

Witness Name: Ruth Allen and  
Paul Hughes-Webb

Statement No.: 1

Exhibits: 1

Dated: 05 November 2024

## UK COVID-19 INQUIRY

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### WITNESS STATEMENT OF Ruth Allen and Paul Hughes-Webb

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We, Ruth Allen and Dr Paul Hughes-Webb will say as follows: -

1. We make this statement, regarding the procurement and distribution to end-users across the four nations of the United Kingdom of key healthcare related equipment and supplies, including PPE, ventilators and oxygen during the pandemic in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 28 June 2024, in relation to Module 5 of the Inquiry. The facts and matters contained within this statement are within our own knowledge unless otherwise stated, and we believe them to be true. Where we refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of our knowledge and belief.
2. We make this statement on behalf of South Warwickshire University NHS Foundation Trust (SWFT) and confirm that we am duly authorised to do so.
3. I, Ruth Allen, was Head of Procurement for South Warwickshire University Foundation Trust from January 2017 until July 2021, before taking on my current role as Associate Director of Procurement for the Procurement Shared Service serving South Warwickshire University NHS Foundation Trust, George Eliot Hospital NHS Trust and Wye Valley NHS Trust.
4. I am responsible for the Trust Procurement and Supply Chain, delivering commercial best practice, continual improvement, business partnering and connecting with

stakeholders to drive best value to support patient care. I am Chartered Institute of Purchasing and Supply qualified, with 23 years of NHS Procurement experience.

5. I, Dr Paul Hughes-Webb, am the Associate Chief Medical Officer for Covid Resilience and Cancer Recovery at South Warwickshire University Foundation Trust. I was appointed as Associate Medical Director for Recovery and Covid resilience on 1st June 2021, prior to this I worked closely with the Chief Operating officer, Chief Nursing Officer and members of Silver command leading the trust's response to Covid.
  
6. I have been a consultant in Intensive Care and Anaesthesia at South Warwickshire University Foundation Trust since March 2014 and am a Fellow of the Royal College of Anaesthetists and Fellow of The Faculty of Intensive Care Medicine. In my clinical work I have experience of working in intensive care units throughout the UK and Australia and have worked as part of major incident teams during my work in a prehospital transfer team in Australia and a prehospital emergency care team in Birmingham.

## **Background**

7. The Trust as a whole provides a range of healthcare services to around half a million people in Warwickshire, with Warwick Hospital mainly supporting patients in the South of Warwickshire, where the population is 310,000 based on the number of patients registered with a South Warwickshire GP Practice. Warwick Hospital's Emergency Department (ED) does receive a large number of patients who do not live in South Warwickshire and therefore the ED can see in excess of 15% of its ED patients coming from elsewhere.
  
8. The Trust operates from a number of sites including: Ellen Badger Hospital, Leamington Spa Hospital, Stratford Hospital and Warwick Hospital. Warwick Hospital is the Trust's largest site and the majority of the Trust's acute services are provided there. These include emergency, diagnostic and pathology, diabetes, audiology amongst a range of other services. Intensive care, cancer care and coronary care are all delivered in dedicated units and surgical procedures are carried out in main and day theatres. Warwick Hospital also has a labour ward, special care baby unit and midwifery-led birthing unit called the Bluebell Birth Centre.



## **Overview of general interactions between SWFT and relevant bodies or organisations during the pandemic**

9. During the pandemic SWFT did not have any direct interaction with the Secretary of State for Health/ the Department of Health and Social Care (DHSC). We did however send representatives to the DHSC webinars.
10. With regards to NHS England, we followed guidance that was issued and accessed their briefings and webinars.
11. We did not have any direct interaction with the Chief Medical Officer and Deputy Chief Medical Officers, although we did receive letters signed by the CMO and CNO sent to all NHS Trusts.
12. SWFT followed guidance that was issued by Public Health England (PHE) and the UK Health Security Agency (UKHSA) and fed back to local PHE/ UKHSA colleagues. We also contributed to regional Public Health meetings. We met with them regularly as part of the local "COVID-19 Health Care Partnership" Infection Prevention meetings. This was a forum for sharing information, data and learning within our System footprint. These meetings were originally held weekly at the beginning of the Pandemic but decreased in frequency as the Pandemic resolved. This group continues to meet as it is a valuable learning forum with key Infection Prevention and Control/ Public health leads attending.
13. Involvement with NHS Procurement is covered in detail later in this witness statement.
14. We did not have any direct interaction with the VentilatorChallengeUK Consortium, Cabinet Office or Government Commercial.
15. We did not have any direct interaction with the NHS Race and Health Observatory.
16. With regards to Trade Unions, we switched all of our regular meetings including the joint negotiating and consultation committee to a Teams platform to allow engagement and attendance from all representatives including regional union officials to still take place. We added weekly meetings for the Trade Union leads to meet with the managing director and HR director, to discuss all issues that would

impact on staff. We kept up to date with individual union channels and information from the TUC. We kept each other up to date with latest briefings from Trade Union Congress (TUC)/ unions on worker issues, Health and Safety updates etc.

17. We had no direct contact with MHRA as an organisation related to the pandemic. We had no direct contact or need to contact MHRA as an organisation. Any communication from MHRA to us and vice versa was via usual established modes of communication.
18. SWFT are not aware of any other interactions with any other relevant body or organisation.

### **Guidance**

19. Relating to the quantity and quality of IPC guidance we feel it was generally poor and issued late, and relied on 'old school knowledge'. Guidance was sent out without speaking to people that were going to operationalise it; written by the Department of Health and Social Care (DHSC) without proper thought. Whilst National guidance was well intentioned, it was felt that it hadn't always been created with enough contribution from operational teams who had with extensive experience of how to implement this within various NHS settings.
20. IPC Guidance changed quickly at the beginning from PPE for a high consequence infectious disease (HCID), e.g. FFP3 mask, visor, long-sleeved gown, then requirements reduced. It wasn't clear whether guidance changed due to evidence that the virus was less infectious and less transmissible or due to the unavailability of PPE.
21. It is felt that national guidance was 'reactionary', as opposed to 'what's the worst case scenario, let's do that and then working back from that when we know anything different'. At SWFT, we chose to go above the national guidance, as opposed to 'hope for the best and then realise we were wrong', which is what it felt to be like from above.
22. Revised guidance issued from DHSC did not make clear what the amendments were so it was up to our IPC teams to 'unpick' the documents and determine for ourselves what the amendments were which was very time consuming and burdensome. We

would then have to amend our own Trust documents to reflect those amendments. The version control on National documents was very poor.

23. We were told by Gold Command at SWFT that we were not to implement guidance that everyone should be in FFP3. Because of the changing guidance that generally reduced the level of PPE that was needed it did cause concern amongst staff.
24. In the early days professional bodies maybe took on a role they were not authorised to do so, with the best intentions, however it was unhelpful to running an organisational response.
25. Once issued, accessing relevant IPC guidance and guidance on the use of PPE was straight forward.
26. It was difficult to set up training to implement new IPC guidance as the guidance changed so frequently.
27. Very early on (towards the end of March 2020, beginning of April 2020), we considered the PPE guidance was lacking particularly in regards to universal masking; we could see the transmission was fairly phenomenal, therefore we introduced universal mask wearing before it became the national standard in hospitals. This caused some challenges within our neighbouring organisations as they felt it put them in a position where they would be expected to do it; however within a matter of days the expectation went out nationally anyway.
28. On occasion some IPC guidance was issued late on Friday afternoons which did put pressure on our IPC Team to review the guidance, firstly to establish what the changes were, and secondly, to determine how significant the amendments were and how urgently this had to be communicated to staff.
29. Whilst National guidance was well intentioned, it was felt that it hadn't always been created with enough contribution from operational teams with extensive experience of how to implement this within various NHS settings. Guidance was often published late on Friday giving operational teams very little time to enact before the weekend, this created confusion amongst staff and the public. If guidance had been discussed with regional clinical networks and then agreed upon before being published this is likely to have achieved a more collegiate and workable real world solution.



## **PPE supplied by the UK government/ DHSC**

30. Because the guidance did not reflect the transmission route i.e. the aerosol transmission of the organism, we felt the guidance on PPE was not adequate to protect our staff; and as the governance around PPE lay with us we felt it necessary to increase the level of PPE for our staff. As mentioned previously, this did however present its own challenges in term of the opinion of our neighbouring Trusts who questioned why we were going above.
31. The question of 'do we feel the guidance was adequate', we feel no it was not adequate for the pathogen. There was guidance for ward care, ICU, NHSE and covid surge, surgical patients etc but it wasn't adequate.
32. The guidance also made very little if any reference to community care health settings.
33. The way guidance was communicated to Organisations was suitable, however, as previously mentioned the timing was poor.
34. We do not feel the guidance on infection control where it related to the use of PPE was adequate.
35. It would have been better if the variations in PPE guidance had been better communicated and clear information provided as to what the changes were; instead of our own IPC Team having to read the entire document to establish what the amendments were.
36. There were issues around the interpretation of guidance. For example 'Was the guidance changed because nationally we ran out of PPE and so it was stepped down' or because the Government generally didn't think it is a problem. Do the Government think this virus was going to kill people, (we know that it did); did they think it can spread by aerosol, (lots of people thought it could, some thought it couldn't). If that was open to interpretation then why wasn't PPE stepped up?
37. With regards to the issue over interpretation and understanding on how the virus was spread; so much emphasis was placed on hand hygiene when really it should have been concentrated on ventilator and air exchange.

38. Related to the supply, distribution or quantities of PPE procured for use in the NHS during the pandemic, on the 17th March 2020 we received communications via the Midsincident NHSE advising of the significant demand for PPE and to prioritise requests; Trusts were being asked to complete a PPE capture template. On 25th March 2020 we started contacting local dental surgeries to see if they could support with PPE requirements. Schools were contacting Warwick Hospital with offerings of visors.
39. In early April 2020 we started engaging with Jaguar Land Rover who were keen to support Warwick Hospital with the production of visors. Given the visors we had received to date via the push pallet were deemed not fit for purpose by IPC, we worked with Jaguar Land Rover on the design of a visor. We also sourced further supply from a local graphic arts supplier.
40. We had some issues with type, quality, fitness for purpose, consistency, arrival times, cancellations or completeness of orders, use-by dates and/ or instructions for use issues relating to PPE procured for use in the NHS during the pandemic. On 6th April 2020 3M 8833 FFP3 masks were delivered into Warwick Hospital Stores, and it was noted that they were past their expiry dates. On seeking clarity for their use, Warwick Hospital were informed by 3M that the product should not be used as they will no longer offer the required level of protection. Meanwhile, PHE issued a response to the Hospital to say that all expired stock had been quality checked and extended the expiry dates. The reason the labels were not updated was apparently down to time.
41. Centralisation of PPE did positively affect supply in terms of quantity, however, in some instances the quality of the PPE supplied was problematic. For example, visors were flimsy with gaps and inappropriate gloves, (vinyl instead of nitrile) were supplied. Warwick Hospital had many examples of receiving Type IIR masks that were questioned in terms of quality but were informed that all quality assessments had been conducted and so to proceed with use, only to be later recalled based on not meeting the standards of splash prevention.
42. There was persistent concern about the quantity and quality of PPE available. Advice changed on a regular basis, giving no assurance that it was proportionate and maintaining staff safety.

43. Warwick Hospital did not experience shortage of PPE or RPE, although there was anxiety that we might; however as previously stated some PPE was of poor quality. We implemented a system where any new item was risk assessed by our IPC team to ensure it was suitable prior to it being implemented.
44. Examples are set out below for recalls of PPE where quality was deemed an issue.
45. Easimask masks were not suitable for clinical environments (11th -14th May 2021). We received communications of unsuitability on 25th May 2021.
46. Obisk facemasks. 13th January 2021 Warwick Hospital reported 12000 Model IR099 Obisk Type IIR masked that had not been passed by IPC. This was escalated. An email response from the Regional Head of Procurement for NHEI stated that any items released to Trusts for delivery are approved for quality assessment and so Trusts' IPC cannot just disregard as inappropriate. The Trust were advised to offer as mutual aid if the Trust did not want to use them. However, 22nd October 2021 the Trust received communication to say that the Obisk facemask may not meet technical specifications for splash protection. This was 9 months after Warwick queried and were told to use them.
47. On 26th May 2020 an alert was received to isolate Cardinal IIR Masks as there were reports the stitching was coming away.
48. On 31st May 2022 Hunan EEXi inherent Type IIR mask were recalled as they fell short of the required standards for splash resistance.
49. In December 2020 Royal mint visors were recalled due to a latex warning.
50. Tiger goggles recalled 9<sup>th</sup> May 2020 as we received notification that they did not meet the current requirements for splash protection.
51. Drager FFP3s masks withdrawn due to receipt of communication 27 July 2021 stating an issue had been identified relating to a manufacturing issue.
52. On a number of occasions there was a lack of CE certification provided with PPE delivered via the Push Pallet. SWFT Procurement would always request

confirmation of CE Certification from PHE and where assurance wasn't received stock was quarantined.

53. SWFT did not experience any issues regarding counterfeit products.
54. SWFT used the emergency request services a number of times for obtaining PPE. Organisations had to reach a certain criteria to be provided with stock and then it was 'demand managed' so we did not always receive the volumes requested. This did ease as the pandemic went on, but it was quite challenging at the beginning.
55. SWFT did use local supply arrangements and initiatives for procuring PPE but had no issues. They were absolutely essential in ensuring continuity of supply when the national or mutual aid was not able to fulfil the requirements of the Trust.
56. Masks could be difficult to fit to staff members who had a large or small face (could be male/female or ethnic minorities) and those staff who didn't have a defined nose bridge (mainly ethnic staff members) it would be difficult to get a good seal. The number of different styles of disposable FFP3 masks helped in trying to get a fit.
57. We are not aware of any circumstances where SWFT healthcare workers or professionals felt pressured to work in care settings with inadequate PPE where aerosol-generating procedures were carried out and which may have exposed them to risk of infection from Covid-19.
58. We are not aware of any issues about the decision to downgrade Covid-19 from High Consequence Infectious Disease (HCID) status, thereby permitting use of PPE rather than RPE, and any consequent impact on the levels of exposure to Covid-19 of healthcare workers or professionals (including whether there was any disparity between staff groups). Although there was significant anxiety as to whether this decision had been made due to unavailability of PPE rather than how the pathogen was spreading. We did continue to use RPE above the national guidance because of this anxiety and the fact we could see in practice that it was spreading by aerosol and not just droplet.
59. Processes relating to the national helpline seemed to be constantly changing and inconsistent in terms of whether your escalation was successful. Often we would be

told to expect a certain amount the following day and it either didn't arrive or it was a reduced volume.

60. No action as such was taken by SWFT on the matters above, and hence no response received from the UK Government/ DHSC, the NHS or any other body.
61. Pre March 2020 the Infection Prevention Team were responsible for staff Face Fit Testing. During the pandemic, due to the increased number of staff requiring face fit testing and the number of different disposable FFP3 masks being delivered via the National push pallet, the Learning & Development Team undertook the majority of Face Fit Testing for both hospital and community staff, (along with some specialist areas who had face fit testers e.g. ICU and IPC staff).
62. NHS England then provided additional Face Fit Tester support and this resource was only removed in March 2023. More SWFT staff were also trained to undertake face fit testing.
63. The Face Fit Tester provided by the external company would not fit test staff on the 3M disposable FFP3 masks or the half face masks, therefore this was undertaken by SWFT staff (trained face fit testers).
64. Initially there was some difficulty gaining the face fit test equipment, and the solution used was in short supply. We reached out to other health care providers e.g. Dentists and construction industry for FFP3 Test equipment.
65. In addition to this, there were problems with face fit testing due to the number of different masks being received via the national push pallet and staff needing to be tested on each different mask.
66. Staff were tested on all available disposable FFP3 masks; if they failed on all, a re-useable JSP Force 8 half face mask was face fit tested, if failed, the JSP air fed respirator was issued. There was difficulty obtaining the air fed respirators as everyone wanted them. Risk assessments were carried out by the manager.
67. As of 31st March 2024 SWFT had £132,000 worth of PPE, made up largely of various brands of FFP3 masks (36,000), 17,500 gowns and 2,000 IIR masks.

68. The reasons why this PPE was not used was because it was not fit for purpose. In addition to this, the DHSC encouraged Trusts to take extra PPE towards the end of the pandemic.

69. Of the excess PPE, £10,000 worth of half face respirator, filters and transparent masks were procured directly by the Trust as opposed to being provided by the UK government/ DHSC

**Procurement by SWFT and supply chains**

70. Below shows in tabular form, a list of contractors/suppliers to whom SWFT awarded contracts for PPE.

		Number of Contracts	Number of Items	Total Cost
<b>PPE</b>	A	16	552,107	£ 242,854.27
<b>Ventilators</b>	B	3	39	£ 28,128.82
<b>Respirators</b>	C	1	309	£ 14,912.00
<b>CPAP machines</b>	D	3	140	£ 39,910.00
<b>Oxygen supplies</b>	E	5	421	£ 27,480.82
<b>Oxygen masks and tubing</b>	F	2	24	£ 2,089.25
<b>Lateral Flow</b>	G	0	0	£ -
<b>PCR tests</b>	H	0	0	£ -
<b>Lab equip</b>	I	N/A	N/A	N/A
<b>Hospital Equip</b>	J	11	626	£ 119,578.02
<b>Critical Care Equip</b>	K	0	0	£ -
<b>Hand Sanitiser</b>	L	0	0	£ -

71. All direct PPE contracted stock was used by SWFT unless we supported other organisations through mutual aid.

72. All direct awards relating to PPE performed satisfactorily.

73. No stock was recouped or written off and no issues were flagged with any suppliers.

74. No direct contract ended in litigation or referral to law enforcement

75. Decisions to purchase over and above the Push supply from UK Government was a decision ratified via our Silver Command up to £10,000 and Gold command for greater than £10,000.

76. The experience and/or training of the members of staff in relation to procurement was that Procurement Managers and Procurement Senior leadership team are all Chartered Institute of Procurement and Supply (CIPs) qualified. The Procurement Team sought assurance from IPC Team and DHSC with regards to technical specifications.
77. The Head and Deputy Head of Procurement lead on all recommendations related to the purchase of PPE and provide assistance to other members of staff where required. Support and assistance were sought from Silver Command and NHS Supply chain and advice requested from NHSE on an ad hoc basis.
78. There were many areas of concern particularly around availability of items and the quality of some of the stock being provided. The Trust had a number of staff that failed the fit test on all FFP3 Masks but hoods and Half faced respirators and filters – (JSP, 3M), were out of stock at many suppliers and the larger Trusts had exhausted a lot of the stock. FFP3 masks were being pushed out to the Trust from the Foundry but stock varied and the supply of different models meant that staff were having to be continuously fit tested in order to wear the new models with confidence. This put additional pressure on staff, until the external fit tester from Ashfield came in to support, however there were on-going shortages of Fit test solution which inhibited the fit testing being undertaken.
79. There was also a shortage of Body bags and the Trust relied on local funeral directors for supply.
80. The Hand Gel supplied was also inconsistent in its supply and the Trust had to invest in a flammable cupboard to ensure safe storage; it was supplied in many different sizes, types and method of dispensing, which resulted in infection prevention issues.
81. Concerns were raised about the quality and suitability of some of the products and some Staff were referred to Occupational Health due to allergic reactions to the hand gel and face masks.
82. There was also a backlog at the crematoriums and Mortuary capacity within the Trust became an issue; during the pandemic a temporary solution was put on site to accommodate the additional deceased.

83. At the start of the pandemic the Trust was not always aware of what items would arrive and the quality of some of the masks and visors were particularly poor.
84. A number of lines of PPE sent via push pallet were declared not fit for purpose but this was often after they had been in use at the Trust e.g. eye protection. Despite being cleared by NHSE they were rejected by the local IPC team.
85. During early March 2020 an Inventory management system was put in place so that stock being supplied via the centre could be recorded and stock levels managed.
86. At the start the Push pallet stock was provided but issued with no knowledge of stock available at a local level. This was being pushed out to the Trust on pallets of varying sizes and the Trust quickly had to hire Storage containers to accommodate the additional stock, we also had to become a picking and packing service to the community settings as the bulk orders only had one point of delivery.
87. At this point the Trust relied on volunteer drivers who worked with the Trust 7 days per week to deliver stock. This was due to insufficient stock being available, and the Trust supplying the wards and departments on a 'just in time' basis.
88. The Trust supplied Daily reports into NHSE, and Procurement Staff worked 7 days per week.
89. FFP3 Masks were supplied but revalidated as they were out of date – This was a concern for staff but NHSE assured the Trust that these were fit for use, despite being out of date based on the original manufacturers labels.
90. Some PPE was declared fit for purpose and then later recalled - after staff had used it, sometimes for long periods of time. This was despite the Trust challenging the quality at delivery and being given assurance by NHSE that it had been through a rigorous process of approval.
91. At the start of the pandemic, distribution and supply was unreliable and chaotic. PPE stock levels dwindled very quickly. For SWFT, who operate to Just in Time principles via NHSSC, they did not have a large warehouse for 'stockpiling' as other Trusts did (to the detriment of supply across the system).

92. SWFT did not experience or identify any fraud or counterfeiting.
93. We did not have any concerns about the ability to carry out due diligence in respect of suppliers of PPE or the effectiveness of such due diligence checks as we used limited new suppliers during the pandemic.
94. We did not experience any concerns with receiving items or delivery issues.
95. Prices clearly fluctuated during the pandemic and it was evident that prices had increased significantly with IIR masks going from 5p each to in excess of 50p each at the peak of the pandemic.
96. There was competition for specific medical supplies in the sense that decisions had to be made quickly to secure stock, particularly around respiratory equipment e.g. CPAP
97. We did not carry out any direct purchasing of key medical equipment and supplies from suppliers abroad.
98. We did not stock pile medical equipment and supplies.
99. SWFT procurement managed and monitored its PPE, medical equipment and supplies consumption rates on a daily basis. Whilst rationing was not something we did we managed stock levels closely to ensure that stock was managed in a Just in time rather than any stock piling in Wards and departments. The site capacity office held a small amount of stock to cover out of hours but also had access to an inventory list that showed where stock was should it need to be moved around to manage consumption overall.
100. With regards to the management of conflicts of interest we had no additional requirements other than in line with current Trust policy.
101. SWFT only procured items through the centralised route as advised by the national team.
102. Centralisation of PPE positively affected supply in terms of quantity, however, in some instances the quality of the PPE supplied was problematic. For example, visors

were flimsy with gaps and inappropriate gloves, (vinyl instead of nitrile) were supplied. Warwick Hospital had many examples of receiving Type IIR masks that were questioned in terms of quality but were informed that all quality assessments had been conducted and so to proceed with use, only to be later recalled based on not meeting the standards of splash prevention.

103. Whilst it was extremely worrying, confusing and chaotic in the first couple of months, once the central PPE foundry went live this helped with transparency.
104. SWFT worked closely with Jaguar Land Rover who designed and provided free of charge visors. A local Graphic Design company also provided visors. SWFT were supported by Schools, Dentists and GP's that had closed in the early stage of the pandemic. In turn when the Dentists and GPs reopened SWFT supported.
105. Based on our modelling and consumption rates and the volumes we were getting from the push pallet and having to request mutual aid, SWFT Procurement Team submitted a paper to our Silver Command recommending a direct purchase of IIR masks. This paper is exhibited at RA/1 [INQ000504925].
106. SWFT Procurement implemented an inventory management module (within Integra P2P system) in May 2020 to support with management of PPE inventory and distribution, in addition to making managing recalls more efficient.
107. When the Trust sought clarity on the use of specific PPE or assurance around CE Markings or expiry dates, guidance was provided by the appropriate body.

#### **Procurement of PPE**

108. With regards to being involved in setting up a separate supply chain or system for buying PPE, sharing and distributing PPE, we were involved in regional collaboration meetings which included representatives from councils, acute, mental health, community trusts and Clinical Commissioning Group. This group supported each other with the supply chain challenges, specifically PPE with mutual aid and a place in which professionals could offer ideas, advice and options to support each other.

109. We did not have to identify our own suitable suppliers of PPE as the majority of the reliance was via the national supply or suppliers who already had accounts with the Trust. For those that were new, SWFT were introduced by another Trust.
110. PPE was distributed via the Procurement, Materials Management and Stores team based on consumption levels. This included daily picking and packing on site for delivery by ISS portering staff and volunteers to our community sites. .
111. We were able to negotiate price to an extent through collaborative commitment e.g. for visors when the push pallet were not sending any.
112. The purchase of additional PPE had to be approved via Silver command and/or Executive decision.
113. In April and May 2020 Procurement were relying on donated PPE to support with the needs of the organisation.
114. Approximately 80% of PPE was sourced via the UK Government, NHSSC, DHSC or mutual aid from other Trusts.
115. SWFT followed IPC PPE Guidance. Half faced masks and filters, which were re-usable were purchased and used in high risk areas and where staff had failed fit testing. Compared to the whole amount of PPE used, this constituted a very small proportion. The Trust also had access to reusable gowns as part of the PPE but these were not purchased, they were provided as part of the linen and laundry contract.
116. SWFT procured, obtained and provided sufficient PPE to all its contractors, agency, locums etc. All staff providing a service, whether directly employed by the Trust or contracted were provided the same level of protective equipment.
117. SWFT participated in daily PPE resilience calls (as supply strengthened the call turned to weekly) at a regional level to ensure everyone had adequate stocks. This was specifically over weekend and bank holiday periods. Mutual aid was provided to any Trusts that required it and we could support. There was no specific sharing arrangements put in place.

118. SWFT managed its stock of PPE using the Inventory management module of its Finance and Procurement system. Expiry dates were checked on receipt of stock and managed accordingly.
119. SWFT did provide PPE for the care sector in our locality as requested by the local Care Homes directly to our Associate Director of Operations for Out of Hospital Care Collaborative and this being agreed at our Silver Command meeting, in addition we provided PPE to private hospital/ clinics; this supported discharge to Care Homes.
120. Some direct awards were made for the purchase of PPE but all was within spend threshold or via a compliant framework.

### **Ventilators**

121. In relation to the procurement and distribution of ventilators and related medical equipment and supplies during the pandemic we had sufficient numbers of ventilators.
122. We only used our own equipment and ventilators which had been purchased pre-pandemic as such we had no issues or concerns with quality, safety, appropriateness or effectiveness of any ventilators or related medical equipment and supplies procured during the pandemic.
123. The ability of staff to use newly delivered ventilators or the training required in order to use them safely was not an issue as we had no newly delivered ventilators.
124. We had no issues with any delays in obtaining sufficient ventilators.
125. We did not call any major incidents as a result of intensive care or ventilator capacity being full or nearly full.
126. There was not any point during the pandemic when a patient who needed a ventilator was not able to get access to one as this never occurred due to the process of transferring patients across the region to maximise ICU bed network availability.
127. We had no concerns related to the areas set out above.

128. Since we raised no concerns there was no response required from UK government/  
DHSC, the NHS or any other body

## Oxygen

129. In relation to the procurement and distribution of oxygen and related medical equipment and supplies during the pandemic oxygen delivery was never a problem. At the start of the first surge, one of our clinicians worked closely with estates to ensure we had an up-to-date map of pipework around the Trust. Diversified flow was calculated for each ward and individual wards were assessed for escalating should high flow oxygen devices be required. These wards were stress tested with high flow devices before patients were admitted, to ensure calculations worked. All oxygen driven devices e.g. anaesthetic ventilators were swapped to air. Ground work and pipe work was rapidly arranged and completed to enable a portable Vacuum Insulated Evaporator to be installed immediately in another part of the site should it be required. Oxygen utilising was recorded on every bed space across the site and this was disseminated to key personnel so they were aware of any impending problems.
130. We had no concerns with the equipment to support patients requiring high flow oxygen; we used continuous positive airway pressure (CPAP) machines that were used for obstructive sleep apnoea patients to deliver CPAP to covid patients on the respiratory ward. These worked effectively and meant we could deliver CPAP and increased oxygen flow. Therefore no action was taken by SWFT as we had no concerns.
131. Since we raised no concerns there was no action to be taken by either us or the UK Government. DHSC, the NHS or any other body.

## Testing

132. We did not suffer from a shortage of test kits, reagents or other testing supplies during the relevant period. We were never unable to provide LFT kits for staff and patient use, as a supply was always available. We were provided with adequate stock throughout the pandemic and were able to support requests for both patient and staff across the organisation. We actually assisted other Trusts on a couple of occasions through mutual aid, who were struggling with supplies.

## **Diagnostic and other medical equipment**

133. In relation to the procurement and distribution of diagnostic or other medical equipment or supplies during the pandemic we did not have a shortage of diagnostic or medical equipment and as such no concerns to raise, address or give examples of.

### **Lesson learned**

134. Examples of good practice at SWFT, include the fact that we held a Silver Command daily. This ensured the right people had the right information and the right people were 'in the room' to make decisions.
135. Further to this, at SWFT, we used our IPC Team as 'gatekeepers'. By this it is meant that our IPC Team reviewed the PPE and equipment that was issued to the Trust and ensured it was fit for purpose before it was distributed across the Trust. If it was deemed unfit, it was quarantined; by doing this we feel we protected staff and patients. Further to this, the IPC gained a feel for how robust certain equipment was which informed our Standard Operating Procedures which we subsequently modified for example depending on how to clean it to keep it functioning, again, protecting both staff and patients.
136. We repurposed CPAP machines that were for use in obstructive sleep apnoea patients to provide CPAP in Covid patients. This gave us a supply of CPAP machines for these patients that were used on our respiratory ward and reduced the number of patients we needed to admit to ICU. Patients were monitored on the respiratory ward and circuits were created by our EBME team. We had no complications or problems associated with these machines that we repurposed.
137. We reached out to the independent sector for ventilators and anaesthetic machines to support the acute trust. We provided mutual aid to the independent sector with PPE when they had short supplies alongside other emergency services such as West Midlands Ambulance Trust and the police.
138. PPE was not always consistent in relation to type or brand which meant that multiple fit testing was required and hoods were often in short supply. CPAP machines were also in short supply, but as previously stated we adapted our own to overcome this.

Gowns and aprons were also in short supply as well as body bags. This was dealt with through system wide mutual aid. The supply of uniforms such as scrubs was inadequate; local groups made and supplied scrubs and mask comforters to prevent skin damage to staff.

139. With regards to the procurement of key medical equipment or supplies during the pandemic the consistency of the quality and type of PPE especially, should be considered to understand where the demand was and for which type of equipment or PPE then reflect that in future planning. Guidance should take into account the impact of future pandemics and anxieties of different groups of staff and their vulnerabilities. Ensure changes to guidance is aligned with supply.

### **Statement of Truth**

We believe that the facts stated in this witness statement are true. We 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

**Signed:** Personal Data

**Dated:** 5 November 2024