbox had received 95 queries (including 1 email received which was a generic circular email which required no response), broadly falling into four main themes:

a. Offers to supply PPE (27).
b. Concerns regarding access to PPE supplies (15).
c. Concerns regarding the correct use of PPE supplies (27).
d. Concerns regarding the quality and decontamination of some items of PPE (15).

The CNO was kept informed about the number and nature of queries received, but the day-to-day management of the mailbox was delegated to her team.

246. It was not possible to identify the area from which many of the queries came, either geographically or in terms of sector in all cases as many correspondents used personal email addresses from which such information could not be gleaned. However, what could be identified was as follows:

Query by Type		Trust Nursing Staff	Trust Medical Staff / GPs	Members of the Public	AHPs	Domiciliary Care	Nursing Homes	Other / Undeclared
Offers to Provide PPE	27			1				26
Query on recommended usage of PPE	27	1		1		3	3	19
Query on PPE Supply Chain issues	15	2	3	1	1		2	6
Query on quality of PPE issued	15	1	2		2			10
Query from GB - referred to PHE	4							4
Other	7			1				6
Total	95	4	5	4	3	3	5	71

247. CNOG staff members considered all the requests received, offering guidance/support, or referring correspondents on to the appropriate service:

- All offers to supply PPE were forwarded to the PPE Strategic Supply Cell in the Department for onward communication to the Business Services Organisation.
- Where correspondents raised concerns over access to / supply of PPE, in all cases these queries were followed up by the team with the relevant Trust single point of contact, the Executive Directors of Nursing, and colleagues in the Department's supply cell. In all cases supplies were either found to be available or made available via the relevant Trust contact.
- In each case where concerns were raised over the correct usage of PPE, advice was provided in line with current PPE Public Health England (PHE) guidance.
- Where concerns were raised regarding the correct use of PPE, the quality and decontamination of some items of PPE, each case was reviewed on its merits, with advice sought from the IPC Cell, or other relevant bodies.

248. Subsequently. a review report [CM/091 - **INQ000411115**] was produced identifying those key themes and lessons learned from the content of the emails received. This was shared with Minister on 12 February 2021, and then with the sector for consideration and appropriate action.

249. Information on the average response time to requests for PPE made through the mailbox is not available. However, queries received were initially assessed as "desk immediate", "urgent" or "routine" and the provision of advice or assistance was prioritised based on that assessment.

250. No formal mechanism for obtaining feedback from health and care staff on the effectiveness of the PPE mailbox existed.

PPE Mailbox Staff and Training

251. As noted the role of the PPE mailbox was principally to provide a single point of contact for queries which were forwarded to the PPE Strategic Supply Cell, Trusts, the IPC Cell etc. to consider and address, or direction given to published PPE guidance. No training regarding supply chains or logistics was therefore relevant or required.

PPE STRATEGIC CELL

PPE Strategic Supply Cell

252. The PPE Strategic Supply Cell was established as a cell within the Health Gold structure and its role was to provide oversight and support for the Business Services Organisation who had responsibility for procuring PPE. The focus of the PPE Strategic Supply Cell was to ensure the Department and Minister were sighted on issues or potential issues with the provision of appropriate PPE for HSC.

253. The remit of the Cell was in relation specifically to Aprons, FFP3, Gloves, Gowns, Type IIR and Eye protection.

254. The PPE Strategic Supply Cell role was to support BSO in its efforts to procure PPE by facilitating engagement with other Departments and Jurisdictions and providing the necessary authority, decision-making and financial support where these matters were outwith the control of the BSO and /or required an expedient response. This involved ongoing engagement with BSO on their stock position

against forecasted demand and facilitating requests for mutual aid with other jurisdictions.

255. The PPE Strategic Supply Cell's main activities included:

a. Daily engagement with BSO on their stock position against forecasted demand (April to September 2020)

b. Engaging on a four-nation level on the development of Personal Protective Equipment Action Plan which was published on 10 April 2020 [CM/090 - INQ000050008]. The plan was set around three strands: guidance, distribution and future supply which was aimed at ensuring that everyone got the personal protective equipment they needed. This engagement allowed for a collaborative working arrangement which included the application of mutual aid, whilst enabling each nation to continue with its own procurement plans.

c. Facilitating requests for mutual aid with other jurisdictions where required (April-May 2020)

d. Identification of a single point of contact within HSC Trusts to support the introduction of a revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List which took effect from 24 March 2020 as per the letter from the Chief Pharmaceutical Officer [CM/092 - INQ000120711].

e. Following the decision to provide personal protective equipment to the independent sector through nominated points of contact within Trusts, where they were unable to source their own supplies, a reporting mechanism was introduced from 6 April 2020 whereby each Trust reported to the Department on the volumes of personal protective equipment they provided to the independent sector – Care Homes and Domiciliary Care on a weekly basis. Reporting and collation of this information was gathered by the PPE Strategic Supply Cell up to its closure however reporting continued via the PPE Liaison up to 31 March 2023.

f. Supporting BSO in engaging with the Department of Finance and The Executive Office to support the successful purchase of stock direct from China through a company which was identified by the Northern Ireland Bureau and Invest NI in China and who had been approved by the Chinese government to export personal protective equipment. (April - May 2020)

g. From 14 April 2020 to 30 June 2020 the Department's Personal Protective Equipment Supply Cell reported daily to the Department of Health and Social Care England on Health and Social Care Northern Ireland personal protective equipment demand and supply data based on information provided by Business Services Organisation [CM/044 - INQ000417496].

h. Oversight of Rapid Review of PPE (April-May 2020) and monitoring the implementation of recommendations (May – September 2020)

i. Seeking Ministerial approval for BSO to develop a Dynamic Purchasing System (June 2020) and putting in place the required Ministerial Direction.

j. Seeking Ministerial approval for BSO to enter into 5 contracts with local manufacturers conditional to them manufacturing product that met both the required technical standards and was accepted for use by Infection Prevention and Control professionals. (30 July 2020)

256. In the context of this role, the Departments PPE Strategic Supply Cell did not have procurement or buying workstreams nor did it contain personnel with expertise in in supply chains, logistics and procurement. BSO continued to maintain its responsibility for procurement and distribution throughout the Covid-19 pandemic. The PPE Strategic Supply Cell was led by a Deputy Secretary Grade 3, Sharon Gallager with a deputy lead Grade 5 Martina Moore from 24 March 2020 until 20 September 2020.

257. Once the supply position was largely stabilised and the processes and supporting tools in place to enable Business Services Organisation to undertake their responsibilities in the new operating environment, the PPE Strategic Supply Cell was formally stood down on 20 September 2020 and a new role of Personal Protective Equipment Liaison (PPE Liaison) role was created within the Department. The Personal Protective Equipment Liaison role was established to provide continued support to Business Services Organisation and specifically a mechanism for managing Assembly business in relation to personal protective equipment supply and seeking approvals at a Departmental/Ministerial level where appropriate.

258. No consideration was given to the equal treatment and transparency requirements of the procurement regulations whilst setting up the Departments PPE Strategic Supply Cell as the PPE Strategic Supply Cell did not procure any healthcare equipment and supplies. The PPE Strategic Supply Cell therefore had no expenditure on PPE and awarded no contracts.

259. Operational procurement was undertaken by BSO PaLS which is the CoPE for healthcare equipment and supplies whose competency has been reviewed by the Northern Ireland Procurement Board as required by Northern Ireland Public Procurement Policy.

Contracts for PPE

260. Contracts were not awarded by the Departments PPE Strategic Cell. Contracts awarded in the wider HSC system would have been procured by BSO. Information on contracts awarded by BSO PaLS for healthcare equipment and supplies including PPE is held by BSO. DoH would not have full details on the number of contracts, total value, defaults, terminations, litigation whether contracts were with manufactures or intermediaries.

Prices paid for PPE and Tests

261. As DoH did not directly procure any PPE, LFTs or PCR it does not have full details of prices sought by or paid to suppliers with the exception of the contract with China for PPE which the Minister signed on behalf of the NI Executive. Details of the price paid for the items included in this order can be found in the sales contract [see paragraph 271 for details].

262. While the Department made funding available through normal business case / finance systems and processes to support delivery of COVID-19 Pillar 1 testing, the Department did not undertake any procurement exercises to support delivery of the testing or issue any new guidance or policy documents in relation to prices paid.

Procurement Process

263. The Department did not undertake direct procurement of healthcare equipment or supplies including tests, as such procurements were undertaken by BSO

PaLS or through UK wide arrangements led by DHSC. The Department did not issue any new guidance, policies or checklists relating to procurement.

264. The Department requires all senior staff to complete a declaration of interests annually and to immediately declare any conflicts of interests that arise relating to their work activities. A register of interests is maintained for senior staff by the Department [see paragraphs 377 – 379 for further details].

PROCUREMENT OF PPE FROM ABROAD

Procurements from abroad

265. Whilst BSO PaLS undertook operational procurement, from late March 2020 every known viable channel both locally and internationally to procure personal protective equipment was explored by the Department.

266. DoH, DoF and BSO worked in collaboration with The Executive Office to successfully purchase significant stock on behalf of the NI Executive direct from China through a company which was identified by the Northern Ireland Bureau and Invest NI in China and who had been approved by the Chinese government to export personal protective equipment.

267. Prior to the contract being entered into steps were taken to provide the assurances as outlined below:

a. Completion of a Successful procurement supported by a positive Due Diligence Report conducted by Company F for the Department of Finance,
b. The assessment of the BSO's Procurement and Logistics Service (PaLS) that the costs represented reasonable value for money compared to the market highs at that time
c. Validation of the products to be purchased by the experts in Infection and Control from the Medicines Optimisation and Innovation Centre; and
d. A review of the terms of the contract concluded that whilst not typical of standard government contracts, given the urgent demand for goods and the market conditions that any risks had been managed to an acceptable level. It was also deemed the procedures followed by the Department of

Finance to secure the contract to have been in line with guidance published by the European Commission.

268. Following the actions outlined above, a submission was presented to the Minister [INQ000377359]. That submission mistakenly referred to the 'Department of Finance Solicitor's Office' - an entity which does not exist. It should be noted that the Departmental Solicitor's Office (DSO) sits within the Department of Finance, as does Construction and Procurement Delivery (CPD), both of whom provided advice on the contract. The submission included the conclusion that "whilst not typical of standard government contracts, given the urgent demand for goods and the market conditions that any risks had been managed to an acceptable level". Having investigated the source of that conclusion, it is clear that it was provided by the Department of Finance and not provided by way of legal advice from DSO. As this did not constitute legal advice, no waiver of privilege occurs. The drafter of the submission has accepted that the inclusion of this conclusion in the submission was as a result of a misunderstanding and that it was not legal advice, and this has been confirmed by liaison with DOF colleagues in order to clarify the position.

Having considered the entirety of the submission and supporting documentation, which was a culmination of all advices and negotiations received to that point, the Minister wrote to the Minister of Finance on 30 April 2020 and sought financial approval to proceed with the contract. Thereafter, the contract was successfully concluded and resulted in an order which was worth approximately £61 million and consisted mainly of Type IIR surgical masks and examination gloves (both regular and long-cuffed)."

269. In May the supplier advised that the long-cuffed examination gloves were no longer available and offered a refund or an opportunity to procure additional regular gloves. Given the continued issues around the availability of PPE, the supply of additional regular gloves was agreed, and a supplementary contract put in place.

270. The procurement of the China contract was led by BSO PaLS and DoF Construction and Procurement Delivery Supplies and Services Division but the contract, as a cross departmental arrangement, was signed by the First Minister, deputy First Minister and Minister of Health on behalf of the NI

Executive. As the procurement leads were BSO PaLS and DoF CPD supported by TEO, InvestNI, DHSC and DoH the Department has limited detail on the negotiation and export process etc.

271. Copies of the contractual documentation have been supplied as part of the M2C Annex C Document Disclosure and are listed below:

- [CM/093 - INQ000377346] Covering email to Private Office attaching SUB-1282-2020 - PPE Supplies from China - 15 April 2020;
- [CM/094 - INQ000377347] SUB-1282-2020 - PPE - China Resource Pharmaceuticals;
- [CM/095 - INQ000377348] Annex D of SUB-1282-2020 - Integrity Due Diligence Report (Draft) - China Resource Pharmaceutical Commercial Group Limited (China) - 13 April 2020;
- [CM/096 - INQ000377353] Annex A of SUB-1282-2020 - DHSC - UK-wide protocol to support the supply of PPE across the four nations of the UK;
- [CM/097 - INQ000377354] Annex E (Co-operation Agreement of SUB-1341-2020) in Annex A of SUB-1405-2020;
- [CM/098 - INQ000377355] Email confirming Ministerial approval SUB-1282-2020;
- [CM/099 - INQ000377356] Cover Sheet from Private Office recording Minister's approval of SUB-1282-2020;
- [CM/100 - INQ000377357] Email to Private Office attaching SUB-1405-2020 - Submission - International PPE Procurement 15 May 2020;
- [CM/101 - INQ000377358] SUB-1405-2020 - PPE - China Resource Pharmaceuticals advising change of order 15 May 2020;
- [CM/102 - INQ000377359] Annex A (SUB-1341-2020) of SUB-1405-2020 - PPE China Resource Pharmaceuticals;
- [CM/103 - INQ000377360] Annex E (Sales and Purchase Contract of SUB-1341-2020) in Annex A of SUB-1405-2020;

Fitness for Purpose

272. The Department is not aware of any problems with fitness for purpose of the PPE items from the China contract.

273. By April 2020 the Chief Pharmaceutical Officer had commissioned the Medicines Optimisation Innovation Centre (MOIC) to develop a process, working in partnership with BSO PaLS and regional IPC leads (chaired by the PHA Executive Director of Nursing, Midwifery & Allied Health Professions), that utilised pharmacist skills to undertake a technical assessment of all PPE items procured for use within the HSC to ensure that they were fit for use.

274. Following due diligence checks undertaken by BSO PaLS, MOIC reviewed and validated all technical documentation associated with each PPE product to ensure that items procured were genuine, fit for purpose, and compliant with relevant legislation e.g. EU Regulation 2016/425, and guidance e.g. PHE guidance on types of PPE for use in clinical settings. The physical design of the product was desktop assessed by regional IPC leads to confirm user acceptability and product performance. This process identified that many items offered for purchase were identified as sub-standard e.g. due to documentation deficiencies or misleading labelling, and that procurement of only safe and effective products was progressed to ensure the safety of HSC staff and patients.

275. During May 2020 there was ongoing discussion at the regular CNO/PHA huddle that a specific ear loop masks were causing fit difficulties across the entire HSC. CNO was kept informed by the chair of the IPC cell who undertook to investigate reasonable adjustments. Following a workshop on fluid shield masks the IPC cell confirmed a number of masks were not fit for purpose and these were subject to independent assessment. These were subsequently removed from clinical areas.

276. There was also discussion regarding alternatives to fluid shield masks that had loops preventing a good fit and the option to utilise clips to provide a tighter fit. In this case CNO supported the proposed approach based on infection prevention and control input and that the IPC cell should carefully monitor feedback.

DOMESTIC MANUFACTURE OF PPE

Encouraging Local Production

277. Whilst BSO PaLS had operational responsibility for procuring personal protective equipment, their efforts were supported by the Departments PPE Strategic Supply Cell and the Construction and Procurement Delivery, Supplies & Services Division of the Department of Finance (responsible for leading on the procurement of personal protective equipment for the non-health sector).

278. The three parties engaged on a near daily basis during this period to ensure efforts were co-ordinated and that opportunities were explored to source personal protective equipment locally and internationally. A focus was placed on maximising the opportunities to strengthen the local supply position and the repurposing of local manufacturing which was investigated with Invest Northern Ireland (the investment and trade arm of the Department for the Economy), and which supported engagement with businesses in this area.

279. The Departments PPE Strategic Supply Cell was aware a key component of the BSO PaLS procurement strategy was to maximise the opportunities to strengthen the local supply position to secure greater resilience and flexibility in the supply chain for the local HSC and to lessen the reliance on securing product internationally with a long lead in time. This approach mirrored the UK Governments MAKE initiative, which was designed to call on UK manufacturers to consider production of PPE for the NHS.

280. Progress was made with a number of local companies to develop their capability to supply Type IIR Facemasks and FFP3 Respirator Masks and on 30 July 2020 Ministerial approval was sought for BSO PaLS to enter into contracts with five local manufacturers conditional to them manufacturing product that met both the required technical standards and was accepted for use by Infection Prevention and Control professionals. BSO proposed the contracts would be for a period of 12 months with options to extend for a further 12 months and given that the first delivery would not be expected until September/October 2020, approval was required as the 12-month period of the contract would span in both that and the next financial year, for which a budget had not yet been agreed.

281. Whilst it was estimated at the time these contracts would have a value in the region of £81m per annum and would provide for supply of 208 million Type IIR facemasks and 5 million FFP3 respirators over the 12 month period, details of any resulting contracts are held by BSO as the procurement lead.

282. While the NI Audit Office report into PPE Distribution and Procurement for the health sector reported that 7 domestic contracts were approved, this does not confirm that contracts were actually entered into. BSO PaLS can provide the chronology of the process and where approvals were granted and at what stage. BSO let the contracts and can therefore confirm those contracts which manifested in production and delivery of PPE for the NI health service

283. Given the significant volume of approaches to government by potential manufacturers to supply personal protective equipment, a process was also put in place in early April 2020 where all offers of help were channelled through the Department of Finance, which undertook a first level triage before directing suitable offers to the Business Services Organisation or elsewhere as appropriate.

284. The Department was not aware of the level of experience of the local manufactures in PPE production or any support given to them regarding compliance, specifications or quality.

285. The Department worked with Health and Social Care Trusts and the existing regional oxygen supplier, BOC, to coordinate and authorise a prioritised work plan to enhance Trusts' infrastructure and capacity for oxygen supplies but was not directly involved in the procurement of oxygen supplies

286. An Oxygen Supply Working Group was established on 25 March 2020 within the HSCB (now SPPG) to oversee and coordinate work in Health and Social Care Trusts to increase oxygen supply capacity in acute hospital sites and community settings (including nursing/residential homes) and ensure it was both sustainable and adequate at times of peak demand.

INFECTION PREVENTION AND CONTROL (IPC) GUIDANCE

IPC Guidance

287. IPC advice was developed on a four-country basis. This was to provide both consistency of practice and clear messages. It also enabled learning and sharing of best practice across the four countries. Across the, UK in each jurisdiction the CNO provided independent advice to their respective Ministers whilst working together on public health policy, generating evidence, and independently advising respective Ministers as decision makers. CNOs provided collective leadership and guidance to their professions across the United Kingdom on a range of clinical and professional matters. These actions and decisions were also informed by CNO's attendance at the UK CMO/CNO joint clinical meeting chaired by Professor Sir Chris Whitty.

288. This UK Senior Clinicians Group provided a forum for discussion and sharing of papers and research from within the UK and around the globe touching on almost every conceivable aspect of our response to Covid-19 including provision of critical care, PPE, Guidance, Care Homes, Testing and Tracing, periods of infectiousness, isolation periods etc. Regular updates were provided at these Senior Clinicians meetings. These discussions informed the strategic development of further policy guidance. As it was a time of heightened anxiety for healthcare workers and the public the aim was to provide clear guidance and messages based on the best available evidence including advice and recommendations from the World Health Organization. Providing UK COVID 19 IPC guidance required both consensus and collaboration across a range of different agencies and organizations. Reaching consensus with such a wide range of organizations including professional bodies, health and safety regulators and trade unions was difficult and sometimes not fully achieved but ultimately helped to provide the guidance to our healthcare systems.

289. The Department established an IPC Cell within its integrated Gold business continuity arrangements. The Cell was chaired by the Public Health Agency's Executive Director of Nursing, Midwifery & Allied Health Professions, with the core membership of the IPC Cell comprising:

- Public Health Agency Nursing and Health Protection representatives.
- IPC leads from the five Health and Social Care Trusts & Northern Ireland Ambulance Service Trust.

- Health and Social Care Board Social Care.
- Regulatory and Quality Improvement Authority Inspectors.
- Health and Social Care Board Primary Care; and
- General Practitioner and Dentistry representatives

290. The nursing profession is often well positioned to hold a leading role in the development of IPC guidelines and their implementation. While not directly involved in the development or operational delivery of these guidelines throughout pandemic period, the CNO was available to provide professional oversight if called upon, particularly to the Chair of the IPC Cell and to the senior IPC practitioner.

291. Representatives from other internal and external organisations were invited to attend the IPC Cell meetings to discuss any specific issues relating to them. The Cell reported through Silver Command into the Department's integrated Gold Strategic Cell. The CNO provided professional support and guidance to the chair of the IPC Cell if called upon. This advice would have been via telephone conversations and was mainly an opportunity to provide professional supervision by talking through potential problems, providing a second opinion, or giving early thoughts on potential ways forward. An example of this would be a discussion of alternatives to fluid shield masks that had loops preventing a good fit and the option to utilise clips to provide a tighter fit. In this case CNO supported the proposed approach based on infection prevention and control input and that the IPC cell should carefully monitor feedback. Another example was providing advice on an early version of guidance to support the use of colour-coded zoning aligned to appropriate PPE. In this case CNO's advice was that it was a good idea but that the guidance leaflet needed further clarification and careful interpretation of the colour zoning approach. CNO also offered to seek further input from CMO colleagues.

292. The Department was not represented in the IPC Cell's membership so it has limited information on the IPC guidance issued. The PHA should be able to provide details about the guidance issued by the IPC Cell including chronology and changes. The PHA should also be able to advise on any differences between UK and NI guidance.

Response to IPC guidance

293. The IPC Cell provided expert IPC advice to Health & Social Care Trusts complementing the expertise that HSC Trusts already had within their infrastructure in terms of expert IPC nurses and medical and public health practitioners.

294. IPC issues were a feature of the majority of nursing and midwifery leadership meetings. It was important for CNO to provide mechanisms to distribute timely information as quickly as possible in a changing environment. Additional conference calls with executive directors of nursing and IPC leads. All Trusts across NI were already required to adhere to the NI regional IPC Manual [CM/104 - INQ000503866] which provided detailed guidance for implementation and standardization across Trusts, and this was amended and updated as new evidence emerged. Early in the pandemic sometimes new guidance issued from the National (4 country UK) IPC cell caused some degree of logistical difficulties and confusion for staff. Such guidance often came out at the end of the week, and this created a challenge to disseminate it over the weekend. It was potentially confusing for staff coming back on duty following time off for rest or sickness absence. The regional (NI) IPC cell brought this to the attention of the national cell and asked that it was issued earlier in the week or not for implementation over the weekend. However sometimes this was unavoidable. The NI IPC cell sent information out through local networks where staff would be more likely to see it, while also developing posters and supporting guidance to make it quicker and easier for staff to understand. An example of this was local donning and doffing guidance.

295. Whilst IPC practices are commonplace in secondary care the additional requirements needed for COVID 19 in for example the care home sector in NI required additional support. In addition, there were other patient related considerations for example, in mental health and learning disability services. Interpreting IPC guidance given its complexity, ongoing review, and updates, created a risk that the guidance would be inconsistently applied, particularly in the context of the rapidity of asks of clinicians in health and social care settings. CNO personally undertook the development of training videos to support all staff. This took a significant period of time and had to be repeated as guidance changed.

296. At the start of the pandemic and due to fear of fatal illness many staff felt they should be wearing FFP3 masks even though the guidance limited it to areas with aerosol generating procedures. The guidance had to be reinforced and communicated widely. The relevant IPC guidance [CM/104 - INQ000503866] was not issued by the Department of Health, but rather was issued jointly by the Department of Health and Social Care (DHSC), Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, Health Protection Scotland (HPS), Public Health Scotland, Public Health England and NHS England as official guidance. It was initially issued in April 2020 and updated with updates through May/June 2020 to address, for example, aerosol generating procedure issues.

Advice on IPC guidance

297. The Department did not seek or issue guidance in respect of Infection and Prevention Control (IPC) but the IPC Cell provided a forum to discuss, develop and provide input to IPC guidance, arrangements, and policies across the region, providing an opportunity to share learning and innovative ideas used in Health and Social Care Trusts to minimise the risk of transmission. Examples of the learning and innovative ideas shared in this forum in relation to minimising transmission risks are:

- The innovation and introduction of the clips applied to looped fluid shield masks to secure a tight fit.
- Changes made to staff rest rooms to allow for social distancing in one trust and shared with others.
- The introduction of donning and doffing stations by one trust and shared with others.
- Introduction of dedicated nursing support for care homes to support infection prevention and control procedures.

298. The IPC Cell linked into the United Kingdom 4-Nations IPC Cell, and this allowed Northern Ireland to have an input in the shaping and influencing of expert advice and guidance. Settled expert advice was shared from the United Kingdom 4-Nations IPC Cell to each of the nations who then would assess the guidance with a view to adopting and/or advising in respect of its

implementation in their respective jurisdictions. Representatives from other internal and external organizations were invited to attend the IPC Cell meetings to discuss any specific issues relating to them. The Cell reported through silver command into the Department's integrated Gold Strategic Cell.

299. A senior IPC practitioner (Registered Nurse) from the Gold IPC Cell acted as the Northern Ireland representative member in the United Kingdom 4-Nations IPC Cell, which generally met daily from January/February 2020, moving to twice weekly in April/May 2020, and then weekly from August/September 2020 through to 2022, and CNO provided professional support to them if called upon.

IPC Guidance impact on PPE Procurement

300. Information on the impact, if any, of differences in IPC guidance in NI on procurement of PPE should be sought from BSO PaLS as the operational procurement lead as the Department does not hold this information. PHA would know if there was any difference between IPC guidance on PPE in NI and GB during the pandemic.

REGULATION OF PPE

Regulation of PPE

301. The Health and Safety Executive requires that where respiratory protective equipment (RPE) is used, it must be able to provide adequate protection for individual wearers.

302. RPE cannot protect the wearer if it leaks. A major cause of such leaks is poor fit since tight-fitting face pieces need to fit the wearer's face to be effective. As people come in all sorts of shapes and sizes it is unlikely that one particular type or size of RPE face piece will fit everyone. Thus, it is a legal requirement that workers using such tight fitting respiratory protective equipment (face pieces/masks) must be fit tested by a competent person for all Aerosol Generating Procedures. This requirement is detailed in Control of Substances Hazardous to Health (COSHH) regulations and is intended to ensure that the equipment selected is suitable for the wearer.

303. It is a matter for HSC Trusts to make the necessary arrangements for fit-testing for their staff in line with the PPE requirements set out in guidance. Fit Testing provision was and continues to be subject to regular audit in all HSC settings across Northern Ireland [see paragraphs 450 – 464 for detail on fit testing].

Regulation easements

304. In relation to LFDs, there were some 'easements' agreed with Medicines and Healthcare products Regulatory Agency (MHRA) in relation to use.

305. Discussions on such issues were typically led by DHSC/ UKHSA as part of the National Testing Programme. One example included the use of Innova boxes on 25 LFTs which were designed for use in testing centres (called assisted testing) whereas, working through UKHSA, NI with the other UK nations secured agreement from the MHRA that these tests could be used as part of home testing by healthcare professionals. The discussions with MHRA were led by DHSC/ UKHSA with DAs involved in these discussions.

306. Under the auspices of the National Testing Programme, all Devolved Administrations including Northern Ireland had ongoing links throughout the pandemic to fora established and led by DHSC/ UKHSA to discuss and raise relevant issues related to regulatory standards and performance of tests; and to receive updates from DHSC/ UKHSA and MHRA.

307. NI engagement with these fora was overseen by EAG-T and was ordinarily attended by PHA staff representing EAG-T.

PPE FOR HSC TRUSTS

PPE for Trusts

308. BSO PaLS was the CoPE for healthcare equipment and supplies in NI and procured PPE for Trusts including PPE provided by Trusts to the care sector. The Department had no expectation that Trust would procure PPE other than

through BSO PaLS and is not aware of such procurements if they did take place.

309. DoF CPD Supplies & Services Division did procure PPE for non-healthcare use by Public Bodies in NI. There was, however, close liaison between DoF CPD and BSO PaLS and they worked together with DoH, The Executive Office and the Department for the Economy (Invest NI) on procurement of additional PPE directly from China most of which was for Health Trust use [see paragraphs 266 to 271 for information on the China contract]. While there would have been some competition from non-health private sector business in NI for PPE, international competition may have been more significant factor in relation to costs.

PPE FOR THE CARE SECTOR

PPE for the care sector

310. A Care Home sector representative (a Director of the Independent Health Care Providers) was included on the BSO structures overseeing work on the provision of PPE in the very early stages of the pandemic.

311. Following engagement with the Business Services Organisation and the sector, interim guidance was issued on 12 March 2020 [CM/105 - INQ000103696] and included one section in relation to PPE, referencing guidance available on the PHE website. The guidance also stated that in the event independent providers were unable to source the appropriate items Health and Social Care Trusts should ensure they work closely with independent providers to ensure they have appropriate equipment available. This requirement was expanded on and detailed in later versions of the guidance, addressing feedback from the sector. The procurement and supply of PPE for Care Homes was therefore partially centralised through the BSO. A Departmental news release [CM/106 - INQ000103692] issued on 14 April 2020 announced that.

"in the past week 1.7 million items of PPE have been distributed by Trusts to the Independent sector which includes Care Homes and domiciliary care

settings. This includes 637,000 gloves, 413,000 plastic aprons and 400,000 liquid repellent surgical masks".

312. In his statement of 27 April 2020 [CM/107 - INQ000103694], the Minister stated: *"ensuring that Care Homes have sufficient supplies of PPE is an absolute priority, and Trusts will work with Care Homes in their areas to ensure that each home has a buffer of PPE stock"*

313. CPD in DoF were circulating details of providers of PPE to the wider public sector. The Department engaged with the Regulation and Quality Improvement Authority (RQIA) at the time and then asked DoF to include RQIA on the distribution list for providers of PPE so that details of PPE providers could be circulated to independent providers such as Care Homes, helping them to access PPE.

314. Subsequent Care Homes Guidance issued on 17 March 2020 [CM/108 - INQ000120717]:

a. requested that the Trusts work with nursing and residential homes on the provision of appropriate PPE.
b. Where homes are unable to source appropriate PPE provision, Trusts were to take into account these needs when seeking supplies from the Business Services Organisation.
c. Trusts had to work with homes to understand requirements and prioritise stock across organisations, where there are any short term limitations on stock. Trusts were to ensure all nursing and residential homes had a named point of contact with whom to discuss PPE provision.
d. Homes were not to be charged for the provision of PPE from Trust stocks.

LFDS AND PCR TESTING IN THE CARE SECTOR

Testing in the care sector

315. Under the National Testing Programme led and managed by DHSC/ UKHSA DoH NI through BSO made Lateral Flow Devices kits available to HSC Trusts to support testing of HSC Trust staff and hospital visitor testing. The

Department, BSO and HSC Trusts did not undertake any LFD procurements as this was undertaken at a UK level.

316. Operational delivery of Covid-19 testing programme for care homes was overseen by the Public Health Agency (PHA).

317. Between 28 July 2020 and 15 June 2021, the Department issued correspondence to the care home sector about the introduction of Covid-19 testing arrangements for care home residents, staff and visitors. This correspondence included information on the availability of tests for residents, visitors and care staff and how these can be obtained. The correspondence did not address the suitability of Lateral Flow Device (LFD) vs Polymerase Chain Reaction (PCR) testing.

318. The following correspondence from the Department is relevant:

- 28 July 2020: COVID-19: Implementation of Planned Regular Programme of Covid-19 PCR Testing in Residential and Nursing Homes – [CM/109 – INQ000437742]

  This letter about the introduction of a planned programme of regular Covid-19 testing explained that testing was to be undertaken through the National Testing Programme and advice was provided for care homes on booking and accessing testing kits through the care homes booking portal on the DHSC website.

  The letter advised that the testing kits to be used for the regular programme of testing were throat and nose swabs. The letter also provided a link to more detailed information about the testing arrangements and a link to the booking portal on the PHA website.

- 16 December 2020: Visiting and Care Partner arrangements in Care Homes: Access to Covid-19 Testing for Visitors over the Christmas period – [CM/110 - INQ000256371]

  This letter provided advice to care homes on how visitors could access Covid-19 PCR testing, if deemed necessary, up to 8 January 2021. The letter explained that testing would be available through:

  - Fixed drive through centres;
  - Walk through test sites;
  - Mobile testing units; and

- By the care home through its regular programme of weekly staff testing using PCR test kits accessed through the national Testing Programme.

- 18 December 2020: COVID-19 Testing arrangements for Residential and Nursing Homes – [CM/111 - INQ000432661]
  The letter included guidance on care partner and visitor testing arrangements, setting out how visitors should access testing over the Christmas 2020 period and up until the 8 January 2021.
- 15 June 2021: Expansion of LFD Self-Testing for asymptomatic visitors to Care Homes across Northern Ireland – [CM/112 - INQ000348909]
  This letter advised that the Department was extending Lateral Flow Device (LFD) testing to all asymptomatic visitors across all care homes with immediate effect.
  The letter advised that through existing communication channels, the PHA would be disseminating detailed guidance to care home providers to support the effective deployment of the visitor testing initiative.

319. Changes to care home testing were made based on expert advice. CMO established a Care Home Task and Finish (T&F) Group to provide effective direction, support and guidance. This group, chaired by the Deputy CMO, Dr Lourda Geoghegan, included key policy and professional representatives from the Department and the Expert Advisory Group on Testing (EAG-T), the PHA, and the Regulation and Quality Improvement Authority.

320. Subsequent guidance about PCR and LFD testing arrangements for care homes and how to access testing was issued by the PHA from 22 December 2021 onwards.

PPE Concerns of Care Sector

321. It is important to note the context of a challenging PPE position across all providers including HSC Trusts. When informed that HSC Trusts were only making limited supplies to care homes and that there was inconsistency across the region, the Department asked all homes to put in place a 'buffer' stock in care homes. The Department planned to convene a meeting with HSC Trusts to discuss how an adequate buffer could be put in place. The issue was, however, resolved before the meeting took place and therefore the meeting did not happen. The Department also contacted a number of care homes directly

following receipt of a list (from the Independent Health Care Providers) of care homes with issues but found that the issues with supply flagged by the Independent Health Care Providers had already been resolved. At least one HSC Trust noted informally that some care homes seemed to be using very high quantities of PPE. This may have reflected practice that went beyond official guidance at the time about when and what type of PPE was necessary. This may in turn have contributed to tensions between expressed care home requirements and what HSC Trusts were willing or able to provide.

322. The PPE Mailbox run by the Department did receive concerns from Nursing Homes and Domiciliary Care Staff and these were responded to with the appropriate advice or passed to the appropriate body to deal with [see paragraph 248 for report on the PPE Mailbox].

Testing concerns of Care Sector

323. Operational delivery of the Covid-19 testing programme for care homes was overseen by the PHA. Guidance detailing the Covid-19 testing arrangements or care homes was issued by RQIA on behalf of the Department and the PHA, with this guidance also made available on the PHA website. Where appropriate, the guidance directed care homes to the PHA to raise queries about the Covid-19 testing arrangements.

BSO PaLS supply of PPE for Care Sector

324. Care Homes Guidance issued on 17 March 2020 so from March 2020 provision of PPE to the independent sector was through nominated points of contact within Trusts where they were unable to source their own supplies was introduced [CM/108 - INQ000120717 & CM/113 - INQ000353600]. A reporting mechanism was introduced from week ending 11 April 2020 whereby each Trust reported to the Department on the volumes of personal protective equipment they provided to the independent sector – Care Homes and Domiciliary Care on a weekly basis [CM/114 - INQ000417493; CM/115 - INQ000417495]. Reporting and collation of this information concluded on 31 March 2023.

Buffer Stocks in Care Sector

325. Correspondence issued by the Department did not include specific advice on the subject of building up of buffer stocks. Operational delivery of Covid-19 testing programme for care homes was overseen by the PHA so it would hold details of guidance issued after 21 December 2021.

Financial Support in Care Sector

326. Significant additional funding was made available for independent sector providers of adult social care in 2020/21 consisting of three financial support packages amounting to £45m alongside an income guarantee for Care Homes and significant support in kind.

327. Wherever possible, the Department sought to put in place a claims based system with Care Homes providing evidence of their additional costs (e.g., for enhanced cleaning) and claiming these costs. In other categories it was accepted that it might be difficult to evidence the additional burden precisely, therefore payments were put in place based on set criteria. Health and Social Care Trusts were asked to oversee this claims process. BSO provided Health and Social Care Trusts advice on the most effective approach to this process, to minimise fraud.

328. The Minister announced financial supports including financial grant support packages with individual Care Homes receiving payments depending on their size:

- April 2020 [CM/107 - INQ000103694] and [CM/116 - INQ000103686] amounting to £6.5m
- June 2020 [CM/117 - INQ000103701] and [CM/118 - INQ000185429] amounting to £11.7m

329. These packages followed engagement with the PHA and Health and Social Care Trusts, advice from HSCB (now SPPG) and close engagement with the sector (including engagement with individual providers, who provided detailed evidence of additional costs and year on year changes). The funding reflected many of the key issues set out in guidance to the sector and learning from each

package of support (including low take up of some elements of the June 2020 package).

330. Following on from the Minister's announcements of additional funding packages, the Department wrote to the Director of Social Care and Children, Health and Social Care Board Directors of Older People's Services, and Health and Social Care Trusts on 30 June 2020 to clarify a number of eligibility queries and establish a mechanism to monitor and report on spend against these allocations. [CM/119 - INQ000103703].

331. In October 2020 further funding of £27m was provided.

332. It should be noted the health and social care services in Northern Ireland are integrated so the Health Trusts have a care responsibility and place residents in suitable private sector care facilities where required.

333. Most of the residents in private care providers in NI are placed, or funded, by the local Health Trust who, due to the integrated nature of health and social care in NI, are ultimately responsible for care provision. The private care providers are registered with, and inspected by, RQIA. If private care providers fail to deliver suitable care the relevant Health Trusts would be responsible for arranging suitable alternative placements or taking over management of the care facility if necessary. The decision to make PPE available to private care providers, where they were unable to source PPE themselves, was informed by this situation.

Market Analysis for Care Sector

334. The Department did not undertake or hold information on market analysis in relation to PPE as BSO PaLS undertook procurements on behalf of the Department as the CoPE for the healthcare sector.

335. Procurement of LFDs and PCR tests was not undertaken by the Department but was via the National Testing Programme at UK level so such analysis may have been done at that level. As Covid-19 PCR and LFD test kits for care homes (to support testing of residents, staff, care partners and visitors) were

made available to care homes at no cost to the provider Care homes were therefore not required to purchase their own Covid-19 PCR or LFD test kits.

PPE FOR PRIVATE HEALTH AND CARE PROVIDERS

Private Hospitals

336. HSCB (now SPPG) agreed contracts with 3 independent hospitals in 2020. There were two phases of contract:

a. The initial contracts (Apr – Jun 2020) which were for commissioning the entire Independent Sector hospitals x 3
b. The subsequent contracts for sessional use of Independent Sector hospitals x 3 (post June 2020)

337. Clause 7C in the North West Independent Hospital (NWIH) contract states that Trust(s) will provide PPE to the Independent Sector Provider as they asked for this. Similar clauses did not feature in Kingsbridge Private Hospital (KPH) or Ulster Independent Clinic (UIC.) contracts because they did not ask for such clauses.

338. In regard to sessional use of Independent Sector hospitals: UIC and NWIH contracts include clause 3(j) which states that "*The fees set out in paragraph (d) shall not include: (vii) PPE*".

PPE FOR HSC-ADJACENT SERVICES AND HSC CONTRACTORS

Locums and Agency staff

339. Health Care providers who work through agencies, or are subcontracted, were not working directly for the Department of Health so it would be for the Trust or organization employing them to advise of arrangements, as the Department would not make specific provision for this.

340. Under the National Testing Programme, Lateral Flow Devices kits were available to HSC Trusts and to Primary & Community Care to support regular

asymptomatic testing of staff; and hospital visitor testing. This policy initially applied to staff operating in higher-risk clinical environments but was later expanded to include all staff operating in the HSC environment including those staff working through agencies.

341. The programme of asymptomatic testing of health care workers was a stated priority for the Department – for example the Department wrote to Trust Chief Executives on 4 June 2021 and met with Trusts on 7 July 2021 to reinforce the importance of this testing. Asymptomatic testing using LFDs was as an additional measure alongside the full suite of public health measures, control and practices in place already at that time.

342. EAG-T established a Program Board (chaired by PHA) to oversee the rollout of this testing for HCWs. The Group also included Trusts, BSO (logistics and data connectivity) and DoH Testing Policy and NI SMART team.

Provision for non-health care staff

343. It was clear, through initial reports on mainstream and social media, as well as discussions at TMG, Gold/Silver structures and concerns being raised by staff, that PPE was either not available to all staff in a timely fashion, or that there were concerns around how the requisite PPE was being managed and shared around those who needed it. The Department did not employ hospital porters, cleaners, security staff directly so it would be for the Trust or organisation employing staff to provide PPE. The Department therefore made no direct provision of PPE to such staff.

344. As noted earlier, at the start of the pandemic and due to fear of fatal illness many staff felt they should be wearing FFP3 masks even though the guidance limited it to areas with aerosol generating procedures. The guidance had to be reinforced and communicated widely.

345. There were 15 queries regarding access to supplies of PPE raised via the PPE mailbox. These issues were raised by range of concerned individuals in Trusts, Nursing and Care Homes, General Practice surgeries and some who did not declare their background. In all cases these queries were followed up by the team with the relevant Trust single point of contact, the Executive Directors of

Nursing, and colleagues in the Department's supply cell. In all cases supplies were either found to be available or made available via the relevant Trust contact.

CONTROL/ASSURANCE MECHANISMS

Controls & Assurance re contracts

346. The application of NI public procurement policy is informed by a series of Procurement Guidance Notes (PGNs) issued by DoF's Construction Procurement & Delivery (CPD) directorate. PGN 03/11 Direct Award Contracts [CM/027 - INQ000503811] covers the award of such direct award contracts (DACs) by Departments and their arm's length bodies (ALBs). The Department disseminates CPD correspondence to its ALBs each time there is an update.

347. A Management Statement and Financial Memorandum (MS/FM) [CM/023 - INQ000503810] has been drawn up by the Department of Health in consultation with the BSO and sets out the broad framework within which the BSO will operate, including the BSO's overall aims, objectives and targets in support of the Sponsor Department's wider strategic aims; the rules and guidelines relevant to the exercise of the BSO's functions, duties and powers; the conditions under which any public funds are paid to the BSO; how the BSO is to be held to account for its performance.

348. In addition, the Accounting Officer appointment letter sets out the responsibilities for the ALB Accounting Officer as stipulated in Managing Public Money Northern Ireland (MPMNI), including safeguarding public funds in their charge and ensuring that they are applied only to the purposes for which they were voted and, more generally, for efficient and economical administration. The Accounting Officer appointment letter also notes their responsibility to ensure value for money: ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, good value and avoidance of error and other waste, judged for the public sector as a whole, not just for the Accounting Officer's organisation.

349. [CM/036 - INQ000503821] (updated in February 2022 by [CM/037 - INQ000503822]) set out the delegated limits for the Department, for HSC bodies and for NIFRS. Table A in the circular summarises the main financial delegated limits where the Department gave delegated authority to HSC and NIFRS to spend within those limits. Except in specified circumstances (e.g. External Consultancy, IT spend), Revenue Business Cases were fully delegated to the Department and to HSC Bodies, with a limit of £250,000 set for NIFRS Revenue Business cases. [CM/038 - INQ000503823], issued in September 2020 provided updated guidance, including delegated limits, for Covid-19 specific funding. All proposed expenditure which was expected to exceed the relevant delegated limits had to receive the appropriate prior approval from the Department or DoF as required before commitment to spend.

350. The process for awarding contracts via direct award was as documented in the DoF '*Revised Procurement Guidance Note 03/11 – Direct Award Contracts*' [CM/029 - INQ000503813] and would have applied to any direct award contracts. The Department supplements CPD DAC guidance with HSC specific instructions on when to seek approval from the Department, approval delegations and HSC DAC application forms [CM/028 - INQ000503812]. The circumstances in which approval for DACs from ALBs must be sought from the Departmental Accounting Officer; these are where the value of the procurement is above the EU threshold, currently £139,688 (including VAT) for goods and services, and BSO Procurement and Logistic Service (PaLS) as the relevant procurement body has RAG-rated the DAC risk as Red.

351. On the 27 July 2020, the Department issued [CM/038 - INQ000503823]. The purpose of this circular was to outline the funding and approval processes in relation to COVID-19. The Permanent Secretary communicated that the Accounting Officer of an ALB can approve COVID-19 related DACs where the expenditure is necessarily incurred as a direct and unavoidable consequence of COVID-19. A record of all COVID-19 related DACs must be maintained by ALBs. On the 24 March 2021, a further circular [CM/120 - INQ000503874], was issued; the purpose of this circular was to withdraw circular HSC(F) 25-2020. The processes and requirements surrounding revenue and capital funding approvals, business cases and related matters therefore reverted to that contained within circulars and other guidance in place prior to the COVID pandemic period. Outside of this period, any over threshold, red rated DACs

were considered by the Department prior to granting DAC approval. While reliance would have been placed on the advice from BSO PaLs, the Department considered the rationale and the need for awarding the Direct Award Contract, prior to granting approval.

Procurement Procedures

352. In Northern Ireland, responsibility for public procurement policy lies with the Procurement Board, chaired by the Finance Minister. All policies agreed by the board must comply with relevant procurement legislation. This guidance applies to all Northern Ireland Civil Service (NICS) departments, agencies, non-departmental public bodies (NDPBs) and all other sponsored bodies.

353. DoF CPD supports the Procurement Board, liaising with the Cabinet Office on legislative matters, helping in the development of new policies, and monitoring their implementation. CPD provides a central procurement function for central government in Northern Ireland, however there are also seven additional Centres of Procurement Expertise (CoPEs) providing professional procurement services.

354. The application of NI public procurement policy is informed by a series of Procurement Guidance Notes (PGNs) issued by DoF's Construction Procurement & Delivery (CPD) directorate. This guidance was available on the DoF website.

355. The Department disseminates CPD correspondence to its ALBs each time there is an update. PGN 03/11 Direct Award Contracts covers the award of such direct award contracts (DACs) by Departments and their arm's length bodies (ALBs); the Department supplements CPD DAC guidance with HSC specific instructions on when to seek approval from the Department, approval delegations and HSC DAC application forms [CM/028 - INQ000503812]. Over the course of the pandemic the Department issued the following circulars in relation to Procurement:

- [CM/121 - INQ000503875] - EU Procurement thresholds from 1 Jan 2020
- [CM/122 - INQ000503876] - Procurement thresholds from 1 January 2022
- [CM/028 - INQ000503812] - Guidance on Direct Award Contracts

- [CM/123 - INQ000503877] - New Procurement Policy Notes
- [CM/124 - INQ000503878] - DAO (DoF) 06/22 Direct Award Contracts
- [CM/034 - INQ000503819] - Procurement Fraud – NI Audit Office Publication
- [CM/038 - INQ000503823] - COVID-19 – Funding and Approval Processes
- [CM/120 - INQ000503874] - Withdrawal of COVID 19 Funding and Approval Process Guidance
- [CM/125 - INQ000503880] - Supplier Relief Due to COVID-19

PROCUREMENT OF VENTILATORS AND RELATED MEDICAL EQUIPMENT

Ventilator procurement

356. The process of ordering, distributing and monitoring demand for ventilator stock across Northern Ireland's critical care units was led by the Critical Care Network Northern Ireland (CCaNNI) in conjunction with the Procurement and Logistics Service (PaLS), which is a part of the Health and Social Care Business Services Organisation (BSO) and is the Centre of Procurement Expertise (CoPE) for the Health and Social Care system. BSO PaLS contacted suppliers in respect of critical care requirements through their normal procurement ordering processes. The role of the Critical Care Network Northern Ireland (CCaNNI) is to provide direction and consistency in the development and delivery of the Critical Care Service within Northern Ireland. In line with its Terms of Reference [CM/126 - INQ000477517], it provides resolved advice on critical care activity to commissioners to inform critical care service commissioning. It is accountable to the Department through SPPG (was HSCB) in the Department. The Department of Health's Gold Command had a role in supporting for consideration and approval HSC bids for expenditure on ventilators and other vital equipment, in line with Covid funding approval procedures, but not in the procurement process.

357. In March 2020 Trusts initially estimated that there was a need for 40 additional mechanical ventilators (30 adult units and 10 paediatric units) to bring the total available ventilators in Northern Ireland to 179 by the end of March. At this time further work was underway to scope the full extent of critical care

equipment that may have been needed to be purchased to ensure that Northern Ireland could respond to the potential number of people who would need such specialised care. Following receipt of a costed proposal from Health Silver on 19 March 2020 [CM/127 - INQ000343987] the Chief Medical Officer on behalf of the Department's Gold Command approved Health Silver strategic case and expenditure bid [CM/128 - INQ000503883] for a further additional 100 ventilators and other equipment for critical care and respiratory services in preparation for the first wave of Covid.

358. Planning and Decision-making processes in relation to the quantity and type of ventilator and other critical care equipment required were led by the Critical Care Network Northern Ireland (CCaNNI). Procurement processes following Departmental expenditure approval were led by BSO PaLS on behalf of CCaNNI/HSC Trusts.

359. Personnel involved in CCaNNI were:

- Chair – Margaret O'Hagan (Director and Chair CCaNNI)
- Clinical Lead – Dr A Ferguson
- Nursing Lead – Ms S Kinoulty
- Network Manager – Nichola Cullen
- HSCB/SPPG Staff– Paul Cunningham, Veronica Gillen, Paula Tweedie, Sarah Donaldson.
- HSCB Directors were– Miriam McCarthy (to May 2020), Paul Cavanagh (from July 2020), Paul Cummings (to June 2020).

360. On 19 March 2020 a paper was sent to HSC Silver outlining the equipment needs for critical care. [CM/127 - INQ000343987]. It was determined that equipment would be centrally sourced, ordered and distributed through normal BSO PaLS procurement processes. The paper was approved by Gold Command later that day (19 March 2020).

361. Spreadsheet outlines order, requisition and order number, supplier, cost, DAC or STA reference Anticipated lead time, delivery date, arrival date and any relevant notes on all equipment ordered for critical care equipment which was managed through CCaNNI and sourced through BSO PaLs. [CM/129 - INQ000503800].

362. When the equipment arrived, it went to a central point in Belfast City Hospital, was checked for damage etc. logged as arriving for payment and distributed to its final destination. A team in Belfast Trust worked with the Critical Care Network (hosted by HSCB) to do this.

363. HSCB (now SPPG) through CCaNNI also supported the distribution of equipment received from UK national stock and provided update to DOH on which equipment could be returned for use elsewhere.

364. Following a meeting on 18 March 2020 with HSCB, PHA and HSC Trusts, it was confirmed that 30 additional Non-Invasive Ventilation units plus 30 AIRVO machines needed to be ordered. [CM/130 - INQ000503886] This was in addition to machines already ordered by Trusts. The British Thoracic Society guidance on the 16th March 2020 was also discussed and it was recognised that staff may need some additional training.

365. Regional respiratory service needs were included in the additional equipment paper [CM/131 - INQ000503887] submitted to Silver on Thursday 19th March 2020, and approved by Gold later that day.

366. Acute Oxygen Supply Working Group managed the business case process for one order of contingency supply oxygen cylinders via Silver Command (June 2020). These cylinders and associated equipment (regulators and transporting trollies) were supplied by Sep 2020. The oxygen itself was budgeted for on a 'short order' basis with BOC. In the event of the pandemic none of this equipment was used and therefore nor was the oxygen supply budget employed.

367. The number of ventilators at end February 2020 available in NI was 139.

Total Number of ventilators	Number in current use	Number maintained under Planned Preventative Maintenance (PPM)	Decommissioned
141	110	31	2

By 15 April 2020 there were 188 adult mechanical ventilators across 10 hospital sites and a further 9 portable ventilators for use during patient transfers between critical care units (based on advice contained in a Ministerial submission [CM/132 - INQ000503888] to provide an update on ventilators and other respiratory equipment in stock, and on order, across the Northern Ireland Health and Social Care system, through either Health and Social Care supply chains or a new United Kingdom national allocation programme

368. The Critical Care Network for Northern Ireland (CCaNNI) led work on the development of planning assumptions in relation to the quantity and type of ventilator and other critical care equipment required by providers. The planning assumptions were based on the maximum surge need of providers and were detailed in a paper that was submitted to health Silver on Thursday 19th March 2020. [CM/131 - INQ000503887].

369. The Department did not set formal targets for the procurement of mechanical ventilators, non-invasive ventilators and oxygen concentrators as. procurement was based on the maximum surge need. An exercise took place with all providers [CM/133 - INQ000503889] to determine what equipment they required in order to surge to the required bed capacity. CCANNI worked with BSO to secure the equipment required to meet this capacity. The Department approved a request for expenditure for the required quantity and type of critical care equipment as advised by Health Silver and CCaNNI [CM/131 - INQ000503887], however it was understood that global supply chains were under extreme pressure and that lead times for equipment consequently could not be guaranteed. Orders placed with suppliers were monitored by BSO PaLS.

370. A submission [CM/134 - INQ000503890] updated the Health Minister regarding the national programme for the allocation of critical care equipment, advising that this scheme was managed for the UK as a whole by the Department of Health and Social Care (DHSC) in England in conjunction with the Cabinet Office and the Department for Business, Energy and Industrial Strategy (BEIS) in two components: firstly, a central programme of procurement and UK-wide distribution of stock on an 'on-loan' basis from NHS England; and, secondly, a Rapidly Managed Ventilator System (RMVS) challenge to UK industry. [CM/135 - **INQ000503887**].

371. Under the first of the national programme's components (a central programme of procurement and UK-wide distribution of stock) the submission advised that NHS England was in the process of procuring a large volume of ventilators, and other equipment, with the intention of allocating this as 'national NHS loan stock' to devolved nations and crown dependencies on a population basis, i.e. Northern Ireland would be set to receive 2.8% of all stock when received. This was to be shipped in phased consignments through to late May 2020, however distribution would also be prioritised to areas of peak Covid-19 need at the time that goods become available and may be withdrawn or stored in stockpiles when no longer in use. A standard operating procedure had been developed by NHS England and shared with HSCNI to help manage and track the stock.

372. Department of Health officials had not been involved from the outset of this programme in decisions around the allocation criteria/process. However, procurement leads from PaLS participated in an initial national telecall on 26 March 2020, along with representatives from NHS England, Scotland and Wales, and reported that NI could expect to receive the following equipment based on capitation at 2.8%:

- 196 mechanical ventilators (total 7000);
- 224 NIV (total 8000);
- 54 Oxygen concentrators (total 5500), and
- 644 Monitoring Equipment (23,000).

373. Under the second component of the national programme (a Rapidly Managed Ventilator System (RMVS)) the Health Minister was advised that this was a large-scale initiative announced by Health Secretary Matt Hancock on 20 March 2020 which involved 13 different work streams. It was progressing rapidly, with an expectation at that time that in the coming weeks tens of thousands of ventilators and other respiratory equipment would be allocated around the UK, also as 'national NHS loan stock'.

374. The procurement, allocation and distribution of ventilators was undertaken by BSO PaLS who should be able to provide details if required.

375. The Department is not aware of any point when a patient in Northern Ireland who needed a ventilator was not able to get access to one. While critical care

capacity was stretched almost to its limit during periods of high surge, at no point did critical care demand exceed capacity. The Department did not experience any significant challenges in the procurement of ventilators and as such is unable to document lessons learned in this regard.

376. Northern Ireland Specialist Transport and Retrieval (NISTAR) transports patients from one unit to another to ensure that patients had access to ventilators.

CONFLICTS OF INTEREST

Conflicts of Interest

377. DoH did not undertake any procurements of healthcare equipment or supplies.

378. In general terms the Department provides guidance on Conflicts of Interests on its intranet available to all staff. The guidance requires all staff from Grade 7 and equivalent upwards to complete a Declaration of Interests form upon appointment and review and update that form annually. The requirement may also apply to individuals or teams at lower grades, depending on their role and circumstances.

379. DoH retains registers of interests for staff and publishes the register for staff at grade 5 and above. The Department is not aware of any conflicts of interest in relation to the China contract.

IDENTIFICATION AND HANDLING OF FRAUD

Identification of Fraud

380. In relation to the identification of fraud nothing specific beyond the normal civil service and arm's length bodies sponsorship and governance processes was applied [see paragraphs 97 – 102 for details].

381. In relation to the China contract a Due Diligence Report prepared by Company F was obtained to provide reassurance that the procurement opportunity was not

fraudulent or suspicious [CM/095 - INQ000377348]. [see paragraphs 266 to 271 for details of China contract]

Fraudulent financial loss on contracts

382. To date the Department is not aware of any financial loss due to fraudulent PPE contractors.

CONTRACTUAL MONITORING, COMPLIANCE AND ENFORCEMENT

Contractual Compliance systems

383. The Department has no details of contract default provisions, payment provisions, checking of standards, termination provisions or flexibility etc.. The Department similarly has no details of payments recouped or breaches of contractual obligations.

384. BSO PaLS as the CoPE undertaking the procurement of healthcare equipment and supplies can advise on its processes and procedures.

STRUCTURE AND CONTENTS OF THE DIRECT AWARD CONTRACTS

Standard terms included in DACs

385. The Department of Health did not award any direct award contracts (DAC) for healthcare equipment and supplies. Under normal processes for awarding DACs, following approval of a DAC application, a contract is awarded subject to HSC contract terms and conditions. The contracting authority is the relevant HSC ALB and the awarding authority is BSO PaLS. The Department of Health therefore does not have a role in, or have oversight of, the standard terms and conditions included in contracts [see paragraphs 210 to 220 for information on DACs].

386. On 30 March 2020, the Departmental Accounting Officer agreed to relax the need for Direct Award Contract (DAC) paperwork to be completed in advance of a procurement as a result of COVID-19. The correspondence advised of the unprecedented and unforeseeable nature of the procurement matters being managed by BSO PaLS due to the Covid-19 emergency and recognised that time was of the essence for the provision of many products to HSC organisations. The Accounting Officer letter granted approval to this temporary derogation to normal approval processes for the period 30 March 2020 [CM/038 - INQ000503823] to 31 March 2021 [CM/120 - INQ000503874].

387. The circumstances in which approval for DACs from ALBs must be sought from the Departmental Accounting Officer are where the value of the procurement is above the EU threshold, currently £139,688 (including VAT) for goods and services, and BSO Procurement and Logistic Service (PaLS) as the relevant procurement body has RAG-rated the DAC risk as Red.

388. BSO PaLS as the CoPE undertaking the procurement of healthcare equipment and supplies can advise on its processes and procedures.

Scrutiny of BSO PaLS contracts

389. The Department in relation to BSO PaLS contracts for PPE had no specific scrutiny beyond the normal arm's length bodies sponsorship governance processes [see paragraphs 97 – 102 for details] was undertaken but from April 2020 to March 2022 the Department paused its formal sponsorship activities related to the governance of its 17 ALBs, including the BSO.

390. Details of procurements undertaken by BSO PaLS will be available from BSO PaLS.

APPROACH TO FINANCIAL RISK

BSO PaLS Financial risk scrutiny

391. From April 2020 to March 2022 the Department paused its formal sponsorship activities related to the governance of its 17 ALBs, including the BSO. This

inevitably led to a reduction in governance scrutiny including around financial risk [see paragraphs 346 – 351 for details of controls and assurance].

WRITTEN JUSTIFICATION OF DIRECT AWARDS

Justification of DACs

392. The process for awarding contracts via direct award was as documented in the DoF 'Revised Procurement Guidance Note 03/11 – Direct Award Contracts' [CM/029 - INQ000503813] and would have applied to any direct award contracts. The circumstances in which approval for DACs from ALBs must be sought from the Departmental Accounting Officer are where the value of the procurement is above the EU threshold, currently £139,688 (including VAT) for goods and services, and BSO Procurement and Logistic Service (PaLS) as the relevant procurement body has RAG-rated the DAC risk as Red. [see paragraphs210 to 220 and 385 to 387 for more information on DACs]

393. On the 27 July 2020, the Department issued HSC(F) 25-2020 [CM/038 - INQ000503823]. The purpose of this circular was to outline the funding and approval processes in relation to COVID-19. The Permanent Secretary communicated that the Accounting Officer of an ALB can approve COVID-19 related DACs where the expenditure is necessarily incurred as a direct and unavoidable consequence of COVID-19. A record of all COVID-19 related DACs must be maintained by ALBs. On the 24 March 2021, a further circular titled HSC(F) 13-2021 [CM/120 - INQ000503874], was issued; the purpose of this circular was to withdraw circular HSC(F) 25-2020 [CM/038 - INQ000503823].

394. The processes and requirements surrounding revenue and capital funding approvals, business cases and related matters therefore reverted to that contained within circulars and other guidance in place prior to the COVID pandemic period. Outside of this period, any over threshold, red rated DACs were considered by the Department prior to granting DAC approval.

Publication of DACs

395. It is the responsibility of CoPEs to publish details of direct award contracts. The Department did not monitor the timeliness of the publication of DACs by BSO PaLS.

DISTRIBUTION OF PPE, KEY EQUIPMENT AND SUPPLIES

Distribution of PPE

396. BSO continued to maintain its responsibility for procurement and distribution of PPE throughout the Covid-19 pandemic. Whilst BSO provided the Department with Surge -v- Demand reports which included information on the net order position and highlighted were deliveries were delayed, the issues were managed by BSO. The Department is not aware of any instance where the issue was escalated for further intervention.

397. The Department was not aware of any centralised plans for the onwards distribution of goods being delegated to local authorities or volunteers.

398. The Department was not aware of delays to specific PPE deliveries although it was aware of the challenging market conditions during both the PPE Strategic Supply Cell and PPE Liaison periods.

399. In March 2020 provision of PPE to the independent sector, where they were unable to source their own supplies, was introduced through nominated points of contact within Trusts [see paragraph 324 for details].

Critically low levels of PPE

400. The Departments PPE Strategic Supply Cell was not aware at any point that the HSC sector ran out of PPE; the main concerns were the level of demand and being able to meet that in the supply environment we were operating in.

401. In addition to receiving daily Surge Forecast v Demand report [see paragraphs 159 and 429 for details] which assisted in the monitoring of the supply and demand position, the Departments PPE Strategic Supply Cell was in direct daily contact with BSO reviewing the position. On occasion where BSO deemed

stock in a particular item to be significantly low, requests were made to the Department for the release of stock from the PIPP stockpile or to process a request for mutual aid from the other UK nations.

402. As highlighted in the Rapid Review of PPE there were initial delays in the process for the release of the PIPP stockpile. As a result, Emergency Planning Branch met with BSO and agreed a new process which saw the development of a PIPP Stock Release Form which set out clearly the information required to enable authorization of release of stock thereby streamlining the process.

Push and Pull Models

403. The "pull" model was a system whereby orders for PPE to BSO by HSC Trusts were generated at hospital wards level, ICUs and theatres, or community facilities such as day centres and community hospitals or departmental level. This was commonly referred to as the Business-as-Usual (BaU) supply chain for high volume consumable products in HSC. Many PPE items were already handled via this system, albeit in much smaller volume before the COVID-19 pandemic.

404. The "push" model is where BSO would push bulk supplies of a designated list of products (including PPE) to Trusts based on an apportionment of stock. This then allowed Trusts to prioritise deployment of appropriate PPE to areas in need and do this in accordance with PHE guidance. Operational details for this new system were agreed between BSO and Trusts.

405. In effect this meant that Trusts would no longer order PPE direct from BSO's BaU system (pulled model), but rather would receive a "pushed" order from BSO available stock which was supplemented by approved access to PIPP stockpiles where appropriate. This would result in all Trusts securing a share of available product and prevent localised stockpiling thus delivering equity in a climate of global short supply and exponentially increased demand.

406. BSO Decided in early 2023 to revert back to its BaU model, however as PPE Liaison understands it, the decision was make in close discussion with the Trusts and a timeframe agreed between them on the switch over. DoH had no role in these discussions. An assessment of its success would be for BSO and

HSC Trusts to determine however in the time of the PPE Strategic Supply Cell operation and PPE Liaison there were no reports of a Trust running out of PPE.

Contracts for Storage of PPE

407. Contracts for storage were awarded by BSO PaLS. BSO PaLS would have knowledge of the costs and performance of those contracts.

408. The Department did approve a business case [CM/136 - RCMG1014 - INQ000513251] for the fit-out of three warehouses in Carrickfergus to accommodate the additional PPE ordered and acquired to deal with the pandemic. The estimated cost of the fit-out and handling equipment at business case stage was £3.25M, which was above the BSO capital delegation, and this was the amount approved by the DoH. Any revenue costs associated with these three leases (and others such as Kinnegar Logistics Base and Nuggent Hall, Belfast) fell within BSO's delegated limit and were approved internally by BSO.

COORDINATION BETWEEN THE FOUR NATIONS & MUTUAL AID

Co-ordination and liaison outside NI

PPE Strategic Supply Cell

409. At a UK level, the Departments PPE Strategic Supply Cell engaged with the other jurisdictions initially through the PPE Four Nations Board and latterly the Strategic PPE Four Nations Board and worked with them on the UK-wide PPE Action Plan which was published on 10 April 2020 [CM/090 - INQ000050008]. The plan was set around three strands; guidance, distribution and future supply, which was aimed at ensuring that everyone got the PPE they needed. This engagement allowed for a collaborative working arrangement which included the application of mutual aid, whilst enabling each nation to continue with its own procurement plans.

CNO

410. At this time through engagement with the UK CNOs the CNO was able to gain agreement under mutual aid to supply 25,000 gowns to colleagues in England

who were experiencing extreme shortages and at a time when we had better availability in the NI stockpile. The gowns were supplied on 18 April 2020.

411. The UK and RoI CNOs had an established forum to discuss strategic nursing and midwifery policy issues prior to the pandemic. During the pandemic, this forum became a shorter and more regular meeting to share information and make national nursing and midwifery decisions. At the start of the pandemic the meetings became 'as required,' frequently daily or several times a week and often at night or on weekends. Where relevant, meetings were moved to weekly. Over the course of 2021, the meetings were weekly then bi-weekly in the latter half of the year. Notes of these meetings were normally taken and held by colleagues from CNO England's office.

412. Each CNO provided a country update and verbal sitrep type report with discussions including any emerging new evidence on IPC and vaccination.

Sharing stock

413. The Departments PPE Strategic Supply Cell is aware of the following sharing of stock from 24 March 2020 to 20 September 2020.

a. Department of Health (NI) benefitted from the receipt of approximately 5.87 million individual items of PPE from the DHSC as a result of 4 Nations Mutual Aid arrangements.
b. Department of Health (NI) benefitted from the receipt of approximately 186,000 individual items of Personal Protection Equipment from the NHS Wales as a result of 4 Nations Mutual Aid arrangements.
c. Department of Health (NI) provided approximately 1.78 million individual items of PPE to the Department of Health and Social Care England (DHSC).

LFD tests

414. There were some instances of mutual aid/ stock loans across the UK nations in relation to LFD stock. Typically, this was managed at official level as availability and supply of LFDs across the UK was not a challenge throughout most of the pandemic period. These loan and replenish decisions were monitored closely by officials through Testing Supply and Demand Management meetings; attended by officials from each UK nation and underpinned by detailed supply and stock data compiled and maintained by

DHSC/ UKHSA. NI stock levels were also monitored closely by the NI SMART Program Board, in collaboration with EAG-T where that was required.

415. There was one instance in December 2021 where England requested a loan of LFDs from Devolved Administrations, including Northern Ireland, at a time when England was experiencing a short-term supply deficit. Northern Ireland had experienced an unprecedented rise in demand for LFDs around this time therefore a submission was prepared seeking approval from Minister to agree to the loan request. Minister granted approval and the stock was replenished to the NI stockpile in January 2022.

PCR tests

416. There were some instances in periods of peak testing demand where NI, working directly with DHSC and UKHSA colleagues, worked to agree a short-term increase to PCR testing capacity (that is, above the NI Barnett share allocation) available through National Testing Programme test sites (Pillar 2) and supporting Lighthouse Laboratory PCR processing capacity. This was monitored closely by DHSC/ UKHSA colleagues together with NI counterparts and returned to baseline levels. The Chief Medical Officer and the Minister were made aware in these rare cases. This was a particularly good example of the benefits of the National Testing Programme operating in practice as a single networked laboratory capacity, overseen and co-ordinated centrally by DHSC/ UKHSA, where demand pressures in one nation were assisted for a short period of time by overall capacity/ demand management across the network. The Department understands there were examples where the other nations benefitted similarly.

417. There were no mutual aid arrangements with the Republic of Ireland for test kits that the Department is aware of.

Four Nations PPE Decision Making Committee

418. The DoH PPE Liaison Officer attended the Four Nations PPE Decision Making Committee from May 2021 until its role was transferred to the UK Reuse, Innovation and Sustainability (RIS) Steering Group in March 2022 that DoH did not attend. It is understood the committee's focus was primarily technical and regulatory. The DoH attendance at the PPE Decision Making Committee was

used to obtain knowledge and share with colleagues across the Department and HSCNI where appropriate and no active role was played in the committee.

419. The PPE Liaison role was undertaken by one Grade 7 who was initially placed in the Covid Response Directorate but then moved to the Regional Health Service Transformation Directorate. The role continued until September 2023

PPE received and provided by NI

420. The Department of Health benefitted from the receipt of approximately 5.87 million individual items of PPE from the DHSC as a result of 4 Nations Mutual Aid arrangements.

421. Table A below details the number of items received and when they were received.

PPE Item	Number Received	Date Received by
Aprons	2,187,850	9 April 2020
FFP3 Respirator Masks	682,200	9 April 2020
Type IIR masks	700,800	9 April 2020
FFP3 Respirator Masks	10,958	14 April 2020
Eye Protection	1,275,000	14 April 2020
Type IIR Masks	436,300	17 April 2020
Eye Protection	22,901	20 April 2020
Type IIR Masks	165,000	20 April 2020
Type IIR Masks	97,900	23 April 2020
Eye Protection	300,000	April 2020

422. The Department benefitted from the receipt of approximately 186,000 individual items of Personal Protection Equipment from the NHS Wales as a result of 4 Nations Mutual Aid arrangements.

423. Table B below details the number of items received and when they were received.

PPE Item	Number Received	Date Received by
Eye Protection	36,000	Early April 2020
Type IIR Masks	100,000	25 April 2020
Gowns	50,000	4 May 2020

424. Table C below details the numbers of PPE provided to the UK Department of Health and Social Care (DHSC) from the Department and the date they were released. The following figures below are lifted from the Covid-19 Update Report dated 6 July 2020.

425. Table C.

PPE Item	Number Issued	Date of Issue
Gown	200,000	3 April 2020
Gowns	50,000	10 April 2020
Gowns	25,000	17 April 2020
Visors	500,000	4 May 2020
Visors	1,000,000	May 2020

GAUGING DEMAND FOR PPE

Data on PPE demand

426. The Department did not place PPE orders and did not have access to real time data on PPE demand. It is understood BSO operated a system whereby orders for PPE by HSC Trusts were generated at hospital wards level, ICUs and theatres, or community facilities such as day centres and community hospitals or departmental level. This was commonly referred to as the "Business as Usual" (BaU) supply chain for high volume consumable products in HSC. Many PPE items were handled via this system and BSO would have had access to that data.

427. LFD stock levels (at NI level – not individual Trusts) were monitored closely by the Department's NI SMART team through Testing Supply and Demand Management meetings; attended by officials from each UK nation and underpinned by detailed supply and stock data compiled and maintained by DHSC/ UKHSA. NI stock levels were also monitored closely by the NI SMART Program Board, in collaboration with EAG-T where that was required.

428. EAG-T established a Program Board (chaired by PHA) to oversee the rollout of this testing for health care workers and to address operational and logistical issues involved; including in supplying test kits to Trusts. The Group included Trusts, BSO (logistics and data connectivity) and DoH Testing Policy; and linked with the NI SMART as needed in relation to LFD supplies.

PPE stocks held

429. From 2 April 2020 BSO provided the Departments PPE Strategic Supply Cell with a daily Surge Forecast v Demand report, for the duration of its operation. [CM/042 - INQ000503825]. The reports detailed BSO assessment of the forecasted demand (as per modelling) against the actual weekly supply, the stock on hand within BSO and HSC Trusts and the net order position. This process was refined with the inclusion of additional information to enable more effective monitoring of the supply position [CM/043 - INQ000503826]. These reports assisted the monitoring of the supply and distribution position. The reports continued to be received by the Department, however the frequency reduced to monthly until July 2023 when DoH advised BSO PaLS that it was no longer needed. The Department has no other details regarding stocks held by individual Trusts or hospitals during this period.

PPE demand in Care Sector

430. The PPE Strategic Supply Cell did not have access to specific data on demand for PPE in the care sector and in community care setting but did from week ending 11 April 2020 receive data on the volumes of personal protective equipment each Trust had provided to the independent sector – Care Homes and Domiciliary Care [CM/114 - INQ000417493].

431. Under the National Testing Programme (NTP), data was held and collated by UKHSA (Supply & Ops Team) and shared with the Department in relation to the number of tests provided to care sector organizations who had registered for the NTP OLT delivery scheme (Organization Led Testing). LFD tests were made available to the care sector and community settings in line with testing policy and were distributed under the UKHS/ DHSC National Testing Programme; and occasionally via established BSO networks.

Modelling of PPE demand

432. Initial modelling was undertaken by the HSCB (now SPPG), in conjunction with the PHA Director of Nursing, in late March 2020. The modelling looked at

personal protective equipment demand across hospital, community, and primary care settings at extreme surge / worst case scenario.

433. It was recognised, however, that there was need for a more dynamic approach. Led by the PHA, work was progressed on the development of a Health Resource Demand Model, which was aimed at predicting and managing key resources, including the production of regional personal protective equipment demand estimates which were then used to inform BSO procurement strategy.

434. The accompanying exhibits documents include the paper on the development of the Regional Healthcare Resource Modelling received from the PHA including the approval process, activity data and model assumptions supporting the methodology and development of the model. A depiction of the draft model is also included: [CM/137 - INQ000130319, CM/138 - INQ000130320, CM/139 - INQ000120798, CM/140 - INQ000130322, CM/141 - INQ000120799, CM/142 - INQ000120800, CM/143 - INQ000120801, CM/144 - INQ000120802, CM/145 - INQ000120803, CM/146 - INQ000120804, CM/147 - INQ000120805, CM/148 - INQ000120806, CM/149 - INQ000120807, CM/150 - INQ000120808, CM/151 - INQ000120809, CM/152 - INQ000120810, CM/153 - INQ000120811, CM/154 - INQ000120812].

435. In relation to LFDs, the NI SMART Programme Board at times provided advice and supporting information to inform NI procurement opt-in/ out decisions. For example, linking closely with DHSC/ UKHSA, the Board and its support team compiled demand/ supply forecast data on an ongoing basis to inform NI opt-in/out of significant UK wide LFDs procurements.

436. The NI SMART team participated in weekly Testing Supply and Demand Management meetings, managed by DHSC/ UKHSA, to discuss the anticipated demand and ensuring that sufficient LFD tests were available in NI across each use case to support testing requirements in the immediate future.

437. The Department is not aware of PPE demand modelling input relating to composition of the HSC system workforce on gender, ethnic or religious background.

438. The LFD demand / use modelling sought to take account of the pandemic trajectory and testing policy / use cases and included different variables to give different estimates.

439. During the period following the closure of the Departments PPE Strategic Supply Cell, BSO PaLS advised the Departments PPE Liaison verbally that the reasonable worst case scenario modelling on which procurement of PPE was based was not true to the first wave of the pandemic use of PPE and that it should be reviewed. In June 2021 BSO PaLS submitted a paper to the Department [CM/155 - INQ000503892], which the PPE Liaison Officer submitted to the Rebuilding Management Board on BSO PaLS behalf, in which a revised reasonable worst case scenario model was put forward for approval. While no formal record exists of the approval, it was provided to BSO to implement. In terms of the impact of changes to IPC guidance, BSO would be best placed to advise if these changes impacted on the revision to the modelling put forward to the Rebuilding Management Board.

Controlling demand for PPE

440. The Department is not aware of any policy or strategy for controlling demand or rationing use of PPE and did not instruct BSO PaLS to cancel PPE orders placed by HSC Trusts.

EXCESS PPE STOCK, STORAGE, MANAGEMENT & DISTRIBUTION

Excess PPE stock

441. BSO PaLS advised that there was more stock procured than needed (in a number of PPE lines). Given the nature of pandemic and changes in IPC guidance the stock levels continued to move on a regular basis. BSO PaLS controlled and managed all logistics for PPE procured so are best placed to advise on excess stock quantities.

Surplus stock disposal

442. Responsibility for surplus stock resided with BSO PaLS. Informal meetings were held regularly between the DOH Liaison officer and BSO PaLS since September 2020 during which discussions were held on surplus stock and what options might be available for BSO PaLS to consider to most effectively manage surplus stock levels.

443. In January 2022 the Minister was asked to agree a way forward in relation to managing surplus stock [CM/156 - INQ000503893]. This put forward a range of partner organisations, including the wider public sector, the third sector, charitable and faith based organisations, in order to minimize the resource cost in storing and managing surplus stock. Associated to this was a request that DoH would cover the necessary write off costs so that usable stock could be passed on where there is a need. The Minister asked that BSO PaLS directly engage with the UK Government on contracts they had put in place for selling on surplus stock and ascertain if this might also be a viable route to reduce stock held by BSO PaLS [CM/157 - INQ000503894]. This was an ongoing situation and with the Assembly and its structures collapsing in May/June 2022 the PPE Liaison Officer is not aware that the Minister was subsequently updated on progress.

Decisions on PPE

444. Responsibility for management of PPE stock, including storage and distribution was held by BSO PaLS. A system was put in place for the care sector to order supplies of PPE, directly from HSCNI Trusts, which were replenished by BSO PaLS as appropriate.

445. BSO PaLS is best placed to advise on process for monitoring, management and distribution of PPE stock.

446. Since September 2020 the Department had a PPE Liaison role with BSO PaLS.

447. Extension of shelf life is a technical aspect of PPE and the Department had no role to play in this as it remained with BSO PaLS to take appropriate action.

448. BSO PaLS, as the HSCNI procurement service, is best placed to advise on optimum stock levels for business-as-usual need for PPE which prior to the

pandemic it set. BSO PaLS, worked with PHA in PPE modelling. BSO PaLS sought agreement from the Department's Rebuilding Management Board to a revised PPE need assessment, based on a revised Reasonable Worst Case Scenario forecast [see paragraph 439].

449. Through regular informal PPE liaison meetings with BSO PaLS, the Department was advised of PPE stock degrading or reaching manufacturers best before date. The Department was not expected to take action in relation to the stock reaching end of useable life, however it would have discussed what options were available for BSO to pursue. BSO PaLS manages all actions in relation to its PPE stock. No formal records were kept of these PPE liaison meetings.

FIT TESTING

Fit testing of PPE

450. The general arrangement is PPE supply, quality, fit testing and guidance for use, are operational matters for HSC Trusts and their responsibility. However, given the extraordinary situation that the pandemic was presenting, the Chief Nursing Officer, as a senior leader in the Department and the leader of the largest profession in the HSC, whilst not directly responsible, was involved in discussions around respiratory protection equipment and the number of concerns which were being raised around failures in the fit testing of masks.

451. The Health and Safety Executive requires that where respiratory protective equipment (RPE) is used, it must be able to provide adequate protection for individual wearers.

452. RPE cannot protect the wearer if it leaks. A major cause of such leaks is poor fit since tight-fitting face pieces need to fit the wearer's face to be effective. As people come in all sorts of shapes and sizes it is unlikely that one particular type or size of RPE face piece will fit everyone. Thus, it is a legal requirement that workers using such tight fitting respiratory protective equipment (face pieces/masks) must be fit tested by a competent person for all Aerosol Generating Procedures. This requirement is detailed in Control of Substances

Hazardous to Health (COSHH) regulations and is intended to ensure that the equipment selected is suitable for the wearer.

453. Fit testing compliance for female staff required a range of face mask type and sizes to be available. HSC supplies were distributed with this in mind. There were shortages of FFP3 masks that were suitable for certain facial features from time to time. Contingency measures would have been put in place by Trusts to ensure they were reserved for those that needed them most. As part of that contingency Trusts would have the ability to review and change the rota should a certain FFP3 mask not be available for staff. The Department understands this was not instigated as central coordination through BSO ensured mutual aid between Trusts. This was one of the reasons for securing local design and manufacture of masks through Denroy a local NI company.

454. PHA through the chair of the IPC Cell established a product review team designed to support the testing of PPE in a clinical environment. This helped ensure the maintenance of PPE standards.

455. Updates on the emerging best evidence and advice in regard to IPC and use of PPE were shared on the CNO communication platform when endorsed and available. Examples of information shared included the development of IPC learning videos on donning and doffing and media campaigns to inform the public and staff in relation to health care professionals coming into a home. The CNO role was around offering supervisory support if called upon to the PHA Director of Nursing, Midwifery & Allied Health Professions as the chair of the IPC cell.

456. Fit Testing Provision was and continues to be subject to regular audit in all HSC settings across Northern Ireland.

457. The Department is not aware of any shortages of fit testing kits or services in hospitals or care settings during the pandemic.

458. Around the time of the early stages of the pandemic, the fit testing providers used by Health and Social Care Trusts in Northern Ireland were:

- Amon Electronics
- G&L Consultancy Ltd

- Healthcare Essentials
- FITTEST.IE
- Task NI.

459. All those companies had been accredited under the Fit2Fit RPE Fit Test Providers Accreditation Scheme (a scheme designed to confirm the competency of any person performing face piece fit testing and operated in line with HSE INDG479 protocols. Additionally, Amon Electronics provided accredited fit test training programmes to all five Health and Social Care Trusts and NIAS Trust which would allow those Trusts to carry out in-house fit testing.

460. All these fit testing companies procured by HSCTs across NI were trained to the required standards and operated in line with HSE INDG479 protocols which state that the Fit Test Protocol must include a minimum of seven test exercises performed for at least one minute each. The wearer must achieve an individual pass result in each of the seven test exercises within one single testing period i.e., if an individual fails one of the exercises, then the test must be repeated. The minimum fit factor pass level which must be achieved depends on the type of face piece being tested.

461. Concerns were raised around the number of staff failing the fit testing of masks due to the range of products being supplied [CM/158 - INQ000120710]. An audit review of fit testing for respiratory masks was carried out on a precautionary basis by Trusts across the health and social care system after it emerged in early summer 2020 that on some occasions an independent contractor had inadvertently applied a fit testing setting not normally used in Northern Ireland. This should have been readjusted to the UK Fit Testing requirements. While clinical advice suggested that any risk to staff arising from this error was likely to be low, to ensure proper compliance and safety for staff, all fit testing certificates in place at that time were reviewed regardless of provider, meaning over 37,000 fit-testing certificates were ultimately reviewed.

462. Of these, over 2,800 staff, across all 5 HSCTs and NIAS were identified as needing a re-test. Health and Social Care Trusts urgently implemented a

retesting programme that the independent contractor completed at no additional cost to the HSC System.

463. The Public Health Agency acknowledged that this incident was a serious breach of protocol and as such presented a safety risk, hence the reason for the commissioning of a Level Two Serious Adverse Incident (SAI) review. We still await the outcome of that SAI.

464. The responsibility for PPE supply, quality, fit testing and guidance for use rests with the HSC Trusts. It would be for Trusts in consultation with BSO PaLS and PHA to consider alternative PPE types such as hoods.

MASS TESTING

Mass Testing

465. The Department understands that Mass Testing in this context is used to describe whole population experimental pilot testing using LFDs for example as undertaken in Liverpool and a number of pilots in Wales, and in Slovakia, shortly after LFDs first became available. Northern Ireland did not undertake such mass testing.

LESSONS LEARNED

Lessons learned

466. Reviews and lessons learned exercises that the Department have been involved in include:

Rapid Review of Personal Protective Equipment

467. On 15 April 2020 the Minister commissioned [CM/077 - INQ000120712, CM/078 - INQ000120813, CM/079 - INQ000120814] a rapid review of personal protective equipment to focus on the appropriate receipt, storage, distribution, and use of personal protective equipment across the health and social care system. The terms of reference for the Rapid Review included an assessment

of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19.

468. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the health and social care system. The final report was submitted to the Minister on 14 May 2020. The accompanying exhibits detail the final report and supporting documentation such as a submission with the background information, Ministerial comments and approval and action plan for the recommendations [CM/080 - INQ000137351, CM/081 - INQ000130338, CM/082 - INQ000120815, CM/083 - INQ000120816, CM/084 - INQ000120817, CM/085 - INQ000120820, CM/086 - INQ000120821, CM/087 - INQ000120822]. The Review made 19 recommendations for the short-term improvement of the personal protective equipment position, which was in preparation for a second wave of Covid-19. Seventeen associated actions were identified to implement the 19 recommendations with a lead official identified against each action on 15 June 2020. [CM/088 - INQ000120714]. Twelve of the actions were assessed as Critical (to be completed within 2-4 weeks) with the remaining five as Essential (to be completed within 4-8 weeks). Progress on the actions was monitored by the Departments PPE Strategic Supply Cell and whilst some of the actions were completed in a relatively timely manner, the initial timeframe for completion proved challenging given the nature of some of the actions.

469. Of the actions deemed critical, three were closed by mid-July, five by the end of July, two by the start of August and one at the end of August. The remaining action was not closed until mid-December 2020. Of the actions deemed essential, three were closed by end of June, one mid-July and the other action at the end of October 2020.

470. The two actions which took longer to close were in relation to the appropriateness of the reuse of personal protective equipment in a period of critical shortage in line with expert scientific advice (Essential) and the development of systems to enable feedback from end users around the quality of personal protective equipment across all the health and social care system and independent sector which could be used to better inform procurement (Critical). Both actions required the lead owner, the Public Health Agency, to engage with key stakeholders and develop supporting products which impacted

on the overall timeline. The Department sought regular updates from the PHA lead on progress of the actions required.

PPE Mailbox Report

471. A review report [CM/159 - INQ000438126] was produced identifying those key themes and lessons learned from the content of the PPE mailbox emails received. This was shared with Minister on 12 February 2021, and then with the sector for consideration and appropriate action.

Emergency Planning Branch Report

472. DoH Emergency Planning Branch prepared a 'Review of Health Gold Command Response to SARS-COV-2/COVID-19' report completed on the 11 November 2021. It covered the lessons learnt from DoH Emergency Operations Centre (EOC) during the first wave of the COVID 19 pandemic [CM/160 - INQ000188797]. A total of 20 lessons and recommendations were identified the majority of which were around early engagement with key partners on situational awareness as the emergency evolved and establishing good communications. One was around the release of the PIPP stockpile.

***"Release of PIPP stock** – there was a sense of panic across the HSC and Independent Sector in relation to PPE and an expectation that DoH would release its entire emergency stockpile (PIPP) to BSO without appropriate justification, including items already in good stock across Trusts. There was delay in setting up a PPE cell and then confusion about the role of the PPE cell. The process improved following recommendations arising from the PPE audit conducted by Internal Audit in April 2020. There is now a template for BSO to complete for release of PIPP which has streamlined the process.*

***Recommendation 2**: Roles and responsibilities for managing PPE during a pandemic, including when and how the emergency stockpile (PIPP) is used, need to be established and embedded in emergency plans."*

473. Recommendation 2 has been completed and the DoH Emergency Plan [CM/161 - INQ000503896] includes updated guidance.

Statement of Truth

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

Signed: Personal Data

Dated: 05/02/25