Witness Name: Neil Guckian OBE

Statement No: 1

Exhibits: 12

Dated: 23rd December 2024

UK COVID-19 INQUIRY - MODULE 5

WITNESS STATEMENT OF NEIL GUCKIAN

I, Neil Guckian will say as follows: -

1. I am Neil Guckian and I held the position of Director of Finance & Contracts of the Western Health and Social Care Trust (WHSCT) in Northern Ireland (NI). I currently hold the position of Chief Executive of the Western Health and Social Care Trust (WHSCT). I write this statement in response to a request from the Inquiry dated 18th July 2024. The statement has been prepared with the assistance of staff from the Trust who had knowledge, experience and access to documents pertinent to the information requested. This is my first statement to the Inquiry.

Overview of the role, functions and activities of the Western Health and Social Care ('HSC') Trust

2. The Western Health and Social Care Trust is one of five Trusts which provide health and social care services across Northern Ireland. Trust services span acute and community care, mental health, learning, physical & sensory disability, children's services and social care to over 300,000 people living in the North West of Northern Ireland. Services are provided across 7 Hospitals (2 Acute Hospitals), 11 Health Centres, 8 Children's Homes, 30 Day Care Centres and 8 Residential Homes. A key feature is its proximity to the border with Republic of Ireland, with a transient population. It has well established cross-border collaborative arrangements with the Republic of Ireland for the delivery of a number of services, including the North West Cancer Centre. Geography is a key challenge for the Trust – it extends over 4842 km2 and is characterised by a mix of dense urban areas and extensive rural communities.

To address this geography, for example, the Trust provided multiple COVID 19 vaccination centres to facilitate access. The Trust has some of the highest poverty rates in NI and UK. 5 of the top 10 most deprived areas in NI are in the Derry City and Strabane Council area.

3. During the pandemic the Trust was connected through the formal Department of Health (DoH) Emergency Planning Structures and their associated command and control arrangements. DoH established its Health Silver Command, and the Trust provided formal reports throughout this period. The frequency and format of these was determined by DoH Strategic Planning and Performance Group (SPPG). The schematic for the initial structure including the specialist "cells" is set out in the attached "**COVID 19 Response – Planning Framework", exhibited to this statement – NG/1 [INQ000512476].** The Trust established its own Trust Silver and Bronze groups which enabled the necessary rapid communication and decision-making processes, flowing to and from DoH Silver. DoH "Cells" reporting to Health Silver had appropriate Trust officers as members or in attendance. DoH were the authority for issuing formal instructions to Trusts via Chief Medical Officer (CMO) Health and Social Services (HSS) Medical Director (MD) Circulars. These were cascaded by the Trust through its Trust Silver and Bronze command and control structures, to specialist Standing Groups or Task and Finish Groups, or as more general Staff Communications, as relevant within the Trust.

4. The Minister of Health commissioned a review of PPE regarding the appropriate receipt, storage, distribution and use of PPE across the HSC system during the COVID 19 pandemic. A review team was established from senior personnel within HSC and consisted of senior clinical, audit and service representatives. The review had a positive assessment of the process and structures in place.

5. BSO PaLS performed a PPE Source and Supply service (including Product Specification & Quality Assurance) in partnership with the Medicines Optimisation Innovation Centre (MOIC) for the Trust during COVID 19, supplying all Trust Acute and Community services, including contracted Independent Sector organisations providing care provision at home (Domiciliary Care) or in Care Homes (Nursing & Residential). The Trust had to establish its own logistics and supportive governance frameworks to ensure that staff and patients had access to appropriate PPE from the outset of the pandemic.

6. During the pandemic, the Trust continued to work closely with colleagues in Construction Procurement and Delivery (CPD) – Health Projects to ensure the continuous delivery of Strategic Capital projects. An example of this was the delivery of the North Wing development (new inpatient wards) at Altnagelvin Hospital in 2020/21. This project was in the late stages of construction when the pandemic arose. CPD - Health Project team worked closely with the Trust to secure continuation of these essential works on site to get the project completed. With the support of the contractor and design team, the works were delivered ahead of programme to provide emergency ward accommodation for the hospital. The provision of the 100% single room ward accommodation delivered through the project provided a vital resource to the Trust, enabling care and treatment of sick COVID 19 patients in a safer, lower risk environment. The delivery of this project was completely dependent on strong, collaborative and patient-focused relationships between CPD - Health Projects and the Trust's Strategic Capital team. Both parties worked 'hand in hand' to deliver what was required to meet the urgent needs emerging. They also ensured that all project management and contractual implications were appropriately dealt with to ensure good governance and delivery of required outcomes. All team members remained onsite during the pandemic to manage the construction and commissioning requirements. They also supported the contractor in protecting their teams working on site, agreeing new protocols and working practices to ensure compliance with relevant infection control requirements to support staff.

7. Formal weekly meetings with Trades Unions commenced on 25th March 2020. These were moved to fortnightly meetings on 1st July 2020. The purpose of this meeting was to update and involve Trade Unions on key decisions and progress of the COVID 19 response plan as it developed. Items covered included staff testing, PPE, Face Fit Testing, Manager / Staff guidance, Homeworking policy development, workforce transfers, childcare, uniform, donations and general surge planning. Targeted engagement also took place on the establishment of a Discharge Hub and service changes involving staff temporary redeployments. Trades Unions also attended Trust Hospital and Community Planning Groups and were a critical member of the Working Safely Together Group contributing to the support provided to staff.

8. The Trusts Head of Infection Prevention worked with the Public Health Agency (PHA) in a number of ways. They were a member of the Infection Prevention and Control Cell (IP&C), Healthcare Associated Infections (HCAIs) and Working group and the

Regional Product Review group. These groups were facilitated with the Public Health Agency. The purpose of the Infection Prevention and Control cell was to oversee the co-ordination of infection prevention and control arrangements across the HSC systems, Primary Care, including services provided by community, voluntary and independent sectors care providers. The HCAIs and Outbreak working group was a regional group set up to examine opportunities to minimise the impact of COVID 19 on HCAIs through a combination of regular testing, high quality infection prevention and control arrangements and supporting the effective management of non COVID 19 outbreaks in health care settings. The Infection Prevention and Control Product Review group was facilitated by the PHA. The scope of work was to ensure that any new Personal Protective Equipment and medical devices being issued to the health care system were fit for purpose, tested and that reviews of the products had been carried out by the Medicines Optimisation Innovation Centre (MOIC). This was a formal process in collaboration with MOIC and the Business Services Organisation to ensure new Personal Protective Equipment and medical devices were reviewed, tested, approved and procured going forward during the COVID 19 pandemic.

9. The Chief Medical Officer (CMO) met with Medical Leaders to provide updates. The Trust Chief Executive attended weekly meetings with the DoH and regional decision makers who were connecting directly into national decision making. The CMO had oversight of the regional Critical Care Network which met 7 days per week and was attended by Directors from all Trusts.

10. The Chief Nursing Officer and Chief Medical Officer for Northern Ireland had oversight of the regional Critical Care Network (CCaNNi) which met 7 days per week from February 2020 until first surge reduced. One of the core responsibilities of the Network was directing and ensuring ventilation support was available. The Director of Acute Services attended with other Directors who had responsibility for critical care from all Trusts, to ensure that critical care staffing and resources were sufficient to support COVID 19 patients who required ventilation. From September 2020 there were weekly huddles with Trust Executive Directors of Nursing, the Director of Nursing at PHA and the Chief Nursing Officer (CNO) to discuss COVID 19 incidence and any planned changes in IP&C guidance. Discussions included workforce changes to meet surge demand.

11. As part of the wider UK response to COVID 19, Manufacturers got involved in building ventilators outside of their normal business. One such manufacturer was McLaren

who in collaboration with University College London developed the UCL Ventura. This small CPAP ventilator was made available free of charge to hospital Trusts. Orders were placed via the website. 10 were requested and sent to the Trust in 2020.

12. The Trust's Head of Pharmacy and Medicines Management worked closely with the Chief Pharmaceutical Officer (CPhO) of the Department of Health (DoH) and any deputies, attending regular meetings (initially daily and then weekly) of the newly-established Pharmacy Surge Planning Group (to become the Pharmacy Leadership Forum). This group, with representation from Trusts, SPPG and the DoH predominantly focused on medicines and pharmacy-related matters. The CPhO wrote to Trusts on 23rd March 2020, outlining new arrangements for ordering BSO Stock Products. The CPhO was involved at the outset of COVID 19 in highlighting the need for Trusts to prioritise medical gas works with the British Oxygen Company (BOC) and shared a briefing paper to DoH Silver on oxygen supply in support of the COVID 19 response with the five Trusts' Heads of Pharmacy on 15th April 2020. **Please see the attached, "Letter to Trust CEO's from Mrs Cathy Harrison, Chief Pharmaceutical Officer" NG/2 [INQ000512480] and "Silver Paper 130420 Oxygen Supply" exhibited to this statement NG/3 [INQ000512481].**

13. I do not believe the Trust worked directly with the Medicines and Healthcare Regulatory Authority (MHRA) during the pandemic.

Experiences of the Western HSC Trust during the pandemic in relation to Infection Prevention and Control Guidance

14. Guidance was updated every few days in the early stages of the pandemic. The gov.uk website references the PHE guidance updates and there were 24 updates from 10th January 2020 until 27th April 2020 with an overall total of 51 updates up to 14th April 2022. The number of updates and changes did lead staff to question the validity of the guidance and confidence in the evidence base to support it. The IP&C guidance was developed by the Public Health England (PHE), Public Health Agency (PHA) or DoH Northern Ireland. There was no consultation or representation from the Trust in their development. In certain circumstances the Trust modified the guidance to make it more stringent, by making dynamic risk based decisions based on local data and trends. An example was delaying implementation of a downgrading of PPE and infection

prevention control measures in December 2021, as local figures indicated another pending surge linked to the emergence of Omicron variant. This assessment was based on local intelligence regarding high community prevalence rates, rising number of outbreaks in community settings, increasing staff absence, integration of learning from incidents/outbreaks.

15. IP&C guidance and guidance on the use of PPE was accessible from the PHE, DoH (health-ni.gov.uk) and PHA (publichealth.hscni.net) websites. It was not always evident when guidance had been updated on the PHE website (gov.uk) and there was a need to regularly check for any updates. These were not always formally communicated to the Trust by the DoH or PHA and it was difficult to ascertain at times if the PHE guidance applied to Northern Ireland. There were some delays in the IP&C team receiving specific NI guidance relating to Care Homes, Supported Living and Residential Children's homes as these were circulated to the specific service areas and not directly to the Trust IP&C team. There was a delay, in the IP&C guidance, of information regarding guidance on ventilation. The principles contained in the guidance issued for dental services had to be adapted and applied across other areas.

16. There were various professional staff groups that issued guidance which conflicted with the national guidance. These mainly focused on the evidence base to support airborne transmission of COVID 19 and definitions of procedures that were categorised as Aerosol Generating Procedures (AGPs) with the recommendations of increased respiratory protection with Filtered Face Piece masks (FFP3) masks. Some examples are the Association for Respiratory Technology and Physiology (ARTP) – Guidelines for recommencing physiological services during the Coronavirus Disease 2019 (COVID 19) endemic phase and the Royal College of Speech and Language Therapists (RCSLT) COVID 19 Advisory Group. The national PHE guidance did not apply to social care settings and therefore additional guidance was issued from the Department of Health, Northern Ireland for these settings. This included Care Homes, Supported Living, Residential Children's Homes and School settings and on occasion did not reflect the national guidance.

17. There were challenges with implementing the IP&C and PPE guidance at the beginning of the pandemic given the number of updates and changes. In the early days of the pandemic there were no supportive resources available to support staff and the IP&C team had to develop videos and posters for clinical staff and teams. This became increasingly difficult with the rapidly changing situation and updates. The number of

staff, the geography of the Trust services and facilities posed difficulties for the IP&C team. Staff perceptions were that PPE guidance based upon supply rather than evidence base, this was reinforced by various media channels. The debate regarding airborne vs droplet transmission fuelled staff concerns regarding safety. This was very evident in particular with increased attention from union representatives and other professional bodies in response to the new variant in December 2020. This led to the position statement from the UK IP&C cell which published recommendations but did not change the guidance, that increased respiratory protection with FFP3 masks was only required when undertaking AGPs on patients with suspected or confirmed infection. Despite this there was a continued perception by staff that this was inadequate as the position statement also stated that SAGE agreed fit-tested FFP3 respirators provide a higher level of protection to the wearer against aerosol/ airborne transmission. This continued and the Trust received a letter from the British Medical Association in July 2021 regarding Aerosol transmission of SARS-CoV-2: wider use of respiratory protective equipment to protect staff. Further review of procedures defined as AGPs in February 2022 by the UKIP&C cell caused concern with staff as they felt that they were now more vulnerable when certain procedures were removed from the updated list.

18. Staff concerns were escalated to the Trust Human Factors group who helped to develop clear messages for staff. The Working Safely Together Group was established in December 2020. Membership included managers from across the Trust and Trade Union representatives. A work stream within the group was the nationally award winning "Working Safely Together" Echo project which linked staff from over 100 facilities to a learning platform which hosted virtual meetings. Subject matters linked directly to the emerging needs of staff including the updating of IPC guidance with communication and planning. The application of "dynamic risk assessment " and "the hierarchy of controls" as per the guidance across different services created a sense of uncertainty and confusion with staff as this led to variations in the implementation of the IP&C guidance and the use of PPE.

19. The guidance particularly during 2020 was updated mainly on a Friday or at the weekend, for example "Guidance on the management of staff, patients and residents who have been exposed to COVID 19" was published on Saturday 4th April 2020.The Trust identified updates to guidance by checking websites. It was difficult to keep up to date and communicate the changes to staff given the timing. The Trust managed

changes in guidance through Trust Silver control arrangements which at this time was operating 7 days per week and Trust communications to staff.

20. The adequacy of guidance for the use of PPE, variations, gaps and the impact generally of any inadequacies, including, for example, issues with interpretation formed the basis of the agendas of regional IP&C cell, HCAI Outbreak working and Trust working groups.

21. IP&C guidance was disseminated and implemented via a range of channels. These channels included Silver and Bronze arrangements which were designed as a cascade mechanism across the Trust and through all departments, to clinical and non-clinical staff. It was fully functional 7 days/week so all guidance could be shared promptly even when new guidance came to the Trust on a Friday evening. The Trust communication team attended Silver daily and developed a communication plan around all changes to guidance. They used various platforms such as the Trust Intranet and Trust Communications (email) to communicate with all staff. The Trust's Communications Team also used social media channels (Twitter and Facebook) to convey messages to the public in regards to infection prevention practices that the public were to adhere to when visiting or attending our hospitals or community facilities. They worked with the IPC team to produce videos, posters, graphics, IP&C/COVID 19 SharePoint sites and discussion boards. The IP&C team set up training programmes both virtual and face to face prioritising high risk areas.

22. The decision to downgrade COVID 19 from High Consequence Infectious Disease (HCID) status, thereby permitting use of PPE rather than RPE reflected the pandemic evolution and the changing level of risk of healthcare exposure to COVID 19. This allowed for those staff to be protected by the use of PPE in contexts where COVID 19 was circulating in the community at high rates. It also reflected the growing concern regarding asymptomatic transmission and thereby by the greater use of PPE (FRSMs) reduced the risk and protected more staff. This was particularly important and evident in specific areas such as Emergency Departments where there were challenges in establishing whether patients met the case definition for COVID 19 prior to a face-to-face assessment. It was also recognised that those staff undertaking higher risk procedures such as Aerosol Generating Procedures continued to be protected by the enhanced RPE recommended.

PPE Supplies and Distribution

23. At the start of the pandemic, there were concerns about the CE certification of PPE. There was a bombardment of offers to supply PPE from companies, for example, who claimed to be 3M authorised suppliers but were not. The Trust checked the certification of any PPE that was procured. In April 2020, the Chief Pharmaceutical Officer commissioned the Medicines Optimisation Innovation Centre (MOIC) to work collaboratively with Trusts, BSO PaLS and regional IP&C leads to undertake a technical assessment of all PPE items procured for use within the HSC to ensure that they were fit for use.

24. There were some concerns about the fit of PPE, for example, in relation to face fit testing, there were disparities between some Black, Asian and Minority Ethnic (BAME) groups in respect of FFP3 Masks suitability, due to the difference in facial structure/size. This resulted in this particular group of staff failing the majority (and sometimes all) of the FFP3 masks stocked at that time which meant they could not work in wards/areas where aerosol-generating procedures were carried out. Furthermore, particular groups of male staff from BAME communities chose not to shave their beards for religious reasons, which resulted in them being unable to be fit tested for any of the FFP3 masks. A small number of male workers also refused to shave their beards due to cosmetic reasons. As a result, these staff either had to be supplied with 'hoods', or redeployed into wards/areas where aerosol-generating procedures were not carried out. Staff had concerns regarding the fit of Paragon FRSMs (they were too small) therefore the Trust offered this and a larger alternative for staff to choose from. In addition, staff were concerned that Tiger Frames and Lenses were flimsy and did not stay on. Changing IPC guidance rendered these obsolete.

25. I was not aware of a national helpline for PPE supplies.

Staff Concerns

26. Any concerns in regards to professionals feeling pressured to work in care settings with inadequate PPE where aerosol-generating procedures were carried out were raised directly with managers who resolved where appropriate. Occupational Health also provided guidance and reassurance for staff. Staff reported concerns regarding flimsy Tiger Frames and aprons. One staff nurse on the COVID ward described her anxiety as she saw the stocks of FFP3 on her ward decrease through the day and not being sure whether they would be restocked on time. The Chief Executive was given feedback and the PPE Lead met with the staff member. As a result we changed the process so that PPE was proactively topped up each day by BSO PaLS staff.

27. In response to staff concerns, the Trust implemented a risk- based approach to the implementation of the IP&C /use of PPE guidance based on a range of factors i.e. local community COVID 19 transmission rates, local COVID 19 outbreaks, learning from incidents and the application of the hierarchy of controls on Trust estates and facilities resulting in differences in the application of the guidance. IP&C participated in additional regional meetings/working groups. The PHA undertook an IP&C Peer Review to provide assurance in relation to the implementation of the IP&C Guidance and risk assessment regarding the variations across the Trusts which the head of IP&C contributed to. To further address the concerns of staff, a Human Factors Group was established with input from our clinical psychologists to help support our staff and develop clear messages with respect to the use of PPE. In addition, IP&C trained staff to act as PPE Guardians/ Safety Officers across the Trust to support the introduction of PPE and implementation of measures across facilities and teams. This provided an assurance framework that staff were using the correct PPE as per the guidance to ensure the safety of staff, patients and to allow for effective modelling of PPE requirements. Due to constrained 3M FFP3 supply, the Trust extended the capacity for face fit testing at Trust level, to ensure all staff requiring an FFP3 mask were properly face fit tested on available compliant supply. A PPE complaints log was established to capture frontline service user experiences and a 'feedback' communication to BSO PaLS on the suitability and quality of PPE supplied. **Please see the attached "Western Trust PPE Feedback Form", exhibited to this statement, NG/4 [INQ000512482]**. The Trust complied with BSO PaLS requests for product recalls. The Trust also supported and availed of a regional mutual aid scheme between NI Trusts, to ensure continuity of supply.

Face Fit Testing

28. To ensure that there was adequate face fit testing (FFT) for staff who used PPE, in March 2020 the Trust arranged for fit-testing to be carried out by a combination of internal Trust face fit testers who had just been trained by a 'Fit2Fit' accredited company, and several external companies (through Direct Award Contracts). Close collaboration within the PPE Advisory Group and links with BSO PaLS were critical to ensure that the needs of the Trust were met. The Trust's face fit testing strategy centred on the premise that all staff carrying out, or working in an environment involving Aerosol Generating Procedures received priority for testing. At the height of the pandemic, the Trust carried out face fit testing across three hospital sites, Altnagelvin, Omagh and Enniskillen, 7 days per week between the hours of 8.00am and 10.00pm with approximately 150 staff being tested per day.

29. In June 2020, an alert was raised regarding fit-testing which occurred due to the Porta count machine being set to the wrong setting (using a weighted setting instead of single exercise test setting) by one of the external companies. This resulted in staff being incorrectly fit tested. As a consequence the Trust worked very closely with the company involved and the Department of Health to take corrective action and provide assurances around the fit testing processes going forward. All impacted staff were contacted, advised of the issue and offered a new appointment with the face fit testing team. Re-tests were subsequently undertaken to Health and Safety Executive (HSE) guidelines and standards. As a result of this Early Alert, the Trust developed a Standard Operating Procedure (SOP) and agreed a number of governance measures to prevent any reoccurrence of these issues. **Please see the attached "SOP Mask Fitting updated Nov 2020", exhibited to this statement NG/5 [INQ000512483].** Additional scrutiny was placed on the test results of both the internal and external testers to identify any patterns or anomalies. In order to improve testing outcomes the Trust regularly promoted staff awareness of the need to adhere to the guidance prior to being tested, i.e. be clean shaven, avoid eating/drinking and smoking. This included publication of posters and further training for the face fit testers. In the event that a member of staff failed their initial face fit test, they were invited back to be re-tested on alternative masks, and only if they failed on all of the available FFP3 masks, were they considered to be trained on a hood. If this too failed, they were moved to a low risk work area following the completion of a risk assessment by their manager. A stock of

FFP2 masks was also held as a contingency for this purpose. Whilst the bulk of face fit testing in the initial stages of the pandemic was carried out by external companies, the Trust developed internal capacity by training a cohort of internal testers. The FFP3 market became less volatile with the introduction of a locally-manufactured FFP3 (Denroy) mask early in 2021, on the basis this was designed to fit a range of face sizes. This mask continues to be the mask of choice for the entire region.

30. The Trust was not impacted significantly by BSO PaLS not arranging for face fit testing contracts nationally, as it created different supply chains through normal procurement processes.

Volume and Cost of Excess PPE

31. The volume, cost and reason for remaining excess PPE at the end of the pandemic (September 2023) is noted in the below table.

Item	Volume	Cost	BSO / WHSCT Supplied	Reason Pushed Stock = Delivery volumes as set at BSO discretion, usually at Fair Share.
FFP3	13K	£ 51K	BSO	Pushed Stock, Small fitting limited demand, Expiry date impinged.
FRSM	41K	£ 12K	BSO	Pushed Stock, Small fitting limited demand, Expiry date impinged.
Caps	51K	£ 7K	BSO	Pushed Stock – Poor quality Theatre Cap
Lateral Flow	5K	£ 0K	BSO	Pushed Stock – Change in IP&C guidance (7PK)
FRSM Adjuster	165K	£ 8K	BSO	Pushed Stock – Change in IP&C guidance.
Visors	5K	£ 7K	BSO	No expected demand for product
Total	280K	£85K		

Donated PPE

32. The Trust was offered donations of homemade PPE, in the early days of the pandemic, but was unable to use these since they did not meet specification requirements due to quality concerns. There were anecdotal reports of individual staff members sourcing their own PPE e.g. visors. The Trust did not invite donations and on 28th March 2020 introduced a managed process to accept donations of PPE from industry and members of the public, for use only if the Trust ran out of stock of PPE which did not happen. The donations centre was closed down end May 2020. At no time during the pandemic were staff relying on home-made PPE.

Trust Oversight of the COVID 19 Pandemic – PPE Perspective

33. The Trust established a number of groups, all linked to the Business Continuity Silver and Bronze Control structures and arrangements.

34. As the former Director of Finance, I chaired Trust Silver, after its first few weeks. We met daily (7 days per week) via a virtual platform. The Group consisted of the Corporate Management Team (CMT) Directors, with other essential roles and ad hoc members agreed by the Chair. Essential roles included Infection Prevention & Control advisor (IP&C), PPE Lead and Senior Doctors. Safety and Communications were standing items on the agenda, and the meeting allowed problems to be raised quickly with actions identified and implemented at pace. The group evolved over time and provided overall management of all aspects of the Trust's response, including determining priorities in allocating resources (people, skills and finance), obtaining further resources as required, planning and co-ordinating actions, reviewing information, overseeing the operational response to ensure actions are completed, submission of daily situation reports (sit-rep) to Regional Health Silver, listening to key groups issues and providing support, co-ordinating communications within the Trust and local population to ensure coherent messaging. **Please see the attached "COVID 19 Response – Planning Framework", exhibited to this statement, NG/1 [INQ000512476].**

35. The Hospital Planning Group was established as part of the governance arrangements in response to the pandemic. This group was chaired by the Director of Acute Services and was made up of senior managers and lead professionals from all sites. The group

met 3 times per week and was responsible for decisions including bed capacity and operational service issues. All issues were escalated to this group which fed into Silver meetings and the regional sit-rep.

36. Three Bronze Controls were established in response to the pandemic. Two hospital bronze controls and a single community bronze control met twice daily, 7 days per week. These groups were chaired by an Assistant Director (AD) on a rotational basis. Each bronze control was led by a co-ordinator and deputy to oversee the operational running of the bronze control. The group was made up of representatives from each service area. Each bronze control concentrated on managing the day to day operational response, including the allocation of resources to include PPE and escalated any concerns to Trust Silver. The group was instrumental in providing a source of daily communication with ADs, Heads of Service and Ward Managers.

37. Several groups were set up specifically to focus on many aspects of PPE. The PPE Modelling Group which was set up by the Finance Department, in collaboration with clinical colleagues and teams to assess the quantities of each type of PPE that would be needed. The work began at the end of March 2020, with a regional modelling group being fully operational by June 2020. Given the range of services provided (in both hospital and community settings) the modelling was complex and reflected regional and national IP&C guidance. Initially the focus was on Aerosol Generating PPE (AGP) and Non-Aerosol Generating PPE (Non-AGP) demand. Finance staff met with key clinical staff to learn the nature of service provision and need for PPE – including both bed-based services and contact demand and developed modelling based on this. The models would calculate daily requirements and modelling helped to inform requests to have drawn down PPE from the regional pandemic store.

38. The PPE Advisory Group consisted of representatives from each Directorate, Trust IP&C and had regular input from the Trust Health and Safety Team. The group discussed PPE stock level, its distribution across the Trust, usage and associated risks. Any concerns were escalated to Trust Silver as needed. Meetings were held at least once a day at the onset of the pandemic to establish systems and ensure timely communication. Meetings reduced in frequency to twice per week as the situation stabilised. There were 4 main work-streams, each led by an Assistant Director or Senior Manager, PPE Governance, Receipt and Distribution of PPE, PPE Supply Chain and Face-fit Testing.

39. The Trust PPE Strategic group was established in July 2020 when stock management had stabilised and a two tier (Strategic and Advisory) model established. The group met weekly and acted as a focus for IP&C, Health & Safety, Supply, Finance, Logistics and Governance to meet together to discuss the strategic use of PPE across the Trust.

40. At the outset of the pandemic, PPE distribution had to scale up over a very concentrated time period and new supply channels had to be set up. As a response to this, a local procurement group was established. Robust governance arrangements for procurement, logistics, product specifications and Value for Money (VFM) were established. This local PPE quality assurance work moved to a regional process through the Medicines Optimisation Innovation Centre (MOIC) and all items to be procured by Trusts or BSO PaLS were vetted for appropriate certificates and meeting standards by MOIC before procurement. Part of this process was a review of these products by the Regional Infection Prevention & Control Cell on which the Trust was represented. This changed was welcomed as MOIC built up an expertise in this area that supported the procurement of quality- assured products in a volatile, pandemic market.

41. The Trust relied on existing Centre of Procurement Excellence (CoPE) BSO PaLS systems to procure key medical equipment and PPE during the pandemic. BSO PaLS established an effective and agile PPE Supply Chain Cell. The Trust fully engaged with this arrangement.

42. In March 2020, the Trust established a local procurement process for PPE, when there was volatility in supply chain. PPE was sent to the Trust Emergency Planning Stores as opposed to PaLS Distribution Centres in the first instance and was distributed out from these Stores. The Trust set up new stock management and distribution systems which was a challenge at the outset. This was a challenge due to the space required, the need to establish logistics quickly, and taking on a range of products that the Trust had not routinely managed. Daily stock counts were carried out in seven new PPE stores on the Altnagelvin site with information reported to BSO PaLS. Requests for stock lines were managed at Regional PPE-supply chain meetings, chaired by the BSO logistics lead, initially through daily 'push' arrangements', based on stock availability and appropriate apportionment. In May 2020, the Trust leased a warehouse to store PPE. It was managed by colleagues from BSO PaLS in line with a service level

agreement with the Trust. A new electronic stock management system (ELMS2) was installed and Trust transport drivers were employed to distribute PPE. When regional stock holdings improved, in June 20, a 'pull system' was introduced, whereby Trusts submitted a PPE re-order form, twice –weekly.

43. In terms of local procurement, the vast amount of PPE was provided through normal BSO PaLS arrangements. In addition, the Trust identified suitable suppliers of PPE. All requests for PPE items were considered by the Trust's Clinical Need Group and emergency shortages of supplies fed back to the Local Procurement Group (LPG). The LPG collated areas of opportunity, based on relevant suppliers of PPE that the Trust's Clinical Need Group had identified, for further consideration by BSO PaLS. This list was then used by the LPG as a list of potential suppliers to access alternative PPE supplies, as needed.

44. The procurement process commenced when, in response to requests from Regional Daily Supply Cell, or from Chief Executive or Director of Finance, the LPG would compile a report of quotes for short supply products. The LPG collated a quote, a sample, a declaration of conformity, specification, delivery time and completed a Value for Money (VFM) template. This was forwarded to the PPE Quality Assurance Group for review. Following a successful review by the PPE Quality Assurance Group, the report was sent to Assistant Director/ Director of Finance for VFM review. A joint decision by AD / DoF and appropriate Director / PPE Lead (Head of Pharmacy) would be made on whether or not to raise the order, taking both specification and VFM into account. Following VFM approval, a requisition was raised for approval by Director of Acute Services and a Direct Awards Contract (DAC) was approved by DoF and forwarded to the BSO PaLS compliance unit within 7 days of requisition placed on EPROC (purchasing system). Any DAC orders above the threshold required an EU notice to be completed within 30 days.

45. PPE was distributed from a local PPE warehouse, using Trust transport fleet resources. This was a change of process as prior to pandemic, BSO PaLS delivered PPE directly to frontline wards. Prices paid for PPE were controlled by BSO PaLS and stocks transferred at cost price to Trusts. Initially, local procurement was necessary due to volatile market conditions and to ensure contingency stocks were available and distributed through normal arrangements. PPE cost was met from a regional business case for PPE consumables from SPPG (DoH). Regular reporting was used to convey

both actual and forecast expenditure to SPPG (DoH), who provided funding to the Trust. This process ceased to operate on 2nd October 2023.

46. The Western Trust routinely procured sufficient PPE to protect contractors, cleaners, security staff, locum doctors, agency nurses and carers and staff who worked in sub-contracted organisations who delivered NHS services.

47. BSO quality and assurance processes ensured compliant PPE was procured and made available to the Trust, under the guidance of MOIC. The only concern noted on stock was the expiry date of pandemic FFP3 masks, which in many cases underwent a 'Re-life' process to extend the expiry date of the mask. This process was completed by FFP3 original suppliers, at the request of BSO. Any 'fit for purpose' / quality concerns were noted by the Trust PPE user groups and communicated back to BSO via the PPE Advisory group. **Please see the attached "Extract from the Trust PPE Feedback Log", exhibited to this statement - NG/6 [INQ000512484].** Local stockholding was typically a 14 day supply holding & replenished weekly from a central (BSO) PPE stores. Any emerging shortages were highlighted early in the process and communicated via a weekly BSO / Trusts forum. Where stocks were likely to remain limited for some time, BSO employed a 'push' system, to ensure all Trusts received their fair share of any available PPE. In the early stages of the pandemic, there were instances were PPE stock was transferred from Altnagelvin to the South West Acute Hospital (SWAH), on an emergency basis, to ensure continuity of supply at SWAH. In addition, the Trusts themselves employed a mutual aid process, to share limited stocks where possible and ensure maximum use of these available PPE stocks.

48. A small number of products were recalled during the pandemic e.g. The Denpro DPL01 FFP3 mask produced before 29th January 2021 was withdrawn from use as a precaution. While the manufacturers' inspection report showed 99.86 % efficacy and masks produced before this date were fully effective and ready for use, a decision was made to withdraw this mask due to potential defects. Issues around quality and fit of SO sourced PPE were conveyed back to BSO. Changing IP&C guidance rendered some supplied PPE unusable e.g. FRSM mask adjusters.

Re-usable PPE

49. The Trust gave consideration to buying re-usable PPE and liaised with the regional re-usable PPE group (PHA) as an informed, regional and Trust decision was required on

whether to purchase and use PPE that was designed for reuse. The Trust required clear, robust decontamination processes to which staff would have input. Critical Care staff were not in support of using reusable PPE in high- risk areas. Northern Ireland did not adopt the PHE PPE Guidance on reusing PPE issued on the 24th April 2020. The Regional IP&C Cell issued a draft rapid review of PPE use and reuse on 4th May 2020. Hoods were purchased for a small number of surgeons and staff in Critical Care who had failed face fit testing. These were also available for relatives visiting loved ones in Critical Care when the visiting restrictions had been lifted, as it would have been inappropriate to face fit test in this situation. Some reusable FFP3 (Pureflo) masks were purchased as a potential back up for staff who had essential patient-facing roles and had failed face fit testing on all available masks. The PPE Team wrote a decontamination and use protocol for these masks which was approved through CMT. These were used for 2-3 members of staff. **Please see the attached "Final version (6) SOP Pureflo 1000 Half Mask Respirator at 06.07.20", exhibited to this statement NG/7 [INQ000512485].**

Procurement by the Western HSC Trust and supply chains

50. All PPE orders awarded by the Trust were fully compliant with Trust procurement procedures. The value of Trust local procurement items was £3.056M, the volume being 579.5K of stock which represented less than 1% of the total PPE units supplied. All contracts were satisfactorily performed. Other details are noted in the below table.

The Contractors to whom the Trust awarded contracts for PPE:

Supplier	Value £M	Type	Volume	Used	Reason / Notes	Satisfactory performance?
O'Neill's	£1.5m	Reusable Scrubs	**I&S**	Yes	Shortage of disposable scrubs at start of pandemic. Business Case developed to move to re-usable scrubs. Reusable scrubs last for 2-3 years, each set of scrubs = 75 issues of non-reusable scrubs.	YES
Full Support Healthcare	£0.129m	Reusable FFP3 Respirators		Yes	Issued to contingency stores	YES

Quintess Denta	£0.019	Reusable Visors	I&S	Yes	Issued to contingency stores	YES
Healthcare Essentials	£0.59m	Disposable FFP2		Yes	Issued to contingency stores	YES
Bloc Blinds	£0.125m	Disposable Visors		Yes		YES
Ascot Signs Ltd	£0.219m	Disposable Visors		Yes		YES
Hospital Services	£0.463m	Disposable Gowns		Yes		YES
J Mullan	£0.011m	Disposable FFP2 Masks		Yes	Issued to contingency stores	YES

51. All costs of the local procurements were reimbursed by DOH. The contingency stocks referred to above were purchased to provide resilience and assurance around continuity. After initial procurement by the Trust, two local suppliers became regional BSO suppliers (visors from Bloc Blinds and gowns from Hospital Services).

52. The Trust Local Procurement Team, was established, at the request of CMT, during the early stages of the pandemic to source, if possible, essential, short supply PPE. This local procurement team consisted of both senior service and finance personnel. There was no expectation on this group to make decisions around clinical equivalence, this being the responsibility of the Trust Procurement subgroup. Any opportunities for supply were notified to BSO PaLS for consideration.

53. Within the Local Procurement Team, procurement experience was provided locally by senior finance personnel and by BSO Procurement branch staff (CoPE – Centre of Procurement Excellence), using existing PaLS contracts and recent awards as a reference point.

54. Local Procurement Team guidance included a specific checklist for use when engaging with potential suppliers, with the Procurement Sub-Group confirming the product met the most recent product specification / need. **Please see the attached "Process to be followed for local procurement of PPE for the Western Health and Social Care Trust during the COVID 19 Pandemic." exhibited to this statement, NG/8 [INQ000512486].** This process required a quote, a sample, a declaration of conformity, specification, delivery date and a VFM assessment. The VFM assessment required me, as Director of Finance (DoF) or the Assistant Director of Finance (ADoF) sign off.

55. The Trust relied on existing CoPE BSO PaLS systems to procure key medical equipment and PPE during the pandemic. BSO PaLS established an effective and agile PPE Supply Chain Cell. The Trust fully engaged with this arrangement. A review team was established by the DoH to consider the effectiveness of supply chain, ordering and distribution. *"The Review Team found that although there had been considerable challenges to overcome, the present state of distribution and control of PPE indicates a fit for purpose and adaptable system which needs capacity to be further scaled up and extended over a longer period."* **Please see the attached, Department of Health, 12 May 2020, Rapid Review of COVID-19 Personal Protective Equipment (PPE), page 4 exhibited to this statement, NG/9 [INQ000512487].**

56. Prior to the lease of a local warehouse, BSO PaLS delivered PPE to the Trust Emergency Planning Stores and not to front-line services as before. This was a challenge due to the limited space available to store and distribute PPE. There was also the need to establish logistics quickly, and to manage a range of non-routine products. The Trust was required to carry out daily stock counts of the various stores to provide up-to-date information to BSO PaLS. Requests for stock lines were managed at Regional PPE supply chain meetings, chaired by the BSO logistics lead, initially through daily 'push' arrangements, based on stock availability and appropriate apportionment. Following the lease of a warehouse a new electronic stock management system (ELMS2) was installed and Trust transport drivers were employed to distribute PPE. When regional stock holdings improved, in June 20, a 'pull' system was introduced, whereby Trusts submitted a PPE re-order form, twice – weekly.

57. As previously noted, local and regional mechanisms were successful in ensuring appropriate use of PPE across HSCNI and maintaining sufficient stock at Trusts to meet local surge demand as highlighted in the rapid review of PPE carried out by the DoH. The Trust adopted a robust governance process to ensure the quality and effectiveness of PPE. The Trust did not identify any issues with fraud during the Pandemic.

58. Deliveries of PPE from BSO PaLS were made in a timely manner- within a few hours to 2 days depending on need. The Trust sent its own transport to BSO PaLS in Belfast or other Trusts on a very small number of occasions. In terms of medical equipment, there were some delays from normal procurement lead times due to the global

demands for the most popular items but this did not affect the response to patient care as the Trust had a good level of equipment in the first place.

Provision of PPE to Independent Sector

59. The Trust was directed to provide PPE for the care sector in its locality. On 12th March 2020 the Trust received DoH Interim Guidance for social or community care and residential settings on COVID 19 noting that independent providers were responsible for sourcing their own PPE equipment. However, in the event that they are unable to source the appropriate items, HSC Trusts were asked to work closely with independent providers to ensure they had the appropriate equipment available to them. The Trust received further guidance on 18th March 2020, dated 17th March 2020, in which it was advised to work with nursing and residential homes on the provision of appropriate PPE. Where homes were unable to source appropriate PPE provision, Trusts were directed to account for these needs when seeking supplies from the Business Services Organisation and to work with homes to understand requirements and prioritise stock across organisations, where there were any short term limitations on stock. Trusts were requested to ensure that nursing and residential homes had a named point of contact with whom to discuss PPE provision and homes should not be charged for the provision of PPE from Trust stocks.

60. The Trust established a single point of contact for independent providers for PPE requests on 20th March 2020. This was a 24hr per day single point of contact. The Trust also established weekly Business Continuity Forums with providers within which queries regarding PPE could also be discussed. This worked well for all providers across the Trust's geography. Staff responded to a request to work in community stores and agreed to be temporarily redeployed to other directorates. The Trust found the single point of contact approach very successful in being able to provide immediate continual support to providers when and where it was required.

61. PPE was supplied to the independent sector (Nursing/Residential Homes, Independent Sector Domiciliary Care Providers, Supported Living Facilities, Foyle Hospice). Modelling for the quantity of PPE required for each care home was undertaken based on occupancy and staff working on each shift. In the community

setting. PPE was provided to both clients and carers in receipt of Direct Payments (DP) via orders placed by the supporting social worker.

62. PPE was supplied through the introduction of a new local ordering and weekly Trust delivery arrangement and was distributed to the independent sector on a regular basis, to ensure optimal community supplies (i.e. reduce the need for storage space at each location). During outbreaks, normal PPE supplies were supplemented by urgent daily deliveries. Products supplied were gloves, aprons, fluid repellent gowns, FRSM and FFP3 masks and visors. In the early few months of the pandemic, up to 40% (estimated) of all PPE consumed was supplied to ISP Care Homes. The total cost of PPE supply to the independent sector during the pandemic (to June 2022) was estimated at £7.9 million and this was funded centrally.

63. In order to keep a reliable inventory of PPE held across the Trust in real time, initially stocks were managed through the Trusts on-site Emergency Store by staff employed by the Planning & Performance Directorate. Seven PPE stores were set up on the Altnagelvin site. Stocks were counted at the start of each day. Following the Trust lease of the warehouse, PPE was 'pushed' to there from BSO PaLS. BSO introduced a central stock management system (ELMS2) to manage daily stock movements and expiry date risk.

64. The cost of the purchase of additional PPE was met from a regional business case for PPE consumables from SPPG (DoH). Regular reporting was used to convey both actual and forecast expenditure to SPPG (DoH), who provided funding to the Trust.

65. The vast majority of PPE (circa 99% by volume est.) used by the Trust was sourced regionally from BSO PaLS, the remaining 1% being locally procured PPE.

66. Ad hoc mutual aid was a feature between Trusts, especially for FFP3 mask supply. This collaboration between Trusts worked well.

67. The Trust made use of any Direct Awards when purchasing PPE as outlined previously. This approach was very successful in being able to provide immediate continual support to services when and where it was required. The Trust awarded the

    Direct Award Contracts following compliance checks by local BSO PaLS staff who placed the order.

Details of Direct Award Contracts are outlined in the table below:

Supplier	DAC Reference	Products	Order value	Date
O'Neill's	STA 8436	Reusable Scrubs	£1.5 million	30/03/2020
Full Support Healthcare	STA 8437	Reusable FFP3 Respirator Masks, Filters & Adapters	£129k	05/04/2020
Quintess Denta	STA 8631	Reusable Visors	£ 19k	30/04/2020
Healthcare Essentials	STA 8466	Disposable KN95 Face Masks	£590k	31/03/2020
Bloc Blinds	STA 8463	Disposable Visors	£125k	03/04/2020
Ascot Signs	STA 8593	Disposable Visors	£219k	18/04/2020
Hospital Services Ltd	STA 8671 STA 8801 STA 8778	Disposable Gowns	£293k £ 85K £ 85K	23/04/2020 15/05/2020 27/05/2020
J.Mullan	STA 8816	Disposable KN95 Respirator Masks	£ 11k	27/05/2020

The total value of these DACs was £3.056M.

Oxygen

68. The Trust was concerned about the capacity to deliver the required oxygen supply to its surge areas including ICU, theatres and COVID 19 wards during the pandemic. The Trust's Head of Estates provided information on the oxygen flow constraints, including capacity calculations based on the current infrastructure within the Altnagelvin COVID 19 Oxygen surge plan. This matter was escalated on 30th March 2020 to the Permanent Secretary and Chief Pharmaceutical Officer at DoH. Construction Procurement and Delivery (CPD) Health Projects confirmed on 3rd April 2020 that the British Oxygen Company (BOC) had agreed that Altnagelvin would be furnished with an additional Vacuum Insulated Evaporator (VIE tank) on the site and internal estates works were also completed to increase the internal oxygen infrastructure capacity.

69. The capacity to deliver required oxygen to its surge areas, ensuring that there was sufficient flow rate of oxygen through the pipes to the bedside, was a further concern. As patients with COVID 19 often needed high flow oxygen or ventilators, the Trust had to manage the overall flow rate in different pipes to make sure that it did not exceed the limits. This had been raised as a national alert. In order to make sure there was sufficient oxygen flow rates to our patients, patients with COVID 19 were cared for in different areas that got oxygen through different pipes to share the load. Pipes were fitted with devices that measured the flowrate in real time and our Estates Department monitored this. Larger vaporisers and wider bore pipework were installed to increase oxygen supply to treatment areas in the hospital. Ward staff completed daily oxygen usage returns with details of the numbers of patients who were on high flow devices. This acted as another early warning. A member of Estates staff entered this information into a report on Alamac. Oxygen status (RAG) was reported on each day to Trust Silver. Action Cards were written. A group of doctors, estates staff and pharmacists met every few days to monitor oxygen status and link into the regional oxygen group. A regional Oxygen Supply Working Group was set up by the Health and Social Care Board in March 2020, chaired by Brian Godfrey (Head of Safety Strategy Unit, DoH). This group had oversight of the need to increase oxygen capacity in our acute hospitals. Brian Godfrey issued a number of letters to Trusts. **Please see the attached "SSU2002 Letter to Chief Executives re Covid 19 Oxygen Supply" NG/10 [INQ000512477] and "Letter from Brian Godfrey to HSC Chief Executives re Covid 19 Monitoring of Oxygen Systems" exhibited to this statement NG/11 [INQ000512478]. Please see the attached sample action card "Oxygen Action Card Bronze Command 29.07.2021 V8" exhibited to this statement, NG/12 [INQ000512479].**

70. The DoH asked the Trust to name an individual as oxygen lead, who would ensure links between clinical, estates and pharmacy staff would be maintained. The capacity of oxygen pipes to deliver sufficient flow of oxygen was tested formally on the Altnagelvin and South West Acute Hospital sites.

71. The Trust did not experience any issues with the supply of liquid oxygen from BOC.

72. Waterside Hospital piped supply is provided from large cylinders on a manifold which do not have the same storage capacity as a liquid tank. There were discussions about installing a liquid tank however these did not progress. Oxygen concentrators were

supplied for use as a backup to the piped supply or for beds that did not have piped oxygen.

73. The Trust had no issue in getting patients home on time who needed, usually temporary, home oxygen cylinders.

Testing

74. With regard to equipment for COVID 19 testing, the original testing platform was Chemagic, which was crowd funded by the Ulster University, and was on loan to the Trust. The Trust purchased robotics for the platform. The COVID 19 testing service within the Trust then moved from Cellular Pathology (due to increasing cancer workloads) to Microbiology. A regional decision was then made for the Trust to move to SeeGene, which was acquired through a business case/DAC. This was purchased from Accuscience, Ireland. There were delays in delivery however other platforms were used to include Belfast Trust testing samples due to additional resources in terms of equipment/staff.

75. The Trust's Microbiology lab engaged in a weekly meeting with the other labs in the region, which included representation from PaLS (Procurement and Logistics Service) & BSO for any IT requirements and the local universities. This meeting assessed the availability and suitability of new testing platforms, which Trusts should receive which platform & the allocation of the number of tests. It also allowed Microbiology to provide updates on progress of testing capacity. This was a challenging time due to the shortages the supply chain was experiencing with demand, particularly for plastic consumables. Most of the tests we wanted to offer had a UK wide allocation, limiting local availability. A lot of tests were only available from suppliers if their platform was already in place. We also received numerous offers of alternative tests which had to be considered, all of which had different sample requirements, IT requirements & were not of the same quality.

76. The membership of the group enabled decisions to be made and actioned when findings affected more than the lab e.g. IT connections, influence and input from PaLS for business cases, advertising on Find a Tender website, advice on the procurement rules in place at the time. As a group, they were able to determine which sites were undertaking testing on the different platforms. These meetings were necessary to co-

ordinate a regional & Trust response. Actions from this meeting were escalated within the Trust through the Pathology General Manager. This group also fed into the Regional Expert Advisory Group chaired by Dr Brid Farrell. The Regional Expert Advisory Group wanted to have different platforms in use throughout NI to reduce the impact of supply chain issues. However, this led to an analyser being used in the Trust which had a low sample throughput, involving a lot of staff time. In addition, these staff were temporary bank/locum staff making the service vulnerable. Temporary funding added to this vulnerability. Not being able to accommodate all samples from the Trust meant some were tested locally & some were tested in Virology, these had different pre-testing requirements. At one time, we had four platforms in use in the lab, along with point of care tests on the ward. Different assays were available at different times, some for COVID 19 only & some also with Flu & RSV along with the COVID 19. Planning these changes, including updating SOPs, staff training, IT requirements was difficult to manage, especially when balanced with kits already in place.

77. COVID 19 testing platforms were agreed via the NI Pathology Network and regional Expert Advisory Group. This was to ensure adequate testing and contingency across the region. Testing requirements changed over the period dependent on CMO guidance. At times there were delays in analysers arriving but alternatives were used. If there were issues with consumables, this was overcome by sharing across the region when necessary. There were limited Cepheid consumables due to the regional allocation which was overcome by ensuring priority areas could access rapid testing.

Ventilators

78. Pre-COVID 19 the Trust had a combined cross Trust inventory of 20 level three ICU ventilators. This was sufficient to manage the initial regional commitment that the Trust had made to patient care. To ensure that the Trust was able to increase to anticipated surge beds, a further 24 Draeger V800 ventilators were ordered through the CCaNNi Network at the end of March 2020. ICU has always had a strong working relationship with the regional CCaNNi team. Ventilator procurement was managed extremely well via the CCaNNi network manager throughout this time. Correspondence directly with the manufacturer enabled the Trust to have confidence that the order would be fulfilled, as the manufacturer had doubled their manufacturing capabilities and were now working on a 24 hours schedule. Ventilators were distributed in batches via CCaNNi and were received in November 2020 as part of the regional roll out.

79. This combined with a well-managed pre-COVID 19 inventory of ICU ventilators enabled the ICU's of this Trust to address patient care without concerns of device unavailability. At no time throughout the pandemic was a Trust ICU patient unable to receive full level three ventilation, as prescribed on any given day by an ICU Intensivist, due to the unavailability of a ventilator.

80. The existing business continuity arrangements and COVID 19 governance structure within the Trust, ensured quality and safety with regard to ventilators and related equipment. Senior ICU staff had oversight of the specification of ICU ventilators being procured into the Trust. The Trust only ordered ventilators suitable for Level 3 ICU acuity patients from our normal supplier. This afforded us the opportunity to ensure that safety and quality were maintained at the highest level. Consumables for these ventilators remained available to order throughout the pandemic. Other medical devices had similar scrutiny ensuring that only suitable products were brought into the Trust for clinical use, for example, Dialysis Machines, Infusion Devices and Monitors.

81. As the Trust only procured ICU ventilators from their normal manufacturer, an acceptable level of familiarity for staff was maintained. Training for staff on newly delivered ventilators was supported by a combination of the company representative, the Critical Care Technologist Team and the ICU Practice Educator. There was no issue with staff ability or training. No safety issues were experienced within ICU in relation to the ventilators.

82. Therefore no issues were experienced or escalated about ventilators during this period. Should concerns have arisen, they would have been escalated internally to the Hospital Planning Group. In addition, a regional critical care meeting was held daily, chaired by a senior leader from Belfast Trust supported by regional commissioning colleagues and departmental colleagues.

Diagnostic and Medical Equipment

83. Initially, there was some concern about access to appropriate stock of key medical equipment, such as ventilators, becoming a procurement challenge due to the global demand. The Trust placed orders for key medical equipment early in the pandemic (March 2020) via BSO PaLS and CCaNNi. Concerns thereafter for delivery of equipment and expected delivery times were dealt with by either BSO PaLS or CCaNNi

depending on who led on procurement. Critical Care did not experience any difficulty in gaining access to equipment but also accepted that the lead time for delivery was extended due to the global demand, for example, ventilators ordered in March / April 2020 were delivered in August 2020.

84. General consumable supplies were either available as normal or if the Trust was concerned about availability, they were 'pushed' out regionally on a percentage basis to each Trust. Some equipment was offered by commercial organisations. All donated equipment was scrutinised by senior Trust staff. As supplies were available from normal sources, this donated equipment was stored but not used on patients or by staff.

85. Medical devices were delivered to a regional store and distributed to areas of the greatest need first. This was the correct approach and provided a guide to the management of other medical device procurement / distribution requirements during this time. It was really important if alternatives were considered, that the correct staff were involved to ensure that quality and safety was maintained and at times this meant turning down products, that were simply not of high enough quality to be available for use with a Trust patient, for example, inappropriate ventilators for the acuity of patients in ICU. Standards even in the face of increased pressure to act had to be maintained, and to ensure that was the case experienced staff had oversight.

86. In managing conflicts of interest, in addition to the Trusts normal process, the Trust continued to engage BSO PaLS as its CoPE. In the case of local procurement where a value for money assessment could not be determined, the Director of Finance and /or the Assistant Director of Finance Capital, Costing and Efficiency was required to declare any interests which may be a conflict of interest in advance of a decision. **Please see the attached "Process to be followed for local procurement of PPE for the Western Health and Social Care Trust during the COVID 19 Pandemic, page 4," exhibited to this statement NG/8 [INQ000512486].**

Learning

87. There are several examples of good practice from the point of view of the Western HSC Trust that might be used to inform the response to any potential further pandemic.

88. The Trust developed a "Working Safely Together in COVID 19" programme, to support staff through the understandable anxieties associated with the work setting and the requirements introduced early on in respect of mask wearing and social distancing. The programme used tools such as the "ECHO" network to connect diverse and larger groups of staff from different work settings. It devised practical guidance and training supports for staff, and enabled ongoing listening to the concerns of staff on issues with their work environment. The programme was subsequently recognised nationally as winner of the HPMA Excellence in People Awards 2021 for the "Excellence in Organisational Development Award". It was specifically recognised for the organisational wide approach, to involving staff at all levels in developing and maintaining safety at work arrangements.

89. The Trust set up a Doctors Hub as an initial response to the COVID 19 pandemic to support medical personnel through a number of measures including, the conducting of referrals to doctors and their families for COVID 19 testing, especially at a time when testing arrangements were limited and signposting medical personnel to COVID 19 advice as appropriate. The Doctors hub provided a Single Point of Contact (SPOC) for doctors and the PPE SPOC for all matters of PPE across the Trust. Medical Education and the Doctors Hub provided a weekly newsletter and a dedicated on line 'Page Tiger' resource that facilitated a SPOC for teaching, training, doctor redeployment and updated clinical guidelines for COVID 19. The Doctors Hub later developed towards roster management for medical personnel.

90. Hospital Management, Critical Care, PPE, Oxygen and COVID 19 Governance Structures as outlined in the statement, facilitated efficient and effective escalation and resolution. Designating a PPE Lead and PPE Manager provided continuity and focus.

91. Psychologists led on a programme of support and wove their way across a range of working groups to ensure high visibility of staff wellbeing in all decision making. They provided critical expertise in the early stages of the pandemic, supporting the PPE group to use Human Factors to help guide the behavioural change necessary for staff

to embrace and feel confident working in PPE. A psychological support helpline was set up, team and individual support sessions, and staff wellbeing training for Managers.

92. Chaplains are considered a critical part of the care and support for patients. Preparation to ensure chaplaincy services could be delivered consistently through the pandemic began before 17th March 2020 within Emergency planning arrangements. Chaplains were provided with PPE and received PPE training and IP&C COVID 19 safety training.

93. The Trust experienced challenges due to the globally limited capacity of Oxygen to upgrade hospital supply entering the pandemic, and all Trusts in NI were reliant on BOC as the single supplier. Initially only the Royal Victoria Hospital as the regional Trauma centre, and the Belfast City Hospital as the nominated Nightingale Hospital, were scheduled to be upgraded in light of the pandemic. Altnagelvin was then selected as the 3rd NI site to be upgraded. The reliance on a single supplier remains a risk for this critical infrastructure. Pandemic Flu planning should consider the critical issue of oxygen capacity and the importance of investing in upgrading infrastructure as part of preparedness planning.

94. The Trust identified learning from the procurement of key medical equipment and supplies during the pandemic, for example, there was insufficient logistical storage capacity provided by the Emergency Planning storage for PPE, particularly when the requirements placed on the Trust expanded to include supply to IS Homes, Carers for those receiving direct payments, Mass Vaccination Centres etc. PPE storage and logistics chains at Trust level need to be permanently expanded to enable greater resilience and storage capacity.

95. In addition, procurement via CCaNNI and PaLS was the most efficient and effective way of procuring equipment and supplies and the regional role of the Medicines Optimisation Innovation Centre in quality assuring PPE gave the Trust confidence in the products being procured. Clear processes were established and the Trust complied with them.

96. Representation from key senior staff at regional meetings ensured that the Trust received a proportionate share of supplies.

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: 23rd December 2024