Witness Name: Amanda Sullivan
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Exhibits: AS/01-AS/62
Dated: 28 November
2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF AMANDA SULLIVAN

I, Amanda Sullivan, will say as follows: -

Overview of the role, functions and activities of NHS Nottingham and Nottinghamshire ICB

Introduction

1. My name is Amanda Sullivan. Since 01 July 2022 I have been employed as Chief Executive of NHS Nottingham and Nottinghamshire Integrated Care Board ("the ICB"). Immediately prior to this, I was employed by NHS Nottingham and Nottinghamshire Clinical Commissioning Group ("the CCG") and its predecessor CCGs, where I was Chief Executive throughout the period that this statement covers.

Approach to the Covid Inquiry Rule 9 Request

2. This witness statement was drafted on my behalf by the external solicitors acting for the ICB in respect of the Inquiry, with my oversight and input. The request, received on 05 July 2024 pursuant to Rule 9 of the Inquiry Rules ("the Rule 9 Request") is broad in scope and goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals in writing, by telephone and video conference. I do not, therefore, have personal knowledge of all

the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

3. Since the period that this statement covers, CCGs have been abolished and replaced by ICBs due to the statutory changes introduced by the Health and Care Act 2022. As a result of these statutory changes, NHS Nottingham and Nottinghamshire ICB was established on 01 July 2022. However, the timeframe which this Rule 9 Request covers relates to the period before the statutory changes took effect and so this statement will refer to the CCG, rather than the ICB.

4. The CCG was set up by the Health and Social Care Act 2012. Prior to 01 April 2020 there were six CCG organisations across Nottingham and Nottinghamshire including Mansfield and Ashfield CCG, Newark and Sherwood CCG, Nottingham City CCG, Nottingham North and East CCG, Nottingham West CCG and Rushcliffe CCG. While for three months of the period the Rule 9 Request covers (01 January to 01 April 2020) these six CCGs were operational, this statement will refer to the sole CCG. This is because there was little variation in staff across the six CCGs and the same staff members were performing the same roles across Nottingham and Nottinghamshire in the pandemic response both before and after the creation of the CCG.

Background

5. The CCG was the commissioner of health services for individuals registered with a GP in the Nottingham and Nottinghamshire area, as well as for urgent care services for non-registered persons. The CCG was responsible for developing plans to meet the health needs of the population, managing NHS budgets, and buying health services for the Nottingham and Nottinghamshire area. The CCG served, and now the ICB serves, a population of approximately 1,270,500 people.

6. The CCG was a clinically led membership organisation made up of the 124 GP practices (as at 31 March 2022) covering Nottingham City and the boroughs/districts of Mansfield, Ashfield, Newark and Sherwood, Broxtowe, Gedling and Rushcliffe.

The member GP Practices were responsible for determining the governing arrangements for the CCG, including delegations to the CCG's Governing Body and arrangements for clinical leadership, as set out in the CCG's constitution.

7. As a commissioner of health services, the CCG entered contractual arrangements with a range of providers of health and care services. This included NHS providers (NHS Trusts and NHS Foundation Trusts), independent sector providers, voluntary sector, and other bodies. Depending on the nature of the contracted provider, they would be required to comply with their own statutory, regulatory, and contractual obligations. NHS providers are statutory bodies in their own right.

8. As of 31 March 2022, the CCG employed 514 staff. The organisational structure was divided into a number of directorates that had responsibilities in the areas of commissioning and contracting, finance and resources, and quality and governance. Additional clinical expertise to commissioning activities was provided from GP Advisors, appointed from member GP Practices. The CCG employed most key functions in house. However, it had a contractual arrangement with Arden and Greater East Midlands Commissioning Support Unit to provide a number of specialist services, including recruitment services, technical procurement services and contract management support. The CCG also commissioned IT provision and technical support through the Nottinghamshire Health Informatics Service, hosted by Sherwood Forest Hospitals NHS Foundation Trust. Exhibited is a copy of the CCG's Annual Report and Accounts 2021/22 **[Exhibit: AS/01 / INQ000504870]**.

9. The primary statutory framework that related to CCGs was the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The NHS Act set out the functions and duties of the CCG, including:

    a. Community health services
    b. Maternity services
    c. Elective hospital care
    d. Rehabilitation services
    e. Urgent and emergency care including A&E, ambulance and out of hours services
    f. Older people's healthcare services
    g. Healthcare services for children
    h. Healthcare services for people with mental health conditions

i. Healthcare services for people with learning disabilities
j. Continuing healthcare
k. Abortion services
l. Infertility services
m. Wheelchair services
n. Home oxygen services
o. Treatment of infectious diseases.

10. In addition, the CCG had responsibilities under the Civil Contingencies Act 2004 in relation to Emergency Preparedness, Resilience and Response ("EPRR"). This was supplemented by the NHS England Emergency Preparedness, Resilience and Response Framework guidance issued by NHS England on 10 November 2015 which was in place at the time of the pandemic **[Exhibit: AS/02 / INQ000113172]**. The CCG's EPRR Annual Report 2021/22 is exhibited **[Exhibit: AS/03 / INQ000504881]**. Under the Civil Contingencies Act 2004 the CCG was defined as a Category 2 Responder meaning that there is a statutory duty to cooperate with Category 1 Responders, which includes NHS England, acute Trusts and emergency services. Following the ICB's assumption of the CCG's responsibilities, the ICB is designated as a Category 1 Responder and therefore subject to the full set of civil protection duties under the Civil Contingencies Act 2004.

11. The CCG was required to have a constitution setting out how it would exercise its statutory functions.

12. I was the Chief Executive Officer of the CCG during the period that this statement covers, and I remain the Chief Executive Officer of the ICB.

Governance

13. In January 2020, the CCG was largely managing its pandemic response through its EPRR arrangements. This included determining what needed to be in place as a system, coordinating with systems partners and having regular webinars on incident response with NHS England.

14. On 03 February 2020 the CCG had set up a system wide Incident Operational Group to coordinate response arrangements. Exhibited is the presentation given at the

Operational Meeting of 03 February 2020, when key figures at the CCG were briefed on the unfolding situation **[Exhibit: AS/04 / INQ000504922]**. The agenda, minutes and actions taken from the Operational Meetings held on 03 February and 14 February are exhibited **[Exhibit: AS/05 / INQ000504923] [Exhibit: AS/06 / INQ000504924]**.

15. As the incident progressed, the CCG moved its incident response into incident command and control, moving into a level four incident. The response needed to move within the overall CCG governance arrangements due to the scale of the incident, particularly when it became clear that the executive team needed to be signing off elements of the response.

16. On 20 February 2020 the CCG published Minimum Operating Standards for patient pathways during the pandemic. It set out that the initial phase will involve the isolation of all individuals testing positive for Covid within the High Consequence Infectious Disease network. This was a live document which was updated multiple times as the situation developed **[Exhibit: AS/07 / INQ000504356]**.

17. On 08 April 2020 the Governing Body formally approved a paper that set put the governance arrangements that would apply during the period of emergency response to the pandemic **[Exhibit: AS/08 / INQ000504863]**. On 14 April 2020 the CCG were informed by NHS England that it was to become the leader for health within the Local Resilience Forum, representing healthcare at any Covid related Strategic Coordinating Group, Tactical Coordinating Group or system wide meetings **[Exhibit: AS/09 / INQ000504902]**.

18. The revised governance arrangements authorised all Governing Body and committees to meet on a virtual basis. The Governing Body would continue to meet on a bi-monthly basis (as scheduled) with additional extraordinary meetings convened as required. The governance arrangements also provided that weekly briefing sessions would be held with the Governing Body members on a virtual basis to ensure that the Governing Body was kept up to date with the CCG's management of the Covid outbreak. The Governing Body's virtual meetings and weekly briefing sessions focused on key items including finance, transformation, quality and statutory compliance, workforce, key risks and mitigation and communications.

19. The governance arrangements suspended all non-business decision making, with a monthly review of requirements and business critical items. All committees retained the ability to meet on a virtual basis to consider business critical matters.

20. A fully operational Incident Co-ordination Centre was established in the week commencing 09 March 2020, following NHS England requirements of an Incident Management Team seven days a week and a 24/7 single point of contact. This was supported by a number of specialist cells covering primary care, clinical quality and safety, logistics, capacity planning, business continuity and service change.

21. The Executive Team were meeting daily in the initial stages of the pandemic, which was moved to weekly when there was no longer the need to meet daily. This was the decision making body and they also called extraordinary meetings as required by the governing body. The Executive Team had responsibility for value sign off and agreeing to CCG actions.

Specialist Cells

22. Below the Executive Team was the Covid Incident Management Team, which was chaired by Sarah Carter who was the Incident Director. The idea of the Covid Incident Management Team was to coordinate the CCG cell leads in a single forum and Sarah Carter acted as a conduit into other tactical groups. The Covid Incident Management Team brought together cell leads to talk about progress in the CCG's incident response, what intelligence was coming through the various cells and how we needed to respond to and mitigate risks.

23. The Health and Social Economy Tactical Co-ordinating Group focused on the clinical and social aspects of the pandemic and was chaired and facilitated by the CCG. Its membership comprised of tactical managers and resilience practitioners from organisations involved in health and social care. The cells reported into this group. Exhibited are its Terms of Reference **[Exhibit: AS/10 / INQ000504865]**.

24. The cells were functional groups of individuals with the key task to support the overall Covid response of which, with regards to PPE, was to source, store and distribute equipment to meet the needs of health and care partners across the system that

were not being served by other local or national infrastructure. They acted as the place where expertise was centralised in responding to different elements of the incident. A significant proportion of their work was the provision of advice on the use of PPE based on national guidance at the time. The cells had a level of delegated decision making and were given a budget.

25. The CCG had a Quality Safety and Clinical Support Cell which included IPC specialists which provided expert IPC advice to all cells and supported the development of clinical and practical guidance. It oversaw and supported the deployment of clinicians from within the CCG into frontline care and provided support as part of the CCG enhanced offer of health and care support to all care homes and home care. The Duty Cell Manager provided a daily presence in the incident management room. The daily incident response ran on a seven day rota where they were on call. In normal circumstances IPC teams work office hours over five days. Exhibited are the Terms of Reference of the Cell **[Exhibit: AS/11 / INQ000504914]**.

26. There was a Care Homes and Home Care Incident Management Cell to support the provision of ongoing care to people in receipt of home care or resident in a care or nursing home. Their role was to ensure independent care homes and care home providers were supported and linked into NHS England guidance and support. The Cell provided a daily presence in the incident management room. It also ensured that the CCG was providing practical support to the sector and liaised with care home and home care system partners to ensure actions were taken to support resilience and delivery. Exhibited are the Terms of Reference of the Cell **[Exhibit: AS/12 / INQ000504872]**.

27. The Service Change Cell was the focal point for review of all service change proposals collated by the Incident Management Team. It would rapidly consider and critically evaluate any opportunities for service change and improvement to ensure a sustainable and effective response to the emergency. The Service Change Cell gave the corporate sign off if a supplier wanted to move towards virtual working, agreed to services being changed and approved patient transport decisions. Exhibited are the Terms of Reference of the Cell **[Exhibit: AS/13 / INQ000504918]**.

28. The Health and Social Care Tactical Co-Ordinating Testing Cell worked collaboratively across the Nottingham system to ensure an effective response to testing requirements and that all operational, scientific and clinical issues were

addressed. The Cell was responsible for coordinating the testing of key workers and other key individuals to ensure that the CCG could maintain critical services and prevent the spread of the infection. Exhibited are the Terms of Reference of the Cell **[Exhibit: AS/14 / INQ000504920]**.

29. The Business Continuity Cell was responsible for ensuring that the CCG managed an effective response to the incident and that it delivered business critical functions. The Cell operated seven days a week and held daily virtual meetings of the Business Continuity Core Group at 9am to review progress against the action log. It would review the staffing situation and receive a daily staffing situation report by 10am and then produce a situation report by 11:30 which would feed into the Incident Management Team meeting at midday. Exhibited are the Terms of Reference of the Cell **[Exhibit: AS/15 / INQ000504871]**.

30. The CCG had a data cell which was looking at the number of cases recorded. At the start of the pandemic the number of positive cases in Nottingham and Nottinghamshire was going up and that was fed into the Covid Incident Management Team.

31. A Primary Care Recovery Group was established, to sit alongside the cells and support co-ordination across GP Practices (which are independent businesses). It was through this Group that risks, supplies and planning for primary care, in relation to PPE could be discussed. Exhibited are the Terms of Reference of the Group **[Exhibit: AS/16 / INQ000504869]**.

CCG's dealings with national bodies

32. The CCG did not have direct workings with DHSC except from through a military figure who was assigned to us in the second week of April 2020. That person was our conduit for reaching into DHSC and through them we attempted to communicate upwards the frustration at the level of availability of PPE from the NHS Supply Chain and the national contingency stocks. They also provided support through the provision of systems advice and helped effective interface with the Local Resilience Forum. The full description of the Military Liaison Officers is set out in a 08 April 2020

email from Roz Lindridge, the NHS England Director of Specialised Commissioning and Health and Justice **[Exhibit: AS/17 / INQ000504919].**

33. The frustration with the availability of PPE was particularly acute in March and April 2020 when the CCG was unable to access any PPE from the NHS Supply Chain and National Contingency Stocks. At this stage there was a sense that CCGs were a forgotten part of the system, as opposed to large Hospital Trusts who were regular NHS Supply Chain customers and could access PPE on a business as usual basis. There seemed a lack of appreciation of the component parts of the NHS and that the CCG was responsible for supplying PPE to frontline staff working at GP surgeries, employed by Personal Health Budgets and providing patient transport.

34. By June 2020 it felt as though there was a greater acknowledgement of our needs. However, there were still further challenges in getting full recognition of the complexity of the responsibilities that the CCG had regarding frontline staff. Before the pandemic the CCG was not a regular NHS Supply Chain customer, and the Supply Chain was prioritising pre-existing customers. As a result, what supplies the CCG did receive were inconsistent and almost always fell well short of demand. There were instances where the CCG were receiving one box of protective gloves a week for GP surgeries that served thousands of patients.

35. A further difficulty that the CCG faced was that, when PPE guidance changed, it would create a new demand and the CCG would have to quickly jump on a new supply chain. As the CCG was not previously an NHS England Supply Chain customer, this was something that we had never experienced before. During the early stages of the pandemic the guidance was changing frequently, and with each revision of the guidance the CCG had to then consider how that related to supplies. If the CCG was supplying a certain type of PPE to a GP surgery and the national guidance changed, then we would need to come off one supply chain and on to another to reflect the change in guidance.

36. NHS England would cascade information down to us. There was an NHS England person assigned to us that we were able to escalate things through and we would raise issues such as a lack of the PPE supplies that were urgently required. At the start of the pandemic there was a real level of fear amongst frontline staff, particularly BAME staff, as there were several communications around this time of them being at a greater level of risk.

37. A further concern was that the national message in the early stages of the pandemic was for people to keep away from hospitals and instead contact their GPs. However our experience was that nowhere near the required amount of PPE was being provided to GP surgeries. There were periods early on during the pandemic in which the CCG was giving out single boxes of PPE at a time. The CCG would provide a GP surgery with a days' worth of stock, which required replenishment after 24 hours. The CCG were procuring its own PPE supplies to supplement what it received from national supplies, but what the CCG managed to source was not enough to bridge the gap to frontline demand.

38. Through our NHS England conduit we could emphasise the situation and conditions that the CCG was working under, and this was a route of escalation in line with regional coordination of the incident. The CCG incident response arrangements were part of the overall NHS command and control structure, with NHS England Midlands establishing their incident management team and incident coordination centre on 24 February 2020.

39. While we were able to escalate our concerns, it felt as though NHS England were limited in what they could do to practically support the CCG. There would often be occasions where the CCG would raise an issue and gain acknowledgement from NHS England, but no solution would be forthcoming. We would often hear that there was limited stock and there had to be extreme caution in how that was distributed. The sense we got was that intensive care units were heavily prioritised over CCGs in the distribution of stock.

40. From March 2020 NHS England would hold regular webinars, these were helpful and gave the CCG a greater understanding of how the situation was unfolding nationally and how we should interpret guidance locally. They also provided an opportunity to escalate concerns. The CCG always ensured that at least one person was at these sessions, as they were key in receiving updates. Exhibited are the Daily Customer Update webinar slides for 23, 24 and 25 March 2020 **[Exhibit: AS/18 / INQ000504877] [Exhibit: AS/19 / INQ000504878] [Exhibit: AS/20 / INQ000504879]**.

41. Following these webinars, executive updates would be provided by the staff members who attended. Exhibited are the updates provided on 06 February and 14 February **[Exhibit: AS/21 / INQ000504904] [Exhibit: AS/22 / INQ000504903]**.

42. At the outset of the pandemic, Public Health England provided expert opinion for the CCG to act on and contributed to EPRR meetings. The guidance updates received by the CCG came through Public Health England central reporting, however this did not always align with local Public Health England teams. During January and February 2020 updates received from Public Health England provided expertise to the EPRR teams locally on the progression of the virus and the level of risk. Exhibited is the Public Health England Situation Report as of 29 January 2020 **[Exhibit: AS/23 / INQ000504866]**.

43. Local decisions were initiated based on national Public Health England guidance, where this existed, then local Public Health England would be asked for final comments. The Public Health England Consultant in Communicable Disease would respond to these questions, sometimes via the Senior Health Protection Practitioner. Email responses were slow as inboxes were busy, so calls were often used. However, availability was difficult due to numerous system calls, so responses were not always timely. In the absence of national Public Health England guidance, local IPC leads would collaborate and develop local guidance, with the involvement of local Public Health England, based on their own experience and expertise.

44. As the pandemic progressed, there was a perception that Public Health England were struggling with capacity to provide dedicated input. Resources were stretched, and timely communications became more difficult due to the overwhelming workload for IPC in both the CCG and Public Health England.

45. While guidance initially came via Public Health England, NHS England then started to produce guidance for primary care. This was not applicable to care homes, so advice started to differ between primary care settings, particularly when DHSC also started to issue guidance.

46. Much of the Public Health England guidance relied on links and sometimes these were broken or did not link to the updated versions of the guidance. This had to be escalated on numerous occasions to ensure that information the CCG was receiving was consistent and correct. The repeated use of multiple links in Public Health England guidance became very difficult to navigate.

47. A consistent theme with the early guidance was that it was focused on acute Trusts and not community settings. There was confusion as to which mask was needed as part of PPE precautions community nurses should take for confirmed cases at home.

48. We initially had limited communication with NHS Supply Chain. Much of the CCG's procurement of PPE was, through necessity, within our systems and we were looking for mutual aid opportunities and to collaborate with local supply teams. Before March 2020, the CCG had never purchased PPE so we couldn't access this via NHS Supply Chain ordering processes. Hospital Trusts who had a history of buying as business as usual customers were prioritised for PPE and it took a while for the needs of CCG's and primary care to be recognised.

49. As part of the process to distribute the national pandemic contingency stocks, a process known as 'push stock' was established by DHSC. This involved palletised delivery of PPE items being sent out to systems based on an estimation of need and to try and ensure a fair distribution of products across the UK. However, the CCG never knew what it was going to get at any point in time. The push stock allocation did not meet the CCG needs in what was a rapidly moving situation. There appeared to be little central co-ordination of the distribution of the national pandemic stock and the NHS Supply Chain ordering and delivery.

50. The NHS Commercial Directorate had oversight of the NHS supply chain and other procurement in the NHS. We had regular contact with them to explain the situation on the ground from a CCG perspective and what was required. There was a constant theme of the CCG telling the NHS Commercial Directorate and NHS Supply Chain what the problem was and them being unable to provide a solution.

51. During the pandemic, and to this day, the CCG was part of the local system procurement support network. CCGs without a transactional procurement department would heavily utilise NHS Commissioning Support Unit to supplement procurement resources and share intelligence of product availability.

Guidance

52. During the pandemic the CCG received a wide range of guidance from statutory, regulatory and other healthcare bodies. National guidance was primarily issue by Public Health England, NHS England and DHSC.

53. One of the main challenges faced by the CCG in interpreting national guidance was that the guidance often did not reflect the situation in the UK supply chain in terms of the actual availability of PPE. Prior to the pandemic the CCG has never previously procured PPE as in normal circumstances providers would source their own PPE. In implementing the large volume of guidance received, the CCG was challenged by the absence of national pandemic stock for particular facemasks, such as fluid resistant surgical masks, FFP3s and goggles which were previously rarely used in Primary Care. As a result, the CCG did not have PPE stocks to meet the need of all primary care settings, or other care settings outside NHS hospitals.

54. The CCG received the first PPE guidance at the beginning of March 2020. The quality of the guidance was, in general, good. However, there was a high volume and changes to that guidance within a short period of time. During the early stages the guidance was changing frequently, and it wasn't always clear when amendments had been made. As a result, trying to get clarity on guidance before it was cascaded down to staff was difficult. Throughout March and into April there was an extremely high volume of guidance being issued, much of it around Aerosol Generating Procedures, which was causing a lot of challenges within the CCG.

Initial guidance

55. The first IPC guidance was issued in January 2020 from the World Health Organisation and Public Health England. This guidance mainly related to IPC requirements for assessing those returning from affected areas overseas, or those confirmed as cases or contacts. A significant proportion of care home staff were from overseas and many were travelling back to the UK, or had recently done so, in the early stages of the pandemic. Public Health England "Key Messages" guidance was published on 31 January which focused on NHS preparedness, reparation, and quarantine, testing and travel advice **[Exhibit: AS/24 / INQ000504898]**.

56. In January 2020 Public Health England published a Q&A blog which was updated during the early stages of the pandemic regarding advice for those who had recently returned from Wuhan. As an indication of how fast the guidance moved during the initial weeks, the CCG was sent an email on 29 February which updated previous Public Health England guidance issued on 24 January that was already out of date **[Exhibit: AS/25 / INQ000504917]**. Attached to the email was the latest version of the

poster issued by Public Health England for use in universities and other appropriate community settings to reflect the updated advice to the public **[Exhibit: AS/26 / INQ000504880]**.

57. When the first cases started being reported in the UK, much of the advice on planning and preparation came from the Consultant in Communicable Disease Control in the local Public Health England team. Prior to more detailed guidance being issued, there was no view that anything needed to be done by the CCG outside of ensuring providers carry out their normal actions and help coordinate a system wide response.

58. At this stage, the CCG was managing with existing arrangements and expectations which were that providers source their own PPE. However, it was quickly identified through the Local Resilience Forum and the Health and Social Economy Tactical Coordinating Group that the CCG should maintain its own supplies of PPE, particularly where it anticipated supply chain issues. The CCG began to source suppliers, which it had never done before. The CCG was ordering PPE based on experience and an understanding that Covid was a respiratory illness and was not required for all contacts.

59. Early guidance on the management of suspected cases from Public Health England differed between Primary and Secondary care settings. Guidance issued on 07 February 2020 stated that suspected cases in Primary Care should be isolated, however there was no requirement for PPE to be worn. For Secondary Care, the guidance provided that a patient be placed in respiratory isolation and that PPE be worn by any person entering the room **[Exhibit: AS/27 / INQ000068933]**.

60. On 16 March 2020 NHS England launched a daily webinar series to Trusts and providers, advising of their business continuity planning and informing on the latest product guidance from Public Health England. These did provide helpful context of the national picture, however they did not consider providers who weren't receiving PPE from the NHS Supply Chain and/or not regularly sourcing supplies. Therefore they did not provide practical guidance for the CCG to procure PPE as we were having severe difficulties in accessing the NHS Supply Chain. They did not appear to recognise the wider challenges for health and care providers in being able to access PPE as per the guidance, in a context where staff were fearful of the risk.

Interpretation of the guidance

61. The CCG disseminated national guidance through the Command and Control structure. There was also the Central Reporting System led by the Local Authority which the specialist cell leads fed into. The Quality and Safety Cell had various leads which would send out guidance to Primary Care settings.

62. Guidance changed frequently, sometimes over the same day and it was not always clear when amendments had been made. Over time, due to the high volume of guidance being issued, new guidance became increasingly reliant on multiple links to other guidance, and sometimes the links didn't work or linked to out of date versions. These errors were raised through local Public Health England leads or NHS England for amending.

63. The use of multiple links added confusion as they were easy to miss. Not all of the Public Health England guidance updates had the changes listed on the webpage. This meant that the whole guidance had to be read over to find what were, in some cases, only very minor alterations. This became frustrating for IPC leads and providers as this was time consuming during a very busy period.

64. A letter dated 28 March 2020 from NHS England refers to the aim of the multiple organisations to work together to make guidance clearer for clinicians. It stated that over the coming days Public Health England, NHS England and NHS Improvement and DHSC in conjunction with devolved administrations would work with the Academy of Royal Colleges to ensure the guidance is clearer for clinical colleagues. This included organising the recommendations using a "place-based approach" to make it easier to understand the PPE requirements. The letter references earlier feedback about PPE supply and delivery and indicates that the issues raised were being dealt with **[Exhibit: AS/28 / INQ000130506]**.

65. On review, this was not dealt with. The different agencies continued to issue their own versions of guidance, and this led to gaps when some were updated causing inconsistencies. The volume of guidance issued remained high between 2020-2022 and the feedback from IPC leads was that there were too many organisations sending out guidance and that having one central reporting centre would have been easier to navigate and would have potentially reduced variation, confusion and conflicts. In addition, the fact that guidance was cross referenced to other

organisational guidance such as NHS England and Public Health England continued to cause confusion and frustration.

66. What made implementation more challenging was that when the guidance came out, it was with effect from that point in time. We would put out communications to staff, but we struggled to manage the immediate demands and extremely limited supplies.

67. There was a pattern of IPC and PPE guidance being issued and then frequently updated, which continued over the first two years of the pandemic. Guidance was often released on a Friday afternoon or before a Bank Holiday Weekend which added to the pressure and confusion of those on the ground, particularly on care homes. As an example of how frequently guidance was updated, the Coronavirus (COVID-19): admission and care of people in care homes guidance was first published on 02 April 2020 and changed a further 29 times. Other related guidance changed, this included testing guidance and DHSC guidance on ordering PPE changed 47 times up to July 2022. Guidance COVID-19 How to work safety in a care home also changed 18 times between 01 April 2020 and June 2021.

68. There were differing sites for Public Health England guidance, one for professionals via a link and one for the public. This sometimes made it difficult for professionals to find the guidance they needed if they were not familiar with how the guidance was issued. The Public Health England site was not easy to navigate, and it was hard to find the relevant section of guidance, particularly as the pandemic progressed and there was an increasing volume of guidance for specific settings, and these were often located in different areas.

69. When the guidance changed there was always a challenge in reinterpreting the new guidelines. DHSC sent out a table setting out what PPE was to be used, but the CCG was often having to interpret guidance that was written from the point of view of NHS Hospital Trusts into what it meant for services which were community based. Often the guidance would not cover primary care scenarios such as care homes, house bound patients or patients covered by Personal Health Budgets. Furthermore, as the pandemic progressed, there was a disconnect between NHS England guidance for Primary Care and guidance that was issued to care homes through Public Health England. It proved challenging interpreting the guidance as to who should be wearing PPE, in what scenarios and how that related to the supply we had available.

70. The CCG would prioritise PPE stock based on the level of risk for different contexts and staff groups in response to the guidance, activity and capacity. We would look at the guidance to see what the change was, what our supplies were, the size of the practices and therefore what we could distribute. The CCG were sourcing and distributing PPE to multiple providers of health and care services, which was a significant undertaking considering we were not previously sourcing, purchasing or distributing PPE.

71. There was also additional frustration when changes to the guidance were shared with the media and reported in the national news before those on the ground had sight of those changes. As exhibited in an email of 15 April 2020, changes to care home resident testing were in the news in the morning before clinicians on the ground received communication or guidance on implementation **[Exhibit: AS/29 / INQ000504896]**.

72. It was not until around the end of April in which the supply of PPE caught up with the guidance. Even when we got the supplies through national ordering and the Local Authority Local Resilience Forum, it was still not enough, and we were still having to order supplies in addition to what we were getting through those routes.

Conflicts in the guidance

73. Guidance was being updated as more information became known, however there was a feeling that some of what we were receiving was not consistent with previous advice. The CCG had the contracts and overall responsibility for nursing in care homes. We were aware that Covid was a respiratory infection, and that Acute Trusts were being instructed to take standard precautions that included facemasks, with enhanced protection FFP3 and long sleeved gowns for aerosol generating procedures. IPC leads in community settings raised concerns regarding the early guidance that was issued to care homes. Public Health England guidance published on 25 February 2020 stated that face masks do not need to be worn in care home settings. This guidance was contrary to existing advice to minimise the transmission of respiratory tract infections in care homes (for example influenza like illness 2018) which stated that facemasks/FFP3 be used for aerosol generating procedures **[Exhibit: AS/30 / INQ000223342]**.

74. This guidance was confusing and hard to justify, and left IPC specialists conflicted as they had knowledge of the existing guidance in place at that time. Staff working in care homes felt uncomfortable with the Public Health England advice, and there was a feeling that it was seeking to preserve PPE stock for acute Trusts, rather than it being the correct advice to follow. My recollection is that our Public Health England local IPC contacts held a similar view. The 25 February guidance was replaced on 13 March with new guidance for supported livings and care homes that included mask use alongside other PPE. This guidance was updated three times and was then replaced in April 2020 with guidance for specific settings.

75. On 29 April 2020 Public Health England provided guidance on managing Covid in the care sector, confirming that PPE requirements were in place for contact with people with or without symptoms. It stated that fluid resistant surgical masks should be worn when providing personal care in a care home which requires a staff member to be in direct contact with a resident and surgical masks should be worn when providing care or working in communal areas where there is no direct contact with residents **[Exhibit: AS/31 / INQ000504875]**.

76. There were some tensions between the CCG and care home managers, primary care, and IPC staff around PPE use and testing, as the CCG was sometimes considered to be responsible for the guidance issued by Public Health England. Some of the early guidance focused on hospital discharges to free acute beds. This led to further tensions and conflicts as care homes were trying to protect their residents, but were under pressure to take untested patients and, until the guidance changed, were doing so without facemasks.

77. There was a conflict in guidance over the prioritisation of FFP3 masks between Public Health England and the Resuscitation Council. The conflict related to whether chest compressions amounted to an Aerosol Generating Procedure. In response to anxiety induced demands from primary care for FFP3 masks that weren't reflective of the supplies available, the CCG referred this to the NUH ethics committee. The Ethics Committee set out that, in the CCG's efforts to achieve the national guidance, prioritisation of FFP3 and FFP2 masks should first be given on a factual need to those actually carrying out an Aerosol generating Procedure as per the national guidance. Prioritisation should then be given on expected need to those most likely to

need to carry out an Aerosol generating procedure, with the higher the likelihood, the higher the priority. Providing FFP3s to those undertaking procedures outside of the guidance was harder to justify, given the national shortages, unless the needs of those carrying out, or expecting to carry out Aerosol generating Procedures, had been met **[Exhibit: AS/32 / INQ000504883]**.

78. The Ethics Committee noted that the contradictory guidance was not helpful and put moral responsibility unfairly on healthcare professionals and providers.

79. If we had no supply issues around FFP3 masks, then the CCG wouldn't have had to take anything to the Ethics Committee, because we would have been in a position to distribute the relevant supplies of FFP3 masks. However, the national shortages meant that the CCG had to consider how to prioritise the supplies that we had alongside the interpretation of the guidance.

80. The CCG, alongside the Local Authority, drew up a prioritisation matrix, but this was never fully implemented, largely because the supply of PPE increased as we entered summer 2020 and it became easier to make decisions around prioritisation.

81. There was also a conflict in guidance from the Health and Safety Executive regarding health and safety at work. There were issues around whether we needed to fit test FFP2 masks. The Health and Safety Executive had standards about PPE but then there were expiry dates and fit testing requirements, which were different from what the Health and Safety Executive would say from an employment perspective. It was later confirmed that fit testing was needed for FFP2 masks. However, consideration was not given to using FFP2 masks as there were no supplies available.

82. A further challenge that the CCG faced in the initial stages of the pandemic, in addition to a lack of clarity around supply and availability, was around single usage. This unfolded through March, where it was initially unclear on whether masks were single use or could be used consistently, causing the CCG significant problems. Guidance was issued on 02 April 2020 that described single use/sessional use for masks and facial protection. Defining sessional use created challenges for IPC and those working in the Quality Safety and Clinical Support Cell.

<u>FFP3/Fit testing guidance</u>

83. In early February the CCG IPC leads were sourcing FFP3 masks and were starting to fit test staff. The fit testing needed to be sourced, as it was not a function previously carried out by the CCG. On 14 February 2020 the Sherwood Forest Hospitals Foundation Trust supported the CCG in providing fit testing training to staff.

84. As the need to have fit test kits in place and staff trained to fit test others became clear, the CCG put orders in via Citycare for FFP3, other PPE and test kits. A very small supply of FFP3 masks were sourced from Nottingham University Hospitals NHS Trust. Much of this early work relied on our close working relationships and expertise within the local community as there was limited guidance supporting the sourcing of PPE. At this time the requirement for PPE was only for a limited number of community staff when they were carrying out swabbing.

85. In the middle of February, the discussions around PPE were in relation to testing stations where people could drive in and have a Covid test. The CCG had very early testing and at that point the guidance was saying everyone involved in testing needed to wear full FFP3 masks, aprons and gloves. However, DHSC guidance was still saying that PPE was not required for Primary Care and that they should only be using PPE for cleaning.

86. On 13 February 2020 it was announced that supply chain and guidance needed to move hand in hand. However, around 20 February concerns started to be raised about shortages of FFP3 masks. These were mostly coming from providers as, at that point, the national message was that there was no shortage of FFP3 masks, however local intelligence had begun to highlight shortages in the deliveries they were receiving **[Exhibit: AS/33 / INQ000504874] [Exhibit: AS/34 / INQ000504913]**.

87. At the end of February DHSC announced that it was moving to the next level of preparation and the beginning of March is when we formally set up our Incident Command Centre. After this point things moved towards being more nationally co-ordinated. While there was still no specific FFP3 guidance at this point, we were being told that there was a very large reserve of PPE in the UK.

88. It was 03 March 2020 when we received the first formal guidance on the use of PPE. It stated that Covid was a highly infectious disease, and that full PPE requirement would change based on scientific evidence. The guidance expected fluid resistant

face masks (Type IIR) and plastic aprons to be utilised in GP practices. It recognised that they needed to get the supply out but stated that there wasn't a shortage, and it would be delivered on a regular just in time basis.

89. At this point a lot of GP practices didn't even have standard surgical masks and there were questions around whether the masks had to be fluid resistant or whether they could be just surgical. There were Type II (surgical) and Type IIR (fluid resistant) masks which raised questions around the guidance because all the interactions up to that point had been about FFP3 masks. The guidance then changed to refer to fluid resistant face masks, which didn't seem to align with what was being said about transmission.

90. The CCG were informed by DHSC that they would send out PPE packs to practices. However, these packs did not contain anywhere near the amount of PPE required for full compliance with the guidance (at this point there was not clarity on whether PPE had to be changed in between interactions with different individuals). Many practices received one box containing around 50 masks, which were basic surgical masks that didn't fit tightly and not reflective of the perceived need for protection due to the fact that FFP3 masks had been advised for usage in previous contexts for the guidance.

91. On 12 March the CCG were informed by DHSC that they were treating the virus like the flu. Handwashing was highlighted as being absolutely critical and it was confirmed that fluid resistant masks and FFP3s were required in high risk areas. This felt like a pinnacle point where there was a greater sense that the shortages of PPE were becoming evident and that it wouldn't be possible to manage the guidance to date on a wider scale and to a broader cohort.

92. This was followed by guidance on 20 March 2020 "FAQs on using FFP 3 Respiratory Protective Equipment (RPE)" which set out that, due to the sudden increase in demand to use FFP3 masks, the supply chain was using supplies put aside for pandemic flu **[Exhibit: AS/35 / INQ000339128]**. The guidance assured as that these masks offered the same level of protection but were a different design and model. Guidance was then received from DHSC which said that in Hospitals those who were positive should be segregated from those who were negative in order to use the least amount of PPE. That was the point where the guidance switched from saying the UK had sufficient PPE stocks to encouraging minimal and careful usage.

93. The 20 March guidance also stated that FFP3 masks were only required when managing a patient with possible or confirmed Covid who is undergoing an Aerosol Generating Procedure and when there were Covid patients in a high risk unit. It was explained that the change of guidance was due to evidence showing that Covid was transmitted through respiratory droplets or by touching a surface also touched by an infected person. As a result the new guidance stated that, when delivering direct care, a Type IIR mask would provide adequate protection.

94. On 20 March Paula Longden, the Deputy Locality Director of Mid-Nottinghamshire Integrated Care Partnership sent an email stating that their practices were continuing to push back that the level of PPE was insufficient. The letter outlined that, despite being provided with the guidance, practices needed more reassurance. On 22 March, CCG management were copied into an email from Dr Thilan Bartolomeuz, the Clinician Lead of the Mid-Nottinghamshire Integrated Care Partnership. The email stated that there was growing anxiety across healthcare **[Exhibit: AS/36 / INQ000504891]**.

95. The 22 March email references a letter sent the previous day by the BMA to the Prime Minister, raising concerns regarding the inadequacy of the provision of PPE to the medical profession. It outlined reports from the frontline of doctors not being provided with the correct type or enough PPE and called for clarification from Public Health England on the discrepancy between the level of PPE recommended in IPC guidance and that of the World Health Organisation as was being used in other nations **[Exhibit: AS/37 / INQ000097910]**.

96. There were also issues in Primary Care caused by the move from full FFP3 masks to surgical masks, with staff members feeling unsafe, in particular the BAME community due to a perception of that group being at greater risk. What was not sufficiently considered in the guidance was how to apply risk based decision making alongside the ongoing supply issues. Practices would make their own risk based decisions, attempting to balance staff safety and patient care.

97. The CCG sent out a template to Primary Care providers to get an understanding of where there was an issue and who needed extra PPE. Ultimately, prioritisation was a decision for practices based on health and safety at work and for the CCG it was how to respond to that in relation to our own supplies at the time.

98. Around this stage in March 2020, the CCG was receiving masks that were beyond the manufacturers use by date and, in some cases, with stickers where a later use by date had been put over the original printed date. In March 2023 the CCG received a supply of facemasks from the national stock which were date stamped with 2016. Initially, we were unsure where in the supply chain this had been done and there was nervousness about them being safe and effective for use, as exhibited in an email chain in late March **[Exhibit: AS/38 / INQ000504916]**.

99. However, the 20 March guidance also confirmed that products appearing to have out of date use by or expiry dates or were relabelled remained fit for purpose and had passed stringent tests. The guidance stated that NHS England had been working with independent test facilities and the Health and Safety Executive who, after being provided with scientific evidence, were content with the assessment that they were safe to use by NHS staff **[Exhibit: AS/39 / INQ000330809]**.

100. However, what was not known was how long past the expiry date the confirmation of adequacy was valid for. As a result, from May 2020, the CCG recommended that out of date masks not be distributed beyond three months of being received by the CCG.

101. The guidance and shortages in supply also presented difficulties around the prioritisation of supplies for FFP3 masks and how to manage them for primary care settings and resuscitation, staff at a higher risk and specialised care homes. The CCG also had to consider Personal Health Budgets and those receiving care at home, particularly when it involved aerosol generating procedures.

102. The CCG had responsibilities for a number of specialist care homes providing nursing care for patients with tracheostomies and ventilators, where FFP3 was needed for aerosol generating procedures. There were specialist patients having home care and those with Personal Care Budgets also needing FFP3 in the community.

PPE supplied by the UK government / DHSC

103. Before the pandemic and the move into a national emergency, the CCG had never procured PPE. We therefore did not have any of our own existing contracts or suppliers for PPE. We were, in that sense, starting from ground zero. We had a broad understanding of what PPE was, but our knowledge of it was limited, particularly in relation to the different mask types.

104. As set out above, the guidance changed as the incident progressed and there became an increasing number of settings where PPE had to be provided. Guidance was updated to reflect the pandemic evolution and the changing level of risk exposure in health and social care settings. The CCG's processes for sourcing, purchasing and distributing PPE therefore had to respond accordingly, along with availability and cost of supplies. The settings in which the CCG provided PPE included:

a. NHS Bassetlaw CCG (part of Nottinghamshire LRF but a different CCG)
b. GP Practices across Nottingham and Nottinghamshire
c. Care homes
d. CMCs – central assessment centres in primary care
e. Out of Hours/GP home visiting services
f. Dental Hubs
g. Optometrists
h. Pharmacists
i. Care Agencies
j. Personal Health Budgets
k. Hospices
l. Community services
m. Patient Transport Services

105. The products that were sourced by the CCG included:

a. Masks – FRSM, FFP2/KN95, FFP3 (disposable and reusable)
b. Goggles – disposable and reusable
c. Visors – disposable and reusable
d. Gloves
e. Aprons
f. Gowns and coveralls – disposable and reusable
g. Scrubs – reusable

h. Fit test kits and solutions
i. Hand sanitiser
j. Disinfectant wipes

106. The CCG maintained an order tracker for all PPE related expenditure from 25 March to 16 October 2020, a copy of which is exhibited **[Exhibit: AS/40 / INQ000504873]**.

107. During the period covered by this witness statement, PPE prices were significantly higher than what they were pre-pandemic and there was an increase in the number of suppliers offering PPE. In those circumstances the CCG attempted to ensure best value in relation to cost, quality, assurance and, where possible, carry out a level of due diligence to ensure the credibility of the supplier and the quality of the product being supplied. However, market conditions were highly challenging. It was a fast moving situation, with PPE often being sold on a first come first serve basis and the CCG had to innovate.

108. The CCG did receive PPE procurement support through the Commissioning Support Unit. However, one of the main challenges we faced was that, while we were a customer of the NHS Supply Chain, we were not one with a history of buying PPE. During the early stages of the pandemic PPE stocks from the NHS Supply Chain were prioritised to business as usual customers, which were typically NHS Hospital Trusts that had been routinely buying PPE. The NHS Supply Chain was focused on getting PPE out to hospitals, A&E and intensive care units and there was a lack of wider understanding about the needs of Primary Care and other providers that the CCG was required to support. As a result, we were largely shut out of the NHS Supply Chain as a route to buying PPE.

109. The CCG therefore had to quickly plan for locally sourcing PPE equipment. While the CCG did receive communications from NHS England regarding alternative wholesalers and distributors, these alone could not meet our needs and we had to meet the gaps that the NHS Supply Chain and National Pandemic Contingency Stocks could not. The vast majority of PPE utilised during the pandemic was sourced locally and we did not purchase any PPE from abroad.

110. During the early stages of the pandemic, the guidance on PPE use changed and the settings and clinical and care groups who needed PPE grew. In March the

guidance expanded PPE usage to primary care, care homes and community providers, and those providers could not access the required supplies. As a result, the CCG was tasked with sourcing supplies as part of the response.

111. The CCG were rapidly having to pull together our own supplies of PPE to distribute to our providers, which is not something we ever did prior to the pandemic or have done since. We resorted to going out to the corporate and education sector to ask for supplies. Colleges and universities in particular donated supplies which was only possible because they were closed.

112. The CCG headquarters, Standard Court, were based in a former Hospital building which had a small storage area and loading bay which we quickly converted into our PPE distribution centre. Through this we could receive, sort and distribute locally donated and procured PPE. In the very early days of the pandemic, the CCG were distributing small quantities of PPE, often with CCG staff using their cars to deliver out to care homes in the local area with one or two boxes of masks. As guidance changed and usage increased, along with sourcing supplies, the CCG subsequently became almost wholly reliant on the voluntary sector for the distribution of PPE, and we coordinated deliveries by volunteer drivers across the local area.

113. Management of the stock room at Standard Court was supported by volunteers from the military and through Team Rubicon UK, who assisted CCG staff in counting the stock, creating inventories, and picking and packing items for delivery. The CCG maintained a tracker of all deliveries to its care providers from 30 March to 12 June 2020, a copy of which is exhibited **[Exhibit: AS/41 / INQ000504906]**.

114. A lack of understanding of the needs of primary care settings was a recurring and frustrating theme of the pandemic response and was felt particularly acutely in the supply of PPE. The CCG experienced problems in registering for the NHS procurement portal once this was implemented. Users such as GP practices and care homes could register. However the CCG struggled to register and there was no recognition that we were registering not to purchase PPE for ourselves, but to give it to other providers and Personal Health Budget patients. It was a challenge to get recognition of why the CCG wanted to be a recognised user.

115. From a national perspective, it felt as though there was a lack of alignment between the NHS Supply Chain, which was the usual way for ordering and receiving

supplies, and the national pandemic contingency stock that was in storage. There did not seem to be a plan for the effective distribution of national pandemic stock and there were issues with getting contingency stock from warehouses across the country out to the point of need.

116. The NHS did have an established distribution system through the NHS Supply Chain. However, as the CCG was not an existing customer of PPE through the NHS Supply Chain, we were excluded in the initial stages of the pandemic. There was insufficient national pandemic contingency stock and, while there was pandemic and flu stock dormant in warehouses, there was often not the supporting logistics infrastructure to distribute it.

117. A push stock process was put in place for the limited PPE supplies that the CCG received from the national contingency stock. The push stock was managed through Local Resilience Forums as this allowed supplies to be allocated to services that required it based on the guidance. Exhibited are the CCG Weekly Distribution LRF Returns for 28 April, 17 June and 26 August 2020 which show the gaps and surpluses in supplies with what was being received through the Local Resilience Forum **[Exhibit: AS/42 / INQ000504910] [Exhibit: AS/43 / INQ000504868]**. The CCG managed supplemented supplies and sourced for all health and care providers listed above, except for care homes which were ultimately supported through the Local Authorities.

118. The push stock allocation was based on population size and delivered on pallets. However there was no visibility of when a delivery would be made or what products were being delivered. As a result, one day you could receive for example nine pallets of hand gel and only one of masks. It was challenging to know when and if what PPE items would be included within the push stock, putting additional pressure on the system and our own local ordering.

119. The Nottingham and Nottinghamshire Local Resilience Forum published a briefing presentation on 14 May 2020 regarding push stock **[Exhibit: AS/44 / INQ000504901]**. This set out the approximate number of items distributed in the previous week, along with stock supply levels and identified risks, issues and escalations. This was accompanied by a Health and Social Care Tactical Coordinating Group Cell Exception Report of the same day **[Exhibit: AS/45 / INQ000504884]**.

120. From April 2020 the CCG started issuing weekly PPE updates, which would outline what we were distributing and current demand. Exhibited are the updates of 30 April, 27 May and 14 July 2020. **[Exhibit: AS/46 / INQ000504909] [Exhibit: AS/47 / INQ000504908] [Exhibit: AS/48 / INQ000504907]**.

121. On 01 April a dedicated PPE Supply Channel was launched for Acute, Community, Mental Health and Ambulance Trusts. From the 05 April Commissioned Healthcare Services, who delivered services in place of NHS Trusts, would also receive pallets of PPE stock. However, as set out in an email from the CCG on 03 April, this did not meet our immediate needs. At this stage we were working on a mutual aid basis locally and with the voluntary sector, which was not sustainable, and GPs and community providers were having to obtain PPE from wherever it was available. The CCG also anticipated further guidance around this time, which would require us to have more PPE across the system **[Exhibit: AS/49 / INQ000504915]**.

122. In an email to the COVID-19 High Risk Response Team dated 02 April 2020, the CCG set out the difficulties it was experiencing with the supply of PPE. NHS Hospital Trusts had been ordering PPE via their normal NHS supply chain route and the DHSC pandemic push stock. Other parts of the health and social care system, such as GPs, Hospices, Out of Hours Providers, Care Homes and Third Sector Providers were struggling to access PPE. The NHS supply chain had struggled to manage demand and seemed to have little understanding of the health and social care system other than hospitals. The exhibited email sets out specific concerns and suggestions the CCG had regarding the NHS supply chain **[Exhibit: AS/50 / INQ000504893]**.

123. One of the key concerns was the lack of visibility on which organisations were on the list. The CCG knew within the Local Resilience Forum which providers needed to be on the list, however we were not consulted on this. We only needed the CCG, Nottinghamshire County Council and Nottingham City Council to register, and those bodies could place the orders and coordinate getting the correct PPE to the right place depending on the procedure being undertaken. We did not want certain providers receiving high specification PPE where this was not needed.

124. An email dated 07 April from the CCG to NHS England details the ongoing issues in accessing PPE that we were experiencing across the system. It sets out

that the last delivery that GP practices had was three weeks prior and that there was no consistency and rationale in what was delivered so practices were running out of supplies at varying rates. The CCG had been supplying PPE to practices from the limited amount we could obtain from the NHS Supply Chain and through sharing across the system and donations. The email also outlined how practices had been ordering through their normal routes but hadn't been able to obtain supplies and called National Supply Disruption Response for urgent pre-packed packs. In only 20% of cases had practices received the packs and even fewer received them within the designated 24 hours **[Exhibit: AS/51 / INQ000504892]**.

125. In anticipation of the ongoing incident challenges the CCG arranged the implementation of purchasing cards via its accounts payable bank (NatWest). The cards had individual transaction limits, monthly spend limits and were restricted for certain categories of spend. These cards were held by key senior managers directly involved in managing the incident. One card was used by the CCG Associate Procurement Director for procurement of PPE. Due to the level of demand and the number of organisations looking to purchase PPE it was a sellers' market and many organisations providing PPE would not do so without prior payment. The procurement card enabled us to buy PPE from wholesalers who would not usually supply and invoice and were operating on a pre delivery payment basis due to the scarcity of stock. This enabled us to make immediate decisions as suppliers would often say that they have a certain number of items of PPE and procurement was on a first come first service basis. The CCG did raise formal purchase orders with a range of suppliers and wholesalers and there were some suppliers supplying on a verbal request and then invoicing after the event.

126. There was a degree of collaboration amongst commissioners and providers across the NHS and local authorities in Nottingham and Nottinghamshire. Market intelligence was shared across organisations. It was not operated as a formal approved supplier list, but intelligence on reliable suppliers would be shared. This also included local manufacturers who opened their operations to produce PPE. It became an informal "lessons learnt" forum and provided a level of wider product and market knowledge.

127. In the wider NHS there was certainly competition for the supply of PPE. There were large hospitals going through stock quickly and while they were trying to help other organisations, there was always a balance of managing their own supplies.

There was information sharing but everyone was making sure they had their own supplies.

128. In May 2020 the CCG published a PPE Strategy to cover the next 12 months as we moved into the recovery phase. The PPE Strategy took into consideration plans centrally and locally with the aim to improve the availability and access to PPE. It set out the CCG would continue to source, supply, and distribute, in line with national guidance, where there is an urgent need across the local system. It would also maintain a stockpile in the event that there was a second peak. The stockpile would be based on an estimate of two weeks to one month's supply **[Exhibit: AS/52 / INQ000504911]**.

129. Trusts had also sought to move to using more reusable PPE due to the challenges in sourcing supplies and the impact of not having supplies in high risk areas. Reusables provided Trusts with PPE that was more readily available and far cheaper than disposable items. As an example, in May 2020 the cost of disposable gowns ranged between £5 to £15 per gown and reusable gowns were £17 to £25. The PPE Strategy set out that the CCG would provide reusable gowns, visors, goggles and masks for relevant settings where this meets the guidance.

130. The PPE Strategy also sought to place greater control on ordering by GP practices through alternative routes, due to the implementation of the logistics and distribution services commissioned nationally from Clipper Logistics Ltd. It set out that, from June 2020, a market price would be provided for products and reimbursement would go up to this price. Products that are not required as per the guidance or part of standard supplies would also not be reimbursed.

FFP3 Masks

131. As the guidance increased settings where FFP3s were required as the pandemic progressed, there was a need for fit testing at scale for services and providers who previously had no knowledge or experience of this. The CCG decided that this needed to be facilitated through the PPE cell. While fit testing was required on a large scale, it also had to be sustainable.

132. An entirely new fit testing set up had to be established. A training provider was sourced to come onto site and provide fit test training as well as doing fit testing.

The CCG set up rooms where fit testing and training took place and established an online booking system for staff and carers to book a session. The CCG took on an individual who was furloughed and volunteered his time, which was again where we were supported by volunteers.

133. As well as communicating to staff in care homes and primary care that they had to be fit tested, the CCG also had to provide fit test training and kits so that staff could be fit tested on an ongoing basis. The CCG organised fit testing sessions which were provided across different locations in Nottinghamshire. This was a significant undertaking for CCG staff. Exhibited is an email dated 20 May 2020 which sets out the list of local GP practices that attended the first fit testing training sessions **[Exhibit: AS/53 / INQ000504887]**.

134. CCG staff were also trained to fit test carers for people with Personal Health Budgets and as part of transition as the pandemic continued. At the time there were 140 Personal Assistants employed directly by Personal Health Budgets. To ensure continuity, the CCG arranged for Personal Assistants to be fit tested with two types of FFP3 masks, with alternatives available for those individuals who could not fit either type. Exhibited is the CCG's strategy for FFP3 fit testing for Personal Assistants employed by Personal Health Budget holders **[Exhibit: AS/54 / INQ000504886]**.

135. In the early stages of the pandemic there was a very limited supply of FFP2 masks, as these were being used in the US. As a result, there was a greater availability of FFP3 masks, but we faced challenges as to their quality and the fact that a range of masks were required to fit individuals. The market conditions at that time meant that the CCG had challenges in procuring the same brand of masks and the brands that most commonly fit the majority of individuals.

136. An additional challenge was that there was a shortage of fit testing solutions at the start of the pandemic. These were needed to fit test staff requiring FFP3 masks. When providers ordered these they were initially out of stock, with supplies improving around April 2020.

137. If the CCG lost a supply source for one type of FFP3 mask, then all staff would require a new fit testing with the replacement manufacturer. At one stage, many of the masks that were supplied through the NHS had a poor rate of successful fit tests, which then meant people were unable to do their job until more supplies

were received. Once the replacement masks were received then staff would have to be fit tested again for that particular brand. The exhibited email from the manufacturer 3M United Kingdom sets out the complexities around fit testing the different types of facemasks **[Exhibit: AS/55 / INQ000504888]**.

138. Where single use FFP3 masks proved not suitable for some people, the CCG did utilise a small number of reusable masks, however these were in limited supply and were expensive. Some members of staff could not successfully be fit tested for a certain mask and therefore couldn't undertake their normal job role and could not come to work or had to be redeployed.

139. A further difficulty the CCG experienced with regard to FFP3 masks was that they were known as KN95s across the US and China and it was a challenge trying to get the equivalent in UK standards. At times we were inundated with offers of KN95s and didn't know if they were the same as FFP3 masks. We would request that IPC colleagues check them but, if we were in doubt, we would not order or distribute them. This was challenging for IPC staff as our experience was with known brands and suppliers. Stocks without branding or homemade items were hard to approve for use. The IPC lead felt under pressure as we knew we had inadequate stocks of PPE.

140. The CCG came under pressure from some of the care homes in the local area as the CCG hosted the infection control team. The CCG were having to support with PPE advice for care homes and were responsible for providing them with information about the facemasks. We were in a position where care homes would have facemasks with Chinese writing on the packages and no CE marking and we could not advise that they use it. However, we also had to make clear that we didn't have stocks from the normal supplies they were familiar with.

141. The CCG had to issue product recalls on Tiger goggles, which were an eye protection supplied to us out of the national contingency stock and had to be quarantined, isolated, destroyed or returned **[Exhibit: AS/56 / INQ000504895]**.

142. We also had problems with the Cardinal Health Type IIR Masks from the national contingency stock where stitching around the nose was coming undone and we had an incident where some of the material came off. On 26 May 2020 the CCG received a summary of five separate complaints relating to the Cardinal Masks and

an investigation that determined that there was a product fault with some of the batches, either with the stitching on the ties or with the foam nose strip. If a product was deficient, it would be isolated, and the issue would be communicated to GP practices **[Exhibit: AS/57 / INQ000504894]**.

Market Research

143. During this period the CCG did not enter into any contracts for the procurement of PPE. The CCG made standalone purchases, often with the same supplier, via raising one off purchase orders and utilising the procurement card and supplier invoices. We managed to build up a trusted relationship with some main suppliers that were local businesses. This was important as it meant that we were confident in a volatile market and gained ongoing insight into the market position. It also helped some businesses to remain sustainable through the pandemic. We never established a call off contract for the supply of PPE.

144. As the procurement of PPE was not a business as usual activity for the CCG, any market research was extremely limited. No PPE was sourced through the normal procurement routes, where the CCG would conduct market research, issue tender packs, and evaluate supplier bids. As the national and international supply chains were not operating normally, neither could the CCG, and we had to think outside of the box and innovate.

145. The CCG went out to local organisations to see how they could work with us. This included the University of Nottingham who designed and worked with manufacturers to produce visors. On 27 May 2020 the CCG wrote a letter in support of the University of Nottingham's nomination for the Royal Academy of Engineering's President's Special Awards for Pandemic Services **[Exhibit: AS/58 / INQ000504921]**. The letter sets out the contribution of the University of Nottingham in meeting the gap that existed in PPE supplies. Particularly early in the pandemic, when supplies of visors were limited, and the University's Centre for Additive Manufacturing and Bioengineering Research Group were instrumental in the provision of 5000 Covid CE marked reusable face shields.

146. While the CCG had no prior experience in sourcing PPE, the people involved were all professionally qualified procurement staff, with a variety of experience in

purchasing healthcare supplies in previous roles. While proportionate due diligence was done around CE marks, market research was simply not an option at this point. There was limited commercial negotiation regarding price, however it was very much a sellers' market as everyone was trying to get the same stock at the same time. The CCG did look at aligning demand with Local Authority partners, as Nottinghamshire County Council had established international links with China.

147. The CCG attempted to undertake what due diligence it could in the context of extremely difficult market conditions. When the CCG entered business as usual contracts with large suppliers outside of the pandemic, then it would carry out substantial due diligence in accordance with standard pre-qualification processes. For example, we would typically examine the past three years of supplier accounts to assess financial standing and ensure that suppliers had all relevant polices, procedures, quality standards and accreditations in place. However, during the pandemic, it was much more informal and on a far smaller scale., and the CCG were ordering one off deliveries for PPE wherever a supplier could be identified.

148. Checks on suppliers were difficult as many companies who hadn't previously supplied PPE were diversifying and adapting their production to produce PPE. Where we identified a supplier that could provide masks, we would undertake some limited checks to see if it was an established company. This would involve a Google search, credit checks and Companies House checks.

149. We did not encounter any incidents of fraud or counterfeiting within our local supply infrastructure. However, as the pandemic progressed, we developed an awareness for the potential of fraud and counterfeit goods through reports in national media.

150. The CCG had a conflict of interest policy which all staff members were aware of. We also maintained a Conflict of Interest Register, in which CCG staff declared all existing and potential conflicts of interest. However, the CCG did not have any identified conflicts regarding the procurement of PPE during the pandemic. Such was the need for PPE at the time, however, that even if a conflict had been identified, it would not have necessarily precluded the CCG from going ahead with an order. We were purchasing PPE from whatever sources we could secure, and it would have been difficult to justify to our providers had we declined a viable opportunity to source PPE.

151. The CCG received all stock that it paid for. There were several occasions where stock arrived late, and colleagues were waiting for deliveries scheduled to arrive before five until ten or eleven at night. There were other occasions where the CCG committed to purchasing PPE from one supplier and then they informed us that the delivery date would be six weeks away, so the CCG would have to look elsewhere for another supplier to fill that gap.

152. There were huge fluctuations in the price of PPE during the pandemic. This was particularly noticeable with Type IIR masks where, in March, we went from paying pennies per mask in a box of 50 to one point where we were paying around £2 per mask. At present, boxes of Type IIR masks can be purchased for £1.17, however at stages we were paying £50 a box.

153. There were points during the early phases of the pandemic when CCG staff would be placing orders for gowns on Amazon. Senior staff would do this on their own credit cards and then claim back the money from the NHS Covid fund. These online orders were hugely expensive, however we were scrambling to plug the gap that the NHS Supply Chain and national pandemic stocks could not fill.

154. The CCG was careful in what it bought not to end up with excess stocks. The CCG anticipated improvements in global and UK PPE stocks and NHS supply and distribution, so when the CCG stood down local PPE infrastructure in summer 2020, there was limited excess stock. When we were winding down our PPE distribution operations, we distributed what existing stock we had left to organisations based on what they had ordered before. The main leftover stock was hand gel, which the CCG had to dispose of rather than distribute. Some hand gel was returned to the original supplier for safe disposal.

155. The CCG did not stockpile PPE during the pandemic, however we held a limited amount of stock at our headquarters based on estimated future demand. We forward bought for two weeks based on previous usage. If we had distributed 50,000 masks the previous week then we would aim to have 100,000 in stock. However, there was a general awareness amongst providers that they should not be stockpiling. We received explicit instructions not to do so on the NHS England Supply Chain daily calls in the initial stages of the pandemic.

156. While this was of limited relevance to the CCG, as we were sourcing most of our PPE from within the local area, we were aware that the NHS Supply Chain were putting demand management on what they would supply.

157. At the point the decision was made to downgrade Covid-19 from High Consequence Infectious Disease status, thereby permitting use of PPE rather than RPE, we were in the thick of it in relation to managing and distributing supplies of PPE. It was at the same time that DHSC/NHS England were saying that they were moving at pace to put in place urgent solutions for PPE and changing the distribution model. FFP3 masks were being prioritised for London Trusts.

158. The CCG did not procure or supply ventilators during the pandemic. We were approached by a few of our providers about sourcing these and directed them to a dedicated NHS email address which linked them with suppliers that could provide ventilators.

159. The CCG did not procure or supply additional stocks of oxygen during the pandemic. The CCG had a home oxygen contract for people who required oxygen and cylinders in their own home, and we did not experience any supply disruption.

Testing

160. On 26 April 2020 we were told in an email from the local Public Health England Consultant in Communicable Disease Control that they had been informed of an offer from DHSC to offer Pillar 2 swabbing to care homes (subsequent swabbing or swabbing of all care home residents). We were asked to nominate on a daily basis care homes who should be prioritised or who want to take up this offer. The offer involved swabs being sent to the home by a courier and the homes would undertake the swabs themselves with the courier picking it up the next day **[Exhibit: AS/59 / INQ000504890]**.

161. Early on the CCG had access to a very limited supply of tests for health and care front line staff, which were distributed to primary care through defined sites. Practices were allowed two tests per practice per week. The challenge was also processing the results which could be managed on a limited basis through the Trusts pathology labs.

162. In a letter of 29 March 2020, NHS England confirmed that, in line with Covid testing policy, testing capacity was to increase. This announced that the number of daily tests available from the coming week was to be double received in the previous week, with further increases to follow. The instructions to Trusts were to identify staff in priority groups such as those working in critical care, emergency departments and ambulance services. We were informed that this would then be expanded into other NHS staff groups as more tests were made available and into other essential public services including social care **[Exhibit: AS/60 / INQ000410627]**.

163. The CCG established a single testing cell for lateral flow tests to approach care home testing, staff testing and testing for the population in Nottingham and Nottinghamshire. This service went live from 04 May. The CCG delivered tests via CityCare and NHCFT to deliver to care homes and test residents as well as provide a mobile testing unit for staff when Public Health England notified us that we had suspected cases **[Exhibit: AS/61 / INQ000504889]**.

164. At this stage the CCG had a significant role in co-ordinating tests but very limited control on the supply of tests. A contact centre had been set up to manage calls on testing.

165. On 06 June 2020 DHSC wrote to Directors of Public Health and Directors of Adult Services, as well as Trusts and CCGs, regarding the extension of eligibility for whole care home testing to include all care homes for adults. On 03 July DHSC wrote again to confirm that they had rolled out whole home testing to all care homes registered on the portal and, since its launch, had been able to provide whole home testing to over 13,500 care homes. The letter announced that from 06 July onwards, DHSC would start to roll out weekly testing of staff and testing of residents every 28 days in all care homes without outbreaks through Pillar 2 **[Exhibit: AS/62 / INQ000051152]**.

Lessons Learned

166. In the event of another pandemic of the same or similar scale as Covid, the ICB would still remain very dependent on the steps taken nationally and would have to work on the assumption that lessons had been learnt by national teams regarding the supply of PPE. While individual ICBs can build up day to day resilience based on current guidance, it would be impossible to maintain sufficient stocks to cover pandemic demand, and we would be relying on better coordination between the distribution of national pandemic stock and NHS Supply Chain ordering and delivery.

167. While initially we were not receiving enough guidance, particularly around PPE usage in primary care settings, by March and April we were receiving too much guidance. This came from a multitude of different bodies and became chaotic, with a sense that there was a disconnect in the guidance, particularly with what was being issued by Public Health England and NHS England. As more bodies started issuing guidance on ever more specific circumstances, it became confusion for frontline staff as to what the correct guidance was. This often resulted in outdated guidance being implemented.

168. The confusion regarding latest guidance and where best to source advice increased demand on IPC specialists in the CCG and Public Health England. Providers became reliant on local expertise to inform them as they were increasingly unsure of what was and was not current guidance as the websites were difficult to navigate. Should a similar incident occur again, a centrally operated system for issuing guidance would provide greater clarity for providers and frontline practitioners. This would involve one organisation disseminating all guidance and maintaining a single website.

169. If guidance is due to change, then those working on the ground should have sight of the planned changes before it is communicated to the media to aid local preparedness. Furthermore, unless urgent, guidance should not be issued on a Friday as there are less managers working over the weekend and therefore decreased capacity to implement any necessary changes.

170. The CCG relied heavily on local expertise and experienced staff in its response to the pandemic. Historically, there had been forms of regular pandemic planning for diseases like swine flu and SARS that staff had experience of. However,

there had been no Public Health England led planning exercises for some time before Covid. Planning would have helped us in assessing any gaps. Pandemics are not predictable but can, to an extent, be anticipated. Planning needs to be prioritised and nationally led, with information cascaded down to providers locally. Preparedness bolsters resilience and reduced confusion.

171. While the measures taken by the CCG partially plugged the gaps in the supply of PPE that the NHS Supply Chain could not meet, and there were other examples of good practice, there were very much based on and in reaction to the circumstances at the time, in what was a fast moving situation. The CCG's conversion of its headquarters into a PPE distribution centre was necessitated by the need for innovative thinking in incredibly challenging circumstances. While it enabled us to distribute PPE throughout the local area via volunteers and CCG staff using their own cars, we would not advocate having to set up our own distribution centre again as the optimal response to a national incident.

172. Whilst local pandemic plans referenced PPE, this was always in the context of the national stocks and therefore did not carry any greater level of detail in relation to the types of PPE and supplies that might be required. Planning and exercising of plans going forwards will reference the full list of PPE that may be required and a description of the types of products. It will also be important to have a defined and standardised approach across partners that is supported by IPC and is owned by the different teams that are responsible for procurement along with service change (incorporating the impact of limited supplies with mitigating actions around service delivery and managing staff risk). This therefore brings in a different cohort of colleagues to planning and exercising for pandemics.

173. In the event of a future pandemic, it would be desirable to align current developments in the context of guidance for PPE and outbreaks i.e. increased usage of FFP3s to demands in the event of a pandemic.

174. Logistically and in terms of costs, the challenges in fitting and using FFP3 masks are significantly greater in a primary versus secondary care setting. This is partly because an increased need for PPE is not budgeted for in primary care. Also, the infrastructure for fit training and testing is not conducive to the primary care setting (i.e. in Nottingham and Nottinghamshire there are 127 individual businesses). Therefore, through national bodies (Health and Safety Executive) it would be

beneficial for greater consideration on how PPE is utilised in healthcare settings, how this is managed for staff safety and the level of risk and in response to changing guidance.

Statement of Truth

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

Signed: Personal Data

Dated: 28 November 2024