Witness Name: Andrew Furlong
Statement No.: One
Exhibits: AF/01 – AF/41
Dated: 29 April 2024

**UK COVID-19 INQUIRY**

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**WITNESS STATEMENT OF ANDREW FURLONG**

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I, Andrew Furlong, will say as follows: -

## Introduction

1. My name is Andrew John Furlong. I am employed by University Hospitals Leicester NHS Trust ("**the Trust**") as a Consultant Children's Orthopaedic Surgeon and Medical Director. I joined the Trust in September 2000 as a Consultant Trauma and Children's Orthopaedic Surgeon. Prior to becoming Medical Director in April 2015, I worked in the following clinical leadership roles: Deputy Medical Director, Divisional Director-Planned Care and Clinical Director-Musculoskeletal Services.

2. As the Medical Director, I sit on the Board for the Trust and have joint responsibility for the delivery of care with the Chief Nurse. I act as the Trust's Caldicott Guardian.

3. I have four Deputy Medical Directors: the Trust's Responsible Officer; a Director of Research and Innovation; a Director of Clinical Education and a Head of Learning from Deaths, all who directly report to me. The seven Clinical Management Group directors also professionally report to me, but their direct line manager for operational matters is the Chief Operating Officer. The Corporate Medical organogram of the Trust is exhibited at AF/01 [INQ000427365].

4. I have formal and informal meetings with my Deputy Medical Directors and the seven Clinical Directors on a weekly basis. One of these meetings include a Senior Clinical Cabinet. During the COVID pandemic, the membership of the Senior Clinical Cabinet was extended to include the relevant expert specialty medical leads; and the frequency of meetings was increased to run three times a week in order to facilitate timely clinical discussion and gain consensus views that could be fed into the COVID tactical and strategic meetings.

**Approach to the Covid Inquiry Rule 9 Request**

5. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input. The request, received by Richard Mitchell, the Chief Executive of the Trust, on 12 December 2023 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.

6. The Trust has three hospitals, the Leicester Royal Infirmary (which has the only Emergency Department across Leicester, Leicestershire and Rutland), Glenfield Hospital and the Leicester General Hospital. The Trust responded to the pandemic with all three hospitals sites in mind. Policies were developed for the entirety of the Trust and wards across the entire organisation were reconfigured to effectively stream COVID, urgent and emergency care and elective pathways. Similarly, the redeployment of workforce was done across all sites, to ensure the Trust's critical services were maintained. As a result, decisions were never taken solely for the benefit of the Leicester Royal Infirmary. I have, wherever possible, tailored my responses to the Rule 9 Request to be as specific as possible to the Leicester Royal Infirmary. However, on some matters, I am only able to provide answers on a Trust wide level.

## Background

7. The Trust is a large NHS teaching Trust providing integrated patient care. We are a national and regional centre for specialist treatment, a renowned biomedical research facility and the local hospital for communities in Leicester, Leicestershire and Rutland. Combined these areas have an approximate population of 1,122,000 people.

8. We have an established international reputation for research excellence in cardiovascular, respiratory, diabetes, renal and cancer medicine. Together with University of Leicester, Loughborough University and De Montfort University we provide world-class training for the future NHS workforce.

9. Leicester Royal Infirmary ("the Hospital") is one of our three acute sites, alongside Glenfield Hospital ("Glenfield") and Leicester General Hospital ("LGH"). As a large health and care provider, the Trust is a significant local employer. We use our economic influence to improve the health and wellbeing of our community through purchasing local goods and services and being a good civic partner. We work with local partners in the health and social care, local authority, voluntary and charitable sectors to improve health outcomes, and reduce the health inequalities that some groups experience.

10. As of 27 June 2022, the Trust had a total of 1892 beds (urgent and emergency care and elective care pathways). The Hospital itself has a total of 1069 beds. The Trust has Intensive Care facilities on all three sites and our cardiology and respiratory services are based at Glenfield. There are 49 commissioned Intensive Care Unit ("ICU") beds across our three sites – the Hospital has 19 commissioned beds at level three and a total of 22 beds at either level two or three.

11. Leicester has emerged as the first plural city in the UK where there is no ethnic group that has a majority. Preliminary research data from the University of Leicester indicates that 59.1% of people living in Leicester are from ethnic minority groups. Whereas, across England and Wales, 81.7% of individuals were of a white

ethnicity. Similarly, 41.1% of individuals living in Leicester were born outside of the UK compared to 16.8% in England and Wales. 43% of Leicester's population is Asian, of whom the majority are of Indian heritage. Leicester also has large Eastern European (Polish, Romanian), Black African (Somali, Nigerian), and Caribbean populations.

12. The Census data also illustrates that the largest age group in the East Midlands is those aged 50 to 54, in comparison to the national average being in the aged 30 to 34 range. Leicestershire and Rutland have a more affluent, older population with more long term conditions whereas Leicester has a more ethnically diverse population who are younger, but with a higher incidence of diabetes and cardiovascular problems.

13. The health of people in Leicestershire is generally better than the average in England. Leicestershire is one of the 20% least deprived unitary authorities in England, however, as of March 2020, about 10.9% (12,415) children live in low incomes families. Life expectancy for both men and women is higher than the England average. However, there is variance, with life expectancy 6.3 years lower for men and 5 years lower for women in the most deprived areas of Leicestershire than in the least deprived areas.

14. During the period of August 2017 to July 2018 Leicestershire had 540 excess winter deaths. This is fewer than the excess deaths experienced in the East Midlands region and England as a whole during the same period.

**Staffing Capacity**

15. In relation to staffing capacity, sickness absence levels increased during the pandemic. A range of mitigations were put in place including internal redeployment, mutual aid and increased system workforce deployment through a Workforce Sharing Agreement.

16. The Workforce Sharing Agreement was developed on 01 December 2020 to facilitate the smooth sharing and portability of staff between employing bodies within the Leicester, Leicestershire and Rutland health and care emergency services system. It sets out the intention of parties to work together to address the anticipated staff shortage issues arising from dealing with or as a consequence of the pandemic.

17. This enabled properly qualified competent and experienced NHS employees to carry out services of the same or similar nature, scope and complexity, to alleviate staffing challenges. This subsequently was amended to also be in place for any emergent emergency staffing shortages, such as industrial action.

18. As of 01 March 2020, sickness absence for the 12-month period immediately prior was 4.1%, and for the period 01 March 2020 to 22 June 2022 the average was 6.7% (sickness 4.1%, COVID 2.0%, shielding 0.6%). The peak staff absence rate was on 31 March 2020, with the total absence rate across the organisation 12.61% (9.14% being COVID related sickness).

19. Staffing shortages were primarily due to 3 key factors:

    a. shielding,
    b. isolation; and
    c. increased demand in certain areas such as the ICU.

20. The country went into lockdown on 23 March 2020, with swab testing introduced on 30 March 2020 and antibody testing on 29 May 2020. Testing occurred for both staff and their household members. Whilst absences relating to COVID increased in the period from when testing commenced to June 2020, this enabled us to safely identify cases in our staff, manage appropriately, and protect others, including patients and staff members. There were some restrictions due to safe testing facilities and limits on the number of people we could test.

21. At the beginning of the pandemic (29 March 2020), a testing program to support the retention of NHS staff was announced, but this in the first instance was limited to key NHS workers. As a result, requests for testing were triaged on a case-by-

case basis, and a waiting list was developed, where necessary, for staff or any household members.

22. This resulted in a handful of staff, although no more than 30 at any given time (27 April 2020), being on a priority waiting list for swabbing to enable them to return to work. These staff did not have to wait more than 24 hours to receive a swab.

23. A total of 12,100 antibody tests were undertaken for Trust staff. Of which 10,700 were returned with no detection of COVID, 1,300 were returned being positive for COVID, and 100 were spoiled, and therefore void.

24. Staff members often had lengthy delays to receive antibody test results. These test results were not able to indicate whether an individual was a carrier, and as a result there was no influence on the onward transmission of the virus. The test only helped detect whether an individual had been infected with COVID or had recovered from it. Test results were unable to detect an active COVID infection. Hence, the value of completing antibody testing was limited.

25. Temporary registers enabled students and retirees to support the organisation through the Bank. Unfortunately, the Trust's People Services systems do not capture the number of staff that joined the temporary register or the date it was introduced.

26. We faced staffing constraints related to the availability of workforce, and the number of trained staff available to provide clinical and patient treatment. Existing workforce capacity was impacted due to challenges linked to shielding, carer responsibilities, sickness, isolation rules as well as aligning to regional and national policies.

27. The specific challenges around national policies were in relation to the COVID testing scheme, and the limited capacity that was initially available, until lateral flow tests were commonly available. This resulted in a number of staff waiting for a test result, and as a result would need to self-isolate (for 14 days at the start of the pandemic) and not attend work while awaiting a diagnostic test.

28. As a result, at the start of the pandemic the Trust experienced staff absence rates ranging between 6.69% (22 March 2020), peaking at 9.41% (29 March 2020), prior to reducing to 5.98% (30 April 2020). The average absence rate due to COVID in the second half of April was 6.22%, in comparison to the two-week period from 22 March 2020 - 04 April 2020 where the average COVID staff absence rate was 8.55%.

29. To alleviate staffing shortages, the Trust established a COVID redeployment hub to ensure staff were correctly redeployed to priority areas. This process was managed by professional leads who considered internal redeployments and the use of volunteers. In anticipation for the increased demand on ICU, the Trust looked to redeploy a number of non-critical care nurses to work in critical care, with training provided to support their redeployment.

30. The National Competency Framework for Registered Nurses in Adult Critical Care – Step One are competences designed to provide the core generic skills to safely and professionally care for the critically ill patient. Nurses normally spend 12-18 months completing these competencies. When nurses start working in Adult Critical Care, they are usually given six weeks of supernumerary time to start and develop the skills and knowledge they will need to safely care for critically ill patients. Completing these competencies or even six weeks supernumerary time during the pandemic was not possible in the timescale available. Despite being unable to provide a lot (or even any) supernumerary time, it was necessary to do whatever could be done to ensure that staff were as prepared as possible to support the experienced Adult Critical Care nurses.

31. Educational courses were offered for all redeployed staff. Consideration was given to the level required for the clinical readiness training. This had to take into account the varying backgrounds of the staff that would be attending. It was decided to organise one day and two day courses. The one day course was designed for staff who had previously worked in ICU but required refresher training and the two day courses was for staff with transferable skills but no previous ICU experience. The session schedule is exhibited at AF/02 [INQ000470992]. A total of 356 staff members attended the training packages. As exhibited at AF/03 [INQ000470993],

87 of the 157 staff members who completed the survey stated this supported reducing anxiety prior to redeployment. Of the staff members trained across the Trust, 56 staff performed clinical shifts at the Hospital's ICU.

32. A Leicester, Leicestershire and Rutland Integrated Care System and NHS Trusts workforce hub was also established to enable workforce sharing agreements across the Leicester, Leicestershire and Rutland system. This operated alongside NHS England's adaptation of existing policies to streamline processes associated with NHS pre-employment checks, visa extensions, and the use of students and retirees.

33. The measures to provide training and redeploy staff to critical areas was effective at a local level. The localised actions to provide staff with training and awareness sessions, such as utilisation of appropriate Personal Protective Equipment ("PPE"), clinical symptoms and approaches to provide patient treatment, supported staff in being prepared to deal with the type of patients presenting at the Hospital.

34. Similarly, the training provided to staff who were redeployed supported the Trust in maintaining patient treatment across its urgent and emergency care pathways.

Effect of the COVID pandemic on staff

35. Staff were only redeployed within the Trust's hospitals. The Trust did not redeploy staff from any other acute setting, nor were Trust staff members redeployed to other healthcare environments. Trust staff working in community settings were redeployed, where necessary, into the acute sector.

36. The redeployment of staff was to ensure both capacity and patient safety was maintained across the Hospital's urgent and emergency care pathway, for patients on both COVID pathways and non-COVID, emergency pathways.

37. Following the first wave of the pandemic, we held a Trust-wide survey aimed at identifying the key lessons from the response to inform future plans. One of the

key topics discussed was staff safety and support. Feedback received through the survey referenced staff largely feeling supported with the provision of PPE and associated training. Overall, as exhibited at AF/04 [INQ000427379], responses from staff indicated that there was a positive correlation towards feeling more safe than less safe at work and staff felt confident they had access to the correct PPE.

38. However, staff also referenced feeling tired, low or numb. Specific feedback received from redeployed staff included struggling to adapt to a different working environment due to the difference in skillset required. Similarly, morale of staff working on the COVID ward was low, with staff being exposed to significantly unwell patients and increased patient lengths of stay, with patients not necessarily recovering. In addition, staff may have been exposed to treating their colleagues, family or friends.

39. Some members of staff expressed concerns about exposure to COVID and there were a handful of cases where they were reluctant to work on COVID wards. Due to the increased pressures on wards due to volume and severity of cases, some redeployed staff did not feel the most supported, and some were apprehensive to return to ICU in future COVID waves.

40. Although staff were never forced to work in COVID wards, they were encouraged. To ensure the flow of information to staff nurses was maintained, information from the Trust's tactical COVID meetings would be disseminated by the heads of nursing in person to wards who would brief on any key changes to national or local policies.

41. A Long COVID absence at the Trust was defined as an absence due to COVID or COVID symptoms of 4 weeks or more. The Trust had a total of 692 staff requiring time off as a result of Long COVID between 1 March 2020 and 30 June 2022. The impacts of staff currently off work and/or working reduced hours as a result of long COVID has been absorbed by the Trust. There are no impacts on the delivery to its essential activities or processes.

42. A total of five Trust staff members lost their lives as a result of COVID. Their roles within the Trust were:

    a. Support Worker, Discharge Lounge;
    b. Consultant Cardiologist;
    c. Health Care Assistant;
    d. Domestic Catering Assistant; and
    e. Domestic.

43. To support colleagues impacted by the death of a colleague, a COVID bereavement checklist was produced to ensure a process was available to support immediate colleagues, families and any facilitate related communications and condolence. This ensured emotional, financial and practical support was provided to staff and families, with clearly identified leads at each stage including wellbeing support provided to staff impacted. As exhibited at AF/05 [INQ000470994], this confidential support was provided through the Trust's AMICA Staff Counselling and Psychological Support Services.

COVID Vaccination

44. The Trust established a Vaccine as a Condition of Deployment Task and Finish Group. As of 18 January 2022, the working group identified the Trust had a total of 1,952 staff that had no record of any vaccinations, and they were contacted via text, email or a letter. Additionally, an all staff communications message was sent out advising staff that if they had not been vaccinated in a Trust vaccination hub, an online form should be completed. From the responses received, exhibited at AF/06 [INQ000470995], (1,270 online forms and 785 emails), 495 staff indicated they already received the vaccine, and 51 staff members responded stating no intention to receive the COVID vaccination.

45. The Trust also held a number of workshop events led by the Deputy Chief Medical Director to promote the uptake of the vaccine. However, a small number of colleagues, exhibited in the feedback at AF/07 [INQ000470996], indicated concerns about the vaccination through these listening events.

46. The Trust followed the national policy, announced by the Department of Health and Social Care ("DHSC") on 10 November 2021, and exhibited at AF/08 [INQ000470997], which stated that individuals undertaking Care Quality Commission ("CQC") regulated activities in England must be fully vaccinated against COVID no later than 01 April 2022.

47. There was concern among some staff members following the announcement of the national policy of vaccination as a condition of deployment. While this did not affect the Trust's clinical delivery in any way, it did mean that management time was taken up with addressing concerns that staff had about the vaccines. In any event, on 8 February 2022 the Secretary of State announced that that the Government intended to revoke the regulations requiring vaccination as a condition of deployment.

48. The existing processes available in the Trust were fit for purpose to review and redeploy staff to mitigate staffing challenges during the period of the pandemic.

**Bed Capacity**

49. Following NHS England and NHS Improvement's discharge policy of 17 March 2020, occupancy of general and acute adult beds, excluding maternity and critical care beds) at the Trust went down from 743 or 83% of total on 17 March 2020, to 577 (64%) one week later and 466 (56%) four weeks after the discharge policy was announced (for the whole of the Trust, which was showing a 79% occupancy on 17 March 2020, it was 60% one week later, and 52% after four weeks. The bed occupancy information for the Trust is exhibited at AF/09 [ INQ000087317 ].

50. Adult ICU beds were showing 58% occupancy (11 patients) on 17 March 2020, dropping to 47% (9 patients) a week later and 100% (19 patients) after four weeks. Paediatric ICU beds were 33% occupied (2 patients) on 17 March 2020, and a week later. Three weeks after the policy's announcement they were 100% utilised

but had dropped to 50% by four weeks. This is because there were only 6 paediatric ICU beds available at the Hospital.

51. While no specific reference was made in existing plans around discharge prior to the 17 March 2020 discharge policy, exhibited at AF/10 [INQ000470999], the following actions were taken to create additional capacity:

    a. On 24 February 2020 the Trust was identifying steps to open up additional capacity through creating a temporary ward area for adults and paediatrics prior to any patient transfers to Glenfield.
    b. To free up bed capacity, on the 01 March 2020, the Emergency Department was split into COVID and non-COVID sections, with direct referrals to assessment areas being implemented.
    c. The Emergency Frailty Unit was vacated to create critical care capacity, and the Acute Care Bay was re-created for non-COVID patients.
    d. Plans for each Clinical Management Group to have consultant inreach into the emergency department was created to support streaming patients out of the department.
    e. On 06 March 2020, the Trust took steps to prepare an Infectious Diseases Unit to receive COVID patients, and any other wards that could be utilised to support admissions process. Preliminary conversations considered utilising existing wards for Gastroenterology patients.
    f. On 19 March 2020, the Trust made a decision, detailed in its Operational Plan for Clinical Management Group and Corporate Services and exhibited at AF/11 [**INQ000427368**], to postpone all non-urgent elective operations, and these measures were planned to remain in place for at least three months.

52. The Trust developed an Escalation Framework, exhibited at AF/12 [INQ000427333], which provided a clear framework for managing demand in response to the pandemic. Through a set of clear triggers for escalating and de-escalating the Trust's alert level, actions for Clinical Management Group and priority workstreams were highlighted to respond to levels of demand, and to take into account any national, regional and local guidance and directives. As part of this, the Hospital had a plan to increase its ICU capacity to a total of 46

commissioned beds, from an existing 19, through expanding into recovery areas, and repurposing high dependency units and paediatric intensive care areas.

53. The Trust also received national directives to increase its ICU capacity:

    a. On 31 December 2020 NHS England and NHS Improvement asked Trusts to surge to 133% of baseline ICU capacity, and on 06 of January 2021, the Trust was asked to surge to 150% of normal baseline.
    b. On 09 January 2021 the Regional Director of Performance, Medical Director, and Chief Nurse wrote to all Midlands acute providers, requesting a further increase, to be delivering Adult Critical Care capacity equivalent to 175% of the normal baseline, this letter is exhibited at AF/13 [INQ000427330]. In addition to this, there was a request to have well developed plans in place that could be rapidly activated to surge to 200% of baseline.
    c. On the same day the Trust also received a letter, exhibited at AF/14 [INQ000427331], identifying the possibility that demand for Adult Critical Care in London may exceed the maximum deliverable super surge capacity. The request from the Midlands Regional Team was for all Midlands Acute providers to potentially accept up to two patients per day for a short period of time.
    d. On 13 January 2021, a further letter was received, exhibited at AF/15 [INQ000427332], to maximise surge capacity within a week, to surge beyond our own needs and enable support to London and the East of England.

54. The Escalation Framework provided a set of triggers and actions to create additional ICU capacity as surges in pressure and escalation increased. Additional bed capacity was identified to expand ICU across the Trusts three sites, which enabled the Hospital to flex from its funded capacity of 19 spaces to 46 beds if needed. Capacity was created through a phased reduction (and cancellation) of elective activity, with priority given to emergency, trauma, cancer and urgent

activity. The additional capacity was used flexibly for elective admissions, emergency takes, and patients with suspected or confirmed COVID.

55. The additional capacity at Level 5 of the Trust Escalation Framework required full scope of additional equipment associated with ICU occupancy. Additional staff would be provided initially from theatres and recovery areas, but then by reducing consultant lead activity within sleep services. After this we would look to reduce consultant pain activity by ceasing all lists at the Trust and only maintaining lists or follow-up virtual clinics with one full-time pain consultant. The trust would then look to implement surge medical rotas. Mutual aid would also be required to support both staff and equipment needs.

56. The Trust's peak in receiving COVID patients into ICU was on 05 Feb 2021 (71 patients), with a total of 85 ICU patients (173% of baseline activity). The Trust's overall peak of ICU admissions was on 03 Feb 2021, (COVID & non-COVID) with 86 patients (69 of which were COVID inpatients) (176% of baseline activity).

57. The Trust had an ICU Cell established during the pandemic, and no specific clinical concerns were escalated around the impact of operating at increased ICU capacities. However, due to the increased number of patients in ICU, there were several escalations regarding drug supply shortages (due to national shortages). As a result, alternative medications to be dispensed were identified and/or the criteria to prescribe medication to patients was reviewed.

58. We monitored the availability of the key drugs below, comparing stock availability with current patient numbers and anticipated demand. These were medicines either under increased demand due to COVID or used for the direct treatment of COVID. Whilst the situation varied with each of the products, there were occasions where we had less than a few days remaining of some of these products. However, through use of an alternative supplier or product, we were able to avoid any total stock outages which would have impacted patient treatment. Note that this list may not be exhaustive as the list of products monitored evolved over time, and that this response should not be taken as indicating that there was a specific supply problem with any of the specific named products.

59. These key drugs included Alfentanil, Atracurium, Baricitinib, Bupivacaine heavy, Cardioplegia 1L bags, Cardioplegia amps, Clonidine, Co-amoxiclav IV, Dalteparin, Dexamethasone oral, Dexamethasone IV, Dexmedetomidine, Fentanyl, Heparin, Insulin Human Soluble 50 units / 50 ml, Meropenem, Midazolam, Morphine, Noradrenaline, Paracetamol IV, Paxlovid, Phenylepherine, Piperacillin-tazobactam, Prilocaine heavy, Propofol, Remdesivir, Remifentanil, Rocuronium, Sodium bicarbonate oral, Sodium bicarbonate IV, Sotrovimab, Suxamethonium, Thiopental, Tocilizumab, Voriconazole, Water for Inhalation.

60. The situation was dynamic, and there were informal conversations around the management of physical & workforce capacity in order to provide care to our patients. This was maintained through sacrificing planned elective capacity, the willingness of staff from ICU and non-ICU backgroundss to provide additional support, diluting staffing levels for patients requiring advanced respiratory support, and the network to move patients on a regular basis between sites.

61. The Hospital did not transfer ICU patients to other Acute Trusts. The Trust always had admitting capacity through the use of the additional capacity identified in the Escalation Framework.

62. The Hospital received a total of 183 patients into its ICU from another acute Trust during the relevant period. This includes a total of 122 adult patients, of which 26 patients were COVID positive. Of the 61 paediatric patients requiring transfer, 4 were COVID related patients. Exhibited at AF/16 [INQ000427334] are the Hospital's ICU figures for the relevant period.

63. The Hospital received a total of 240 emergency and non-emergency transfers from other hospital's ICUs. This included 67 adult patients transferred to the Hospital's ICU and 173 paediatric patients. Of the adult patients transferred from a different hospital, 48 were from another Trust. All of the paediatric patients transferred in were from a different Trust.

Ventilators

64. A donation agreement, exhibited at AF/17 [INQ000427369], was drafted up between DHSC and the Trust which enabled the transfer of equipment between both parties. Specifically, this enabled the transfer of ventilation and associated medical equipment for the financial year of 2020-2021, and included:

    a. mechanical ventilation;
    b. non invasive ventilation;
    c. oxygen concentrators; and
    d. patient monitors.

65. From the Trust's records, a total of 29 ventilators were ordered or requested during the 2020/21 period utilising COVID funding to support the expansion of ICUs and critical care wards. The vast majority of equipment ordered was utilised and still is in use.

CPAP Machines

66. As we have a long term ventilation service at Glenfield, we had access to a large number of home ventilators (NIPPY 3+) which could be used to provide CPAP therapy, with oxygen.

67. The Trust, via our head of Medical Physics, obtained additional ventilators (Trilogy OBM) through NHS England centralised stores. We had 20 commissioned at Glenfield around November 2020. These were more efficient at conserving the oxygen supply as they had an oxygen blender. Additionally, we had 20 Maxtech high flow oxygen stacks which were purchased at the beginning of the pandemic, although these were not used until the summer of 2020 due to concerns about oxygen consumption and treatment efficacy.

68. We worked closely with colleagues across the Trust to share equipment and consumables as required.

Oxygen

69. The Trust anticipated high demand on its oxygen supplies, especially with the expected number of patients receiving treatment via ICU and high dependency wards (through having CPAP and NIPPY devices). A Task & Finish Group was established and considered whether the Trust had sufficient oxygen supplies and whether the site was configured to deliver oxygen to wards.

70. The Trust originally reviewed the configuration of oxygen circuits, to ensure its infrastructure separated the delivery of oxygen to high risk areas, such as ICU and higher dependency areas which were not on the same oxygen circuit. Through this review, it was confirmed that the Emergency Department, Acute Care Bay, Adult Frailty Unit & Acute Medical Unit were on one oxygen circuit, and the ICU, Emergency Decisions Unit, Emergency Frailty Unit & Gynaecology Assessment Unit were on a second oxygen circuit.

71. The Trust developed a Standard Operating Procedure, exhibited at AF/18 [INQ000427370], which identified pre-alarms at 75, 80 & 85% which indicated when the levels of oxygen flow neared capacity, to ensure preemptive measures could be taken to prevent the situation from further deteriorating. This process highlighted actions for clinical staff on providing oxygen treatment (i.e. criteria to step up & step down patient treatment).

72. The Trust monitored the use of oxygen via a daily situation report, which highlighted the maximum flow rates (oxygen utilised %) over the last 7 days, and this was shared to the Trust's senior leadership team for awareness.

Renal replacement therapy machines

73. The Trust experienced no shortages of renal replacement machines through the pandemic. The Consultant Nephrologist, Deputy Head of Nursing for Renal Services and General Manager met daily with unit and ward managers during the

early weeks of the pandemic, and thrice-weekly for the remainder of the time-period (2020 through until 2022) to ensure a reporting mechanism was available to escalate any shortages.

74. Additional Dialysis machines were purchased for the ICU through COVID funding, but while shortages on ICU were projected, they never materialised, and the Trust were able to support patients through the provision of intermittent Heamodialysis in that environment.

75. The Trust already had in place established mechanisms for monitoring and managing medicines supply issues, exhibited at AF/19 [INQ000427335]. As a basic measure there was a process that created a fortnightly Shortages Information Spreadsheet available on the Trust's intranet. There were also different pharmacy actions in the escalation process for the COVID response plan that the Trust was employing, which prompted increased awareness of stock and usage.

76. Practically, the increased vigilance involved closely monitoring stock levels and usage of key products, primarily those used on ICU, with meetings at different frequencies - one to three-times weekly depending on how acute the situation was. Where shortages were anticipated, alternatives were suggested and contingency measures (such as review of prescribing) were put into place to manage usage.

Co-operation with the independent healthcare sector

77. The Trust does not hold specific data on the exact activity that was allocated to the independent sector. However, the Trust utilised Nuffield Hospital, Spire Hospital and Tollerton Hospital to maintain treatment for non-COVID conditions and to carry out elective surgery. Each Clinical Management Group would prioritise referring patients that required cancer treatment, were clinically urgent and for diagnostic activity.

78. The most common patient treatments re-allocated were aligned with guidance published by NHS England on 31 March 2020 (Utilisation of IS Support during

COVID-19), exhibited at AF/20 [INQ000427371], which provided good practice guidelines to accelerate the use of independent sector capacity. This included utilising existing independent sector capacity through the use of elective activity (cancer surgeries, endoscopy, cardiac surgery, chemotherapy etc), urgent non elective activity, and surgical step down patients.

79. Treatments re-allocated by the Trust included elective surgery, bowel cancer screening, urology, dental, maxillofacial, vascular, endoscopy, orthopaedic activity, and long wait outpatient activity (those waiting longer than 70 weeks for an assessment).

**Infection Prevention and Control**

80. To support decision making around the use of Infection Prevention and Control ("IPC") guidelines, the Escalation Framework had localised alert levels to influence the Hospital's response to the pandemic. For instance, the recommendation that face masks be utilised in clinical areas was prompted by the number of cases in Leicester, Leicestershire & Rutland and confirmed cases in Leicester's hospitals.

81. Similarly, as exhibited at AF/21 [INQ000427338], relevant visual guides, processes and flow charts were developed for Leicester's hospitals, such as the PPE required for specific patient pathways. A guide was also published for the processes and forms associated with screening patients prior to admission and decision making tools for staff to correctly refer patients into pre-identified side- rooms, exhibited at AF/22 [INQ000427336]. This facilitated the development of COVID and non-COVID patient pathways, which enabled the safe management of patient flow.

82. The Trust's Communications Team also created a number of internal visual aids, exhibited at AF/23 [INQ000427337], to direct patients, the public and service users on how to safely adhere to IPC guidelines during the pandemic. This included

ensuring identified patient pathways were adhered to, such as the utilisation of pre-assessment and cohorting areas for COVID patients outside of the Emergency Department and social distancing in public spaces.

83. The Trust would receive key letters, directives and information requests via a Single Point of Contact, which was monitored by the Trust's Emergency Preparedness, Resilience and Response ("EPRR") Team between 08:00 - 17:00 Monday - Friday (and extended hours during periods of escalation as set out by NHS England). Through established command, control and communication networks, this guidance was circulated to the Chief Nurse and the associated deputies, including the lead for IPC.

84. Information was adopted for local use within the Hospital. This would then be worked through the IPC COVID Working Group and approved via the Trust Tactical COVID Group, to ensure guidance was approved, understood and realistic to implement at the Hospital. The Tactical COVID Group met daily at 11:00 and had representation by the Trust's senior leadership team. This was supported by daily communications briefings, and briefings held at each ward by the Clinical Management Group's Heads of Nursing.

85. The Trust would approve and cascade updated information and guidance through its command and control mechanisms established by the EPRR Team. A number of operational cells were established to coordinate the Trust's response to each element of the pandemic, and the Trust's Tactical COVID Group was a central point for a Trust-wide guidance to be approved, discussed and cascaded. This would meet on a daily basis at the height of the pandemic, to ensure queries or concerns were promptly addressed, and a shared situational awareness across the Trust was maintained. Supporting this were daily communications briefings, which would highlight the latest situation and any key updates, policies or guidelines that were recently implemented.

86. The Trust identified key leads and deputies for each Clinical Management Group and Corporate Service. This ensured updated guidance would be disseminated to key leads to implement via their operational cell.

87. The above methods were the mechanisms the Trust utilised to mitigate impacts of late updates to policies and guidelines. Operational teams, especially at the start of the pandemic, were sometimes left confused due to the short notice regarding changes to policy and the detail behind the updates.

88. When responding to the pandemic, the Trust experienced a number of practical challenges to effectively implement IPC guidance across the organisation. One key concern was around the stock of equipment, due to the increased use. To address this, matrons completed daily stock checks to ensure adequate supplies were available. In addition, the availability of stock, and the inconsistency of available masks, caused a challenge to clinical staff needing to be mask fit tested on that specific mask; whilst there was an adequate provision, and at no time did the Trust run out, there was no consistent supply of one mask.

89. To minimise infection spread, all clothes worn in clinical areas, or environments with COVID positive patients, needed to be washed at extremely high temperatures. At the beginning of the pandemic, the Trust had challenges in acquiring a suitable supply of scrubs that enabled staff to change clothes to safely manage infection risk. This was resolved through Leicester charities, and other organisations, making and donating scrubs.

90. Patients with infections often need to be treated and isolated separately (i.e. COVID, flu A & flu B need to be separated), however, the physical estate has a limited number of side-rooms and inadequate ventilation. This led to challenges in managing all infections, and side-rooms being unavailable to manage COVID patients. This increased the risk of hospital acquired infections and the likelihood of experiencing outbreaks on wards, but was managed by cohorting appropriate patients where possible.

91. Hospital outbreak management policies also challenged patient flow, as areas would need to be closed to admissions for considerable periods of time after positive results, for the ward to be cleaned or for existing infectious patients to be

discharged. With the lack of side-rooms available, this often resulted in wards with a number of "empty closed beds".

92. Upon admission to the Hospital, patients usually required COVID tests. This would require patients to be isolated until a test result was received (potentially up to 24 hours to wait for a PCR test result).

93. During the early days of the pandemic Estates and Facilities received many requests to segregate areas. This was undertaken in consultation with IPC colleagues because there was a concern that some requests could compromise the existing ventilation systems, and so cause an increased risk of cross infection. Space constraints in old buildings limited the ability to segregate areas and maintain functionality, for example, a lack of ward-based ventilation meant that segregation could block natural air flow and lead to overheating, as most wards had no, or very limited, mechanical ventilation. Wards which were designed for natural ventilation were compromised because of the later requirement to fit window restrictors to meet safety regulations.

94. The condition of existing ventilation systems, which were beyond their normal life, was suboptimal; they did not reach their original design specification and were not compliant with modern standards. We did however isolate patients, as per IPC recommendations, cohorting patients and creating COVID bays, wards and pathways as necessary to separate COVID positive and negative patients to reduce the likelihood of any hospital acquired infections.

95. The Trust also adapted the use of the Hospital to adhere to IPC Guidelines. This includes reducing the number of beds on COVID wards due to the requirements to have two metres per bed space, increasing the number of doors on bays to contain the flow of air in wards. Sizes of clinics and seating areas were also reduced, again due to social distancing requirements.

96. Asymptomatic testing for patients began on 27 April 2020, following a letter from NHS England and Public Health England on the 'Expansion of patient testing for COVID-19' to support the effective management of COVID in healthcare settings, exhibited at AF/24 [INQ000000038]. Trusts were asked to expand testing for non-

elective admissions, including those who were asymptomatic, due to the additional testing capacity available for laboratories. The Trust first implemented asymptomatic testing for key clinical employees in May 2020, following advice and guidance published by Public Health England.

97. On 13 March 2020 the Trust started testing symptomatic patients, regardless of travel history. The aim was to test all patients with evidence of pneumonia, acute respiratory distress syndrome or influenza like illness. Prior to this, from 25 February 2020, the Trust had been testing patients returning from areas of concern (even when asymptomatic), as well as patients that met both epidemiological and clinical criteria.

98. The Trust was following localised standard operating procedures that provided staff with clear patient pathways for managing care. These covered the identification of potential COVID cases, through to coordinating the initial assessment, testing, and admission plan for patients.

99. The Trust's EPRR Team originally developed a Standard Operating Procedure, exhibited at AF/25 [INQ000427373], in conjunction with our IPC team, on 24 January 2020. Original testing expectations included samples to be processed and dispatched to Colindale and Birmingham Microbiology Centres (provided by Public Health England). The Policy was updated in an ongoing manner, to reflect guidance published by Public Health England.

100. The Trust does not hold any evidence of a shortage of test kits or testing supplies. However, there was a shortage of reagents, due to the demand for tests and the supply of testing platforms from companies such as Cepheid, Mobidiag, and Hologic all being limited during periods of the pandemic. Due to international demand and production shortfall, this occurred at various times over the length of the pandemic but was most common in the first 12 months. To ensure test kits were utilised most effectively, platforms which supported rapid turnaround times for results were primarily utilised in the Emergency Department, this allowed the department to prioritise operational flow.

101. The requirements to test patients for COVID status prior to admission into the hospital had an impact on the flow of patients across the Trust. Patients awaiting test results would receive them within 4 - 24 hours of the test being completed (pending whether a rapid or routine test was completed). During the surges of the pandemic, when high numbers of COVID patients were admitted, this impacted the flow of patients and caused challenges in safely isolating patients prior to admission onto wards.

102. Rapid turnaround tests were prioritised for patients in the Emergency Department, to ensure a safe and timely process was available to treat patients and, where necessary, admit to wards. There was no prioritsation process for specific staff roles to access lateral flow tests. These tests were distributed by the Trust's procurement team to Clinical Management Groups at the Hospital, however an emergency store was available with the duty managers for any member of staff that required urgent lateral flow testing.

103. Asymptomatic testing was available for all patient-facing staff on a twice-weekly basis. Staff who are patient-facing generally refers to those involved in direct interaction with patients such as doctors, nurses, allied health, porters, catering and domestic staff. This mirrored national guidance published by NHS England on 30 October 2020. This was implemented across the Trust from 19 November 2020.

104. Patient testing frequencies also mirrored guidance published by Public Health England and NHS England, via the format of updated IPC Guidance, exhibited at AF/26 [INQ000427374].

105. For example, patients on a negative COVID elective pathway would be tested upon admission. During the patient stay, if symptoms were to arise, testing would take place and acted upon accordingly. A patient would also be tested again 48 hours prior to discharge, to confirm they were negative, or to inform discharge planning. Patients arriving via an emergency pathway would be split into either a COVID or non-COVID pathway, following an initial test. Upon admission, patients would be screened on a daily basis, and re-swabbed and isolated if any concerns arose. Patients would again be swabbed prior to discharge.

106. The Trust followed national letters and directives circulated by NHS England and DHSC. However, there may have been, on occasion, slight delays in implementing policies, to ensure consistency across partners in Leicester, Leicestershire and Rutland. This provided opportunities to localise policies and guidelines and to ensure clear messaging was cascaded and understood by all staff.

107. The Trust followed Public Health England's National Communicable Diseases Management Plan and Outbreak Management Toolkits.

108. The Trust's IPC team held meetings with system partners (NHS England, Clinical Commissioning Group and Public Health England) to inform them of existing outbreaks as well as the precautions and actions the Trust were undertaking as a result. This would then be formally reported to NHS England (via iiMARCH and SitReps via online portals).

109. In the event of nosocomial outbreaks, the operational impacts were essentially localised staff sickness, meaning an increase in the problem of maintaining adequate staff availability, and resulted in spreading resources around and diluting staffing levels. Also, as wards would be required to be isolated for 10 days following the last COVID positive test result, the ward would be closed to new admissions until patients had been moved to side-rooms, or discharged, and the ward cleaned. This frequently led to closed empty beds, which posed challenges to patient flow.

110. During the relevant period a total of 1038 patients had a probable hospital acquired infection, meaning their earliest positive COVID test came after 8 days in inpatient admission. Nosocomial infections peaked in January 2021, with 133 suspected hospital acquired infections, falling to no suspected hospital acquired infections in June 2021. A second peak occurred in January 2022 with 106 suspected hospital acquired infections, falling to 30 in June 2022. A breakdown of nosocomial infections at the Hospital is exhibited.

**PPE & RPE (Respiratory Protective Equipment)**

111. As the Trust is an identified site to receive referrals, especially for patients requiring intensive care or Extracorporeal membrane oxygenation, we utilised materials (PPE, RPE, and medication) faster than others. As a result, the Trust would be one of the first that would escalate concerns around the availability of products. In order to mitigate this, Task and Finish groups were established to risk assess availability and use of products, adapt clinical practice, and find alternative mechanisms to provide treatment where necessary, ensuring a consistent approach was available Trust wide.

112. With an increase in demand for products there were shortages in the NHS supply chain and, as a result, the Trust's Procurement & Supplies Team had to identify and obtain items from new sources and rely heavily on mutual aid with neighboring acute trusts, across the region and beyond.

113. In the event that mutual aid would be required, the Trust's EPRR Team would reach out to partners via the Single Point of Contact email account and request support for the particular item in demand. This process was later adopted by partner agencies and was commonly utilised during and after the pandemic to mitigate any unexpected shortages of equipment where no supplies can be purchased.

114. The Trust experienced issues with obtaining hand sanitiser, which rapidly went out of stock, and we relied heavily on mutual aid from other trusts for the first six months of the pandemic. As PPE was required to be worn more frequently than before, this caused a surge in use. The NHS supply chain was not able to meet demand, nor the national PPE push, so the trust had to procure from new sources between March and June 2020.

115. Whilst the turnaround time from order to delivery was, in the main, fairly rapid, and the centralisation of stock was beneficial in terms of responsiveness, the quality, and on occasion, quantity of orders was not consistent. This lack of

consistency meant the trust were often having to make urgent mutual aid requests to ensure adequate supplies.

116. We utilised the Emergency Request System specifically for mortuary body bags and experienced no issues with this process.

117. The Trust also requested mutual aid through its Single Point of Contact, reaching out to neighboring Acute Trusts. This included high dependency care consumables, such as non-invasive ventilation circuits, oxygen concentrators, CPAP devices, Qiagen Extraction Kits (to support taking COVID swabs), adult feeding supplies, PPE (gowns, masks, aprons, sanitisers and gloves), tracheostomy tubes, and cannulae.

118. Approximately 85% of the time, requests for mutual aid were successful, hence the process established by the Trust was effective and was later implemented by the region.

119. At different times during the pandemic the Trust received items that weren't suitable. There were certain brands of FFP3 masks provided which were deemed by the Infection Prevention Team not to provide adequate protection. The Trust received eye protection which was recalled as not meeting the necessary standard. There were also occasions where supplied gowns were too large, or too long, making them unusable.

120. In early March 2020 the Trust received Cardinal Health masks, from the National Stock. They were fit tested using Portacount Quantitative Testing machines (a recognised testing machine recommended and supplied by most mask manufacturers) and had a 100% failure rate. These masks were initially thought to expire at the end of March, within 21 days from receipt; it subsequently became apparent that, when the date label was peeled back, the masks' original use by date was 2015, and they had been re-labelled with a use by date of the end of March 2020.

121. Furthermore, the masks were not individually packaged, so all remaining masks in the package would be potentially contaminated by particles as soon as

the first one was removed from the package, and they had an odour making it unpleasant to wear them for longer than a few minutes.

122. In effect, these masks were useless as anything other than being worn as a surgical mask (which staff were advised to do, in the absence of sufficient surgical masks being available). Staff were also advised that they should be changed as often as felt needed if the smell became an issue for them. This was reported to the Regional Incidents Coordination Centre.

123. As the masks failed the fit test process, they were downgraded from a FFP3 mask to a FRSM standard and sent to the Renal team as they were identified as a higher risk. The deputy head of nursing has suggested the Renal teams used approximately 480 masks per day. The Trust was required to submit Situational Reports back to NHS England – specifically the 'Stock List Clipper Logistics Return' and on the 15th April 2020, the Trust has reported a total of 438 boxes (of 50 masks) remaining. In total this meant there was 21,900 masks remaining. Staff at the Trust would have used these until stocks were exhausted.

124. The HSE originally queried the Trust's approach to fit mask testing on 09 April 2020. The Trust's Health and Safety manager responded to this in a letter on 19 April 2020 setting out that all front line staff identified in high risk areas receive fit mask testing and related training. The letter explained that the supply of FFP3 masks changing manufacturer, make and model on a weekly or daily basis made the face fit testing redundant as the Trust had to constantly repeat the process when the mask type changed. It stated that to mitigate any risk, the Trust had made numerous resources available to all staff concerning PPE and the correct fitting of masks. Following this letter, exhibited at AF/27 [INQ000427375], the Trust received no subsequent questions or queries.

125. The Trust moved away from the HSE requirement to fit test staff for each particular FFP2 and FFP3 mask that was available. Instead, the trust would fit test staff to an FFP3 mask "standard of fit" and enable staff to assess their fit of mask (fit checking). It should be noted that, prior to the pandemic, the Trust had led a program of fit testing in clinical areas for a mask that suited the member, rather than all masks available. The program paper is exhibited at AF/28

[INQ000427339]. It's also relevant that the HSE guidance had a clause that stated that masks should be fit tested where reasonable and practical.

126. The Trust purchased ten Portacount machines which reduced the time taken to undertake a fit test from 30 to 15 minutes. These machines were in use across all sites. The Trust additionally established a team of staff trained to undertake fit testing clinics which could run throughout the day, including evening and weekends across the Trust.

127. The IPC Team identified areas where testing should be prioritised and targeted testing in these. Vulnerable staff, including those with underlying health conditions, were fit tested and provided with PPE appropriate to the activity they undertook.

128. The training provided by the Trust ensured that all staff were made aware the importance of performing a user seal check to make sure they were getting an adequate seal from their respirator. It also made clear that staff who did not pass a fit check were aware that they may not enter a high-risk clinical area or undertake a high-risk procedure. Training also continued to ensure fit testing was available for staff groups who had not previously been fit tested (e.g. cleaning and food handling teams, phlebotomists, pharmacists) but for whom, in the pandemic, this would be relevant.

129. Mask fit testing ceased on 16 April 2020. While the Trust does not have the exact date fit mask testing recommenced, an email outlining timescales to restart FFP3 fit mask testing was circulated on 24 July 2020, and this was discussed on the same day at the Trust's Tactical COVID-19 Group.

130. NHS supply chain had been unable to provide a consistent stock of masks. In practice, this meant that we had very limited stock of the FFP3 masks on which staff had previously been tested.

131. On numerous occasions the Trust's IPC and EPRR team contacted Regional Operational colleagues, and supply chain contacts, to highlight the problems with inconsistency of quality and supplied items. In early March 2020,

having identified these issues and raising concern regarding Brexit stocks, the Trust's IPC team had attempted to obtain confirmation on available mask types, and assurance of their supply to inform fit testing strategies; a month later there had been no confirmation received.

132. Under the supply chain conditions at the time, no Trust had any control over the types of masks that were provided. Public Health England guidance had changed a number of times in the weeks before the decision was made and had meant that we had used up some supply fit-testing groups of staff where a surgical mask was later considered adequate protection.

133. Each week we received deliveries of different types of masks. By early April 2020 we'd received four different types of masks in as many weeks, which meant that some staff had repeatedly been fit tested and, moreover, that we had used stock that might otherwise have been used to protect patients and staff. Not all of the items received were suitable for use.

134. Prior to the decision to change approach the Trust had seven different types of masks in stock and approximately 4,000 staff who required repeated fit testing, roughly 2,000 of whom would need the testing repeated, dependent upon what stock was received, as the available mask type had changed.

135. Each test took between 15 and 30 minutes. Even with the increased fit testing capacity over seven days per week it would have taken a number of weeks to test all staff on all available masks. This would also have meant that IPC resources would be diverted to support the program of testing, which otherwise could be supporting staff in clinical areas to use PPE effectively, safely and consistently. This would also have been taking an assumption that the variety of masks available would remain limited to those items already in circulation, and that stock would from this point have been reliable and consistent.

136. The decision to derogate was reviewed on a daily basis, as part of the PPE Strategic and Tactical group discussions, with a view to returning to the full program of testing as soon as the supply of FFP3 masks stabilised. The opinion of the Consultant in Medical Microbiology and Lead Infection Prevention Doctor

was also sought as part of the policy change. The Trust had an established mask fit testing program, and this had been in place for a number of years prior to the pandemic. Part of this program involved ensuring individuals were aware of how to fit check their mask. Our staff safety record is not by accident and the Trust worked hard to keep staff safe and well.

137. It was felt that the least harm would be obtained by releasing FFP3 national emergency stock that had been identified for mask fit testing. Whilst this was not in line with standard practice outside of a pandemic situation, it was felt to be consistent with the requirement on employers under the Health and Safety at Work Act 1974 "to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees." It should also be noted that the COVID pandemic was not business as usual, and that the Trust did not expect staff to work in COVID positive areas without fit testing, where they were not comfortable with their mask fit.

138. In addition to this, the Trust completed a COVID-19 Post Peak Debrief, whereby feedback from staff who had needed to use PPE indicated that they felt they had access to the right level of PPE for all or most of the time during the first wave of the pandemic. In addition, the overwhelming majority stated they felt confident in putting on, taking off, and using this equipment, which is likely a reflection on the significant investment in training provided by the Trust.

139. FFP3 masks had been used for some time, mainly on high-risk wards and areas (such as ICU and respiratory units), and so fit testing was in place prior to the pandemic. This was something usually undertaken by unit-based trainers. The process, exhibited at AF/29 [INQ000427340], was updated and adjusted to need when the 'outbreak of international concern' was declared. Drop in sessions were made available for staff to attend, in addition to bookable slots, these were available to arrange via HELM.

140. In mid-March 2020, external fit testers were sent by Public Health England to review the Trust's existing fit testing processes, following the issues identified with the Cardinal Health masks. They deemed the testing staff "…to be well-trained and informed. The fit test equipment was on the whole set up correctly in

accordance with manufacturer's instructions and the correct fit test protocols, pass levels and exercises were used."

141. There were no documented circumstances where a lack of PPE or RPE resulted in patient or staff safety being impacted detrimentally.

142. Nonetheless, the Trust did experience an inconsistent supply of PPE, and often had to source, or utilise, alternative products that clinical colleagues were unfamiliar with. This uncertainty in supply of PPE did cause challenges with local areas 'hoarding' stock or attempting to restock areas sooner than necessary.

143. In addition, inconsistent supply of items did result in the Trust receiving products that typically were not utilised. This led to scenarios where staff received PPE that may not be suitable for individual staff members (i.e. a particular variety of mask may not provide a good fit or seal for a specific individual). However, in such circumstances, staff members would be provided an alternative product and, if necessary, staff would be referred to occupational health to ensure appropriate redeployment opportunities were identified.

144. Through the Trust's Single Point of Contact mailbox, information around product recalls were received occasionally, whereby the Trust did need to request products to be recalled and replaced with an alternative product. This added pressure to the staff on wards to (a) identify relevant stock; (b) return stock to Procurement & Supplies; and (c) Procurement & Supplies having an adequate alternative item to replace any returned stock.

**Visiting Restrictions**

145. Visiting Guidance for Families was under constant review and updated regularly throughout the Pandemic in line with national guidance. In March 2020 visiting was suspended in line with the guidance provided by NHS England, exhibited at AF/30 [INQ000399381]. There were exceptions, such as

compassionate visiting for palliative patients, where one visitor was allowed, as per national guidance, and there were different approaches for paediatric patients, and for women in labour. These were in line with the national guidance however.

146. As each of piece of national guidance was published, the visiting restrictions at the Trust were formally reviewed. This review also included analysis of the extensive feedback received from families, carers and friends gathered through a bespoke visiting survey platform to ensure visiting was flexible and responsive to both national guidance, the local situation and family and carers feedback.

147. The first version of the Trust Visiting During COVID Standard Operating Procedure Trust Guideline was finalised on 4 September 2020 and is exhibited at AF/31 [INQ000427341]. This referenced NHS Visitor Guidance published on 08 April 2020 and also adhered to the NHSI "Visiting Healthcare Inpatient Settings Principles During COVID Pandemic" document published in July 2020 and exhibited at AF/32 [INQ000058539]. Compassionate visiting was available for patients and families who required it, whether in person or virtually and this was reviewed daily by the clinical teams.

148. Overall, the Trust Guidance was updated nine times between 4 September 2020 and 3 March 2023 when version nine of the "Hospital Visiting During COVID Standard Operating Procedure Guideline" was retired from the Policies and Guideline Library.

149. The Trust facilitated contact between patients and their loved ones through several different ways. In person visiting was allowed to specific wards and areas, through assigning a minimum of one hour visiting time appointment each day from the point of admission. Prior to the visit, visitors would be asked if they had COVID symptoms, were provided information on social distancing and face mask wearing and allocated a specific visiting time. Only two visitors per patient were allowed each day, each wearing a face covering when entering the ward.

150. In addition to this, the Trust acquired iPads and electronic devices to support patients make video-calls to family, friends, and carers. Staff would

support patients and, where needed, facilitate these conversations and arrange times with the families to ensure contact between patients and their loved ones was maintained.

151. During periods when visiting inpatient areas was not permitted, patient property 'drops' were available, and a dedicated phone line was established to support families and carers with the support of Patient Information Liaison Services.

152. The Trust's Visiting Policy referenced patients who required assistance, such as patients with learning disabilities, autism, mental health problems, or cognitive issues, such as dementia. Consideration was given to those with communication difficulties, those who were struggling to meet their emotional, religious, or spiritual care needs, and patients receiving difficult news, for example in relation to their healthcare prognosis or general wellbeing. Patients requiring extra support were permitted to have someone with them at the time of an appointment.

153. The patient feedback, which is exhibited at AF/33 [INQ000427344], obtained from various patient focus groups identifies that, whilst it was difficult for friends, family, and visitors in general, there was an understanding that the measures in place were for the safety of all.

154. The Trust's Patient and Community Engagement team completed a review of carers' experiences on hospital services during the pandemic from November 2021 to March 2022, the overview of which is exhibited at AF/34 [INQ000427376]. The main concerns escalated from carers were the restricted access across areas during the pandemic (as a result of national guidance being implemented), inconsistency between approaches from various wards, and improving the identification of support for carers acknowledging the constraints placed upon the Trust and external agencies because of the pandemic restrictions.

155. There were moments of inconsistency between the application of visiting rules, and certain areas were better at involving carers in patient care plans and providing greater access to the patient. Therefore, there was room for

improvement for carers to be seen as part of the team to support the patient, as an asset to wellbeing. Carers play an important role in learning more about the patient and improving patient experience treatment plans.

156. Nonetheless, feedback received did mention staff displayed empathy to carers where they couldn't accompany patients, and chaplaincy support provided the religious support to patients in the absence of visitors or carers. Staff did provide carers (where possible) with PPE to facilitate patient visiting, and ICU staff were very good at providing families with information about patient wellbeing and treatment plans.

157. Overall, I believe that a fair balance was struck between minimising the risk of infection and enabling patients to benefit from the support and comfort of visitors and/or carers. We were able to find this balance through experiences of each wave, learning from them and having conversations with families, friends and visitors through conversations held at the Patient & Community Engagement Team. As such, we were able to adapt internal visiting policies.

**Patient Treatment & Care**

158. At the beginning of the pandemic, all elective surgical procedures at the Hospital were paused, with theatres being repurposed to be prepared for an influx of COVID patients. All surgical specialties stopped operating on benign, non-life threatening conditions, and outpatient activity was converted, where possible, into virtual appointments.

159. The Trust implemented a phased approach to standing down outpatient activities. While originally able to maintain outpatient activity for high-risk patients, alongside skin cancer, and other urgent & emergency care activity, as the peak of the COVID wave arrived only clinically urgent activity was maintained. The Trust continued Endoscopy services for 2 week waits, cancer, and priority 2 emergency

patients, and considered cancellation of routine and planned patients, pending bed capacity or staff availability.

160. There was also a phased reduction of elective capacity, to manage demand in the Trust's ICUs. With anaesthetic services required to focus on COVID admissions, maintaining oesophagogastric cancer activity was significantly impacted, as this could only be delivered at the Hospital. Patients were offered prolonged chemotherapy or chemoradiation, and mutual aid resections in other areas.

161. Cardiology Catheter Lab procedures were able to continue treating urgent patients but had to reduce the number of Lab sessions due to the availability of workforce, and transcatheter aortic valve implantation work was ceased. Urgent and emergency cases were also reduced due to a reduction in bed-base and ICU capacity. Living donor transplants were ceased in accordance with national guidance and limitations with theatre capacity. High-risk deceased donor transplants were also paused.

162. In order to effectively respond to pressures, treatment pathways had to be adapted. The emergency surgical take was moved to the LGH, where elective activity was therefore significantly reduced at the beginning of the pandemic. The endoscopy pathway was also significantly reduced with only high risk 2 week wait patient cases being maintained, resulting in a significant backlog currently, with cancer surveillance patients waiting past their planned date.

163. To maintain outpatient appointments, virtual appointments were utilised to safely discharge patients from the Hospital. Virtual wards were set up so patients could be monitored remotely from their usual place of residence, rather than requiring an inpatient bed. Ophthalmology services were moved to the community.

164. An assessment area was created outside of the Emergency Department to ensure patients in the reception area were not exposed to potential COVID patients. Inside the Emergency Department, pathways were established to ensure clear flow of COVID and non-COVID patients across the emergency floor.

165. As outlined, the Trust utilised the private sector to maintain treatment for non-COVID conditions and to carry out elective surgery. This was done in alignment with the good practice guidance published by NHS England on the utilisation of the independent sector. Treatments re-allocated by the Trust included elective surgery, bowel cancer screening, urology, dental, maxillofacial, vascular, endoscopy, orthopaedic activity, and long wait outpatient activity (those waiting longer than 70 weeks for an assessment).

166. Women's and Children's Clinical Management Group prioritised their workload to ensure they continued emergency and cardiac services and stood down elective activity to only provide emergency and cardiac services during specific waves of the pandemic. Original waves of the pandemic focused on adult patients, therefore paediatric ICU staff were redeployed where necessary to support adult ICU capacity and staffing demands.

167. Service delivery was stood down in a phased approach. The Assisted Conception Unit was reviewed in line with national guidance and demand as the pandemic progressed. Maternity units absorbed patients within existing capacity and screening undertaken within the inpatient wards. Patient reviews continued to be delivered for gynaecology elective admissions, and cancer patients but as demand for COVID increased, only clinically urgent patients would be reviewed. Only clinically genetic patients would be treated, and gynaecology wards would take COVID patients as outliers when capacity required this.

168. However, for the large part, business as usual was maintained for maternity, neonatology and gynaecology services. Emergency pathways remained on Gynaecology Assessment Unit. Where there was a shortage of postnatal beds, patients were assessed on whether they could be discharged or transferred to St Mary's Birth Centre.

169. To keep patients and staff safe, processes were established for both the walk-in and ambulance arrivals entrance to safely allocate patients to the appropriate area of the department dependent on their covid status, these are exhibited at AF/35 [INQ000427377]. This enabled safe environments for COVID

and non-COVID patients. Patients were asked a series of questions to understand their symptoms and risk factors; if the patient did not have COVID, they were streamed to a non-COVID environment for ongoing treatment and management; this included minor injuries.

170. Patients who had COVID or were at high risk were streamed to the COVID environment created within the overall Emergency Department; fortunately, this area already had cubicles with doors on, meaning patients could be managed safely whilst receiving emergency care. Patients presenting to the emergency department with ischaemic heart disease received appropriate treatment for their condition in either the non-COVID or COVID environment of the department, depending on their infection status. This approach to the management of COVID and non-COVID patients was in place for both adults and children.

171. In the six months prior to the pandemic (September 2019 - February 2020 inclusive), the average ambulance handover time at the Hospital was 56 minutes and 9 seconds, with the highest average ambulance handover time being in January 2020 at 1 hour, 7 minutes and 53 seconds. During the remainder of 2020, the average handover time was 45 minutes and 13 seconds, therefore illustrating COVID did not have a negative impact on handover times.

172. Ambulance handover times at the Hospital increased from July 2021 - June 2022, with the average handover time being 1 hour, 25 minutes and 34 seconds. Peak average handover time was 1 hour 40 minutes and 26 seconds in April 2022.

173. No concerns were raised regarding an absence of national decision-making tool. A Trust decision-making tool to escalate care, and checklists were developed, from professional society documents, together with input from emergency medicine, acute medicine, intensive care, and respiratory medicine. However, the principles behind decisions were unchanged from pre pandemic practice.

174. A decision-making tool, which is exhibited at AF/36 [INQ000427378], was put together by the Trust at the start of the pandemic (end of March 2020) and

updated at regular intervals throughout as evidence and national guidance changed. The tool was put together with input from emergency medicine, acute medicine, intensive care and respiratory medicine. However, the main principles guiding decisions to admit to ICU were unchanged from normal pre-pandemic practice in that consideration was made of magnitude and potential reversibility of acute pathology, clinical frailty, other comorbidities (e.g. heart or lung disease), reduced physiological reserve caused by advanced age, and patient wishes.

175. The Trust set up a regular tactical group and clinical cabinet to review and approve key aspects of Trust policy and process during the pandemic. Updates to guidance were approved through this group.

176. Criteria for admission to ICU on the main COVID units at the Hospital did not change during the pandemic. A retrospective data collection of decision making of all referrals to ICU at the Hospital was made during the first wave of the pandemic, this is exhibited at AF/37 [INQ000427346]. The conclusions were that there was no identifiable change in ICU admission decisions.

177. The acute oxygen and respiratory support guidelines for the Trust were reviewed early during the pandemic, informed by rapid guidance provided by the British Thoracic Society and Intensive Care Society. COVID specific guidance relating to target saturations, oxygen flow rates and delivery interfaces was provided, this is exhibited at AF/38 [INQ000427346]. Later in the pandemic there was significant concerns that there might be shortages of oxygen during periods of peak demand, and an Oxygen Cell was convened which met weekly to develop a mitigation plan. In the event, shortages did not arise but one of the mitigations was the potential to lower saturation thresholds for those patients deemed unsuitable for treatment on ICU.

178. In the initial stages of the pandemic, treatment with CPAP or high flow oxygen was not advised for patients suitable for intubation outside ICU (this was based upon national guidance), but as reports came in from China and Europe that these modes of respiratory support could be effective, guidance quickly changed. CPAP and high flow nasal oxygen were provided on the respiratory ward outside ICU with the expert support of the acute respiratory response team. We

were able to provide effective respiratory support using these modes of treatment working closely with ICU to ensure transfer if treatment failed. Local guidance was updated in line with this and represented a change from pre-pandemic guidance and initial pandemic guidance outlined above.

179. The Trust participated in the UK wide recovery respiratory support trial comparing Chronic obstructive pulmonary disease, high flow nasal oxygen and simple oxygen in COVID showing these modalities could reduce intubation rates albeit not mortality. Our clinical outcomes in patients requiring respiratory support were better than average for the UK.

180. The Hospital did not experience oxygen shortages and did not need to introduce mitigations. There were times when capacity on ICU was very stretched and undoubtedly thresholds for admission to ICU and eligibility for ICU care rose. This was uncomfortable at times for respiratory teams who needed to care for critically ill patients on the respiratory ward without the facility for intensive monitoring that would normally exist on ICU.

181. There were sometimes disagreements between respiratory and ICU teams about where such patients should be managed because of our concern that patient safety and outcomes would be compromised by not transferring to ICU and also at times that patients who might benefit from ICU care were not being offered it. However, the recollection is that these disagreements were infrequent and, generally, working relationships between ICU and respiratory teams were very good. It is probable that these stresses on capacity caused adverse impacts on patients on occasion, however quantifying this is very difficult.

**CQC Inspection**

182. The CQC inspected the Hospital on 12 and 13 April 2022, with an overall rating provided as the Trust requiring improvement. Specifically, improvement was required for services to be deemed safe, effective, responsive to people's needs and well led. Services being caring was assessed as 'good'.

183. The inspection of urgent and emergency care and medical services were due to concerns about the quality of services. These concerns included waiting times for patients, delays in care and treatment, delayed discharges, and delays in being able to hand over patents waiting in ambulances.

184. The key findings were that patients and the community of Leicester, Leicestershire & Rutland found it difficult to access General Practices, and patients were signposted to receive treatment through Urgent Treatment Centres. This included higher acuity patients as a means of attempting to prevent admissions into the Emergency Department. However, admission avoidance schemes across Leicester, Leicestershire & Rutland had varying levels of success.

185. With the Trusts Emergency Department covering the whole of the large Leicester, Leicestershire & Rutland community, a city centre based hospital, with poor patient flow across health and social care, led to a great amount of pressure being placed on the Emergency Department. This resulted in long delays to care and treatment and had the effect of causing long ambulance handover delays, with a high number of hours lost, causing delays in ambulance services responding to 999 calls.

186. Delays to care and treatment were also caused due to specialisms not always providing sufficient inreach cover into the Emergency Department, especially overnight, as patients were not allocated until they were accepted by a specialist.

187. A perceived lack of system support (i.e. limited discharges and challenges with discharges, including 8pm cut off times to transfer patients out to other care settings in Leicester, Leicestershire & Rutland) further caused delays and this pressure was expedited by the number of medically fit patients for discharge that remained in acute services, as a result of limited capacity in community and social care services.

188. There were delays in moving patients off ambulances into the Emergency Department and into triage when the department was full. This resulted in delays

in assessment and treatment for some patients. Patients were not always able to access services when they needed it and did not always receive care promptly. Specialists were not always able to review their patients in the Emergency Department within agreed timescales, which increased blockages in the department and delays to treatment. This led to poor patient flow within the Hospital and delays in accessing hospital beds for patients who required admissions.

189. As a result of the high demands on the service and capacity pressures, the premises weren't always suitable to keep patients safe due to insufficient space to accommodate all patients in the Emergency Department and some areas being unsuitable for the purpose they were being used for.

190. Patients waiting on ambulances for over 30 minutes outside of the Emergency Department were assessed by an advanced care practitioner and monitored regularly by ambulance staff. Concerns were escalated around completing assessments in the back of an ambulance and how seriously ill patients may deteriorate rapidly without a senior Emergency Department medical review. Guidance from the Royal College of Emergency Medicine recommends patients should be offloaded from ambulances within 15 minutes of their arrival at the Emergency Department. However, on 11 April 2022 at 8pm the longest ambulance delay was 4 hours and 6 minutes, with the average time for a patient to stay on an ambulance in April 2022 being 112 minutes.

191. Harm reviews for patients waiting on ambulances for over 120 minutes were completed, with no incidence of significant patient harm for these patients. However, harm reviews were completed for patients waiting in the Emergency Department for long periods of time and senior nurses identified several incidents of harm on patients in this group (including a number of falls). Consequently, ward based matrons were deployed to the Emergency Department to ensure the ongoing needs of vulnerable patients were identified quickly.

192. There were also delays to walk in patients. An initial clinical assessment should take place within 15 minutes of a patients arrival to the Emergency

Department, but from 22 March - 18 April 2022 between 23% and 64% fell within this criteria. Delays were mitigated through a Visual Assessment Clinician assessing patients prior to streaming them to the correct area for a full assessment and treatment. However, delays to immediate treatment may have led to a rapid deterioration in some patient's conditions leading to poorer patient outcomes.

193. The Trust experienced long delays in assessing, treating and admitting or discharging patients, with national targets for Emergency Departments not met. This inability to review and admit patients increased overcrowding and reduced flow in the Emergency Department, resulting in concerns around patients deteriorating without early intervention from specialists. There were instances where patients were admitted to a hospital bed unnecessarily due to a lack of face to face specialist reviews. The insufficient bed capacity across the Trust led to concerns around the quality of care provided to patients.

194. Staff responded to patient risk through completing risk assessments for each patient and identifying and quickly acting upon patients at risk of deterioration through the National Early Warning Score (NEWS2). This information is displayed electronically, with a dashboard to aid in recognition of patients at risk and enabling senior nursing and medical colleagues to have oversight of the clinical risk of unwell patients, with escalations to senior clinicians for deteriorating patients. In addition, multi-disciplinary huddles were completed across wards to discuss risks and care plans for individual patients on wards.

195. As a result of the CQC Audit, the Trust developed an Action Plan, which is exhibited at AF/39 [INQ000427347]. A series of improvement measures were identified. For instance, medical in-reach was expanded into the Emergency Department to be a 24 hour, 7 day a week service in order to facilitate timely decision making. To ensure patients were effectively seen, the Trust reviewed the remit of GPAU, clinics and Same Day Emergency Care Services as a means to try and extend service provision. The Trust also refreshed and relaunched interprofessional standards, as well as provided Teams training on how to accept e-referrals to reduce the delays in specialty reviews for patients.

196. A ReSPECT tool was rolled out at the start of the pandemic. A standard part of deciding whether to admit a patient for ICU support would be to explore the patient's wishes about such an escalation of care and to respect any refusal related extraordinary life-prolonging measures. This was then recorded via a ReSPECT form. Most of the work exploring a patient's wishes would be done by the emergency, acute or respiratory medicine teams. I do not recall any formal guidance being given on this process.

197. Paper-based ReSPECT forms were introduced at the Trust on 1 January 2020, just prior to pandemic. The use of a paper based document enabled the recorded decision to be used in a number of settings, such as home, acute hospital, or community inpatient setting. Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR") decisions would also be recorded in the patients' electronic record.

198. Our patient safety team, patient liaison service and medical examiner's office have not shared any concerns regarding an over representation of any specific patient group in relation to the DNACPR process. Due to how our electronic patient records are constructed, we cannot supply an accurate record of DNACPR forms completion rates based on protected characteristics.

199. During the relevant period our adverse events management database (DATIX) reported 38 events relating to DNACPR, however, none of these events relate to concerns regarding prehospital DNACPR notices. Our system only captures formally recorded adverse events, and we cannot provide data of any potential informal or verbal concerns that were not captured on the system.

200. The medical examiners noted an increase in the number patients arriving in hospital with DNACPR forms, however this time period overlaps with the pre-planned roll out of ReSPECT forms. The increase in the number of DNACPR forms was therefore anticipated prior to the start of the pandemic. It is therefore impossible to ascertain cause and effect of the pandemic on DNACPR completing within the community the Trust serves.

201. The Trust provided clear guidance to all staff regarding the completing of ReSPECT forms during the pandemic. There were numerous guidelines, frequently asked question guides, and support from our palliative care team, such as the guidance produced by respiratory teams regarding symptom management for patients with COVID and how to withdraw respiratory support. This material was disseminated electronically, given the requirement to minimise face to face contact during most of the pandemic. However inpatient 'face to face' support was provided by our palliative care teams where appropriate.

202. Given the complexity and comprehensive nature of the guidance, it is not possible to provide an in-depth summary. The overarching theme was to ensure an empathetic approach where patients and families were invited to participate in all decision making. Where ceilings of care were reached, there was a focus on rapid symptom management, a considered withdraw of respiratory support with family support and, after death, prompt bereavement support being offered.

203. The Trust had a People Operational Cell established during the pandemic. It was reported on 19 May 2020 that the Equality & Diversity Council were impressed by the Equality, Diversity and Inclusion ("EDI") workstream at the Trust, and this would be used as good practice examples across Local Resilience Forums.

204. Concerns were raised around homeless people and their ability to social distance and access healthcare should they develop symptoms. The Trust engaged with Leicester City Council and established a helpline to support the homeless, providing temporary accommodation as well as hot meals and packed lunches. The use of facemasks resulted in challenges in expressing and understanding emotion displayed by patients and staff members. This was addressed through the introduction of clear face masks as good practice.

205. As a means to address potential health inequalities during the pandemic response, the Trust attempted to utilise multiple platforms to share information. This includes translating leaflets into various languages, creating video packages

to be circulated on social media and utilising faith networks to further cascade information to local communities.

**Impact on hospital staff**

206. The Trust took practical steps to minimise the impact of the pandemic on the physical health of staff members. This included the provision of PPE and associated training on use. COVID testing was introduced, and lateral flow tests made available for staff. Rooms at the Hospital were converted into wellbeing rooms to provide space for colleagues to rest. Free food and water were provided and donations such as hand cream, food, drinks, and toiletries were distributed among staff. Equipment and procedures for home working were provided where possible.

207. During the relevant period all staff had access to emotional and psychological support provided by AMICA including modules on their website. Schwartz rounds were run on a monthly basis. These were structured forums where staff could come together to reflect on the stresses and dilemmas that they faced. The Health and Wellbeing Team also organized and delivered awareness sessions which signposted staff to areas of support.

208. Trauma Risk Management delivered support across the Trust to colleagues impacted by trauma, moral distress and moral injury, the guidance of where to seek help is exhibited at AF/40 [INQ000427362]. REACT training was available through the NHS People website. This was designed to support managers and those with caring responsibilities to identify the need for and facilitate a supportive mental wellbeing conversation using the REACT mental health conservation model.

209. The NHS England initiative "Wellbeing Wednesdays" were advertised by the Trust, but we do not have any records of the number of colleagues that accessed them or any feedback regarding them. The Trust also set up virtual wellbeing rooms, but nobody joined these.

210. Physical wellbeing areas were set up locally by teams where space had become available due to either virtual working arrangements or the fact that there was no visiting or access by members of the public. These were temporary and funding was made available through Leicester Hospitals Charity to help furnish them with equipment and supplies such as radios, coffee machines and snacks. They were well used but it was not possible to record numbers. The Clinical Education Centres converted areas into wellbeing spaces with reclining chairs and refreshments available.

211. The Trust developed a collaborative document for managers and employees to support staff with long COVID. This contained links to other plans and guides to help staff, as well as advice from local and national networks, services and support groups. The document detailed the practical work related guidance regarding matters such as annual leave and returning to work processes.

212. When returning from work after suffering from Long COVID, a gentle approach was recommended to support staff with symptoms such as fatigue. A support document was set out and is exhibited at AF/41 [INQ000427363]. A therapeutic return could be considered over the course of 2 - 4 weeks where staff remain certified as being off sick but attended work for less than 16 hours per week and were paid according to the sick pay they receive. Staff would be considered as supernumerary and not expected to fulfill their full role, with the aim of seeing how staff felt and if they may be fit for work with any potential adjustments. Alternatively, a phased return could be considered over a period of 4 weeks with hours building up gradually.

213. The Trust was able to safely maintain staffing capacity across its critical areas. The Trust's Redeployment Hub was able to redeploy staff to critical areas, but also ensure any vulnerable staff were provided appropriate mechanisms, either in their existing place of work or redeployed to a lower risk area.

214. A local risk assessment tool was developed and implemented at the Trust on 19 May 2020, with training for line managers. 15,400 risk assessments had been completed to 31 December 2022. Risk assessments sought to identify any

risk factors and reasonable adjustments, which enabled colleagues to remain at work with appropriate support and adjustments / redeployment. The specific risk factors named within these assessments were:

a. Age (over 60, under 60 with health conditions or over 60 if BAME)
b. Sex
c. Body mass index
d. BAME
e. Pregnancy (28 weeks)
f. Medical conditions
g. Complex health problems
h. Work area risk

215. Concerns were raised related to confidentiality, the ability to make adjustments and the levels of risk posed in different clinical areas. In the early stages of the pandemic there was little knowledge of the vulnerability factors. Staff were reluctant to engage at times and managers required training on systems.

216. Line managers were requested to complete a risk assessment for all staff, to ensure reasonable adjustments were available for those who had vulnerabilities and, where required, support would be requested to People Services and Occupational Health Services. While the Trust's IPC team did not specifically complete any EIAs prior to, during, or post-pandemic, they utilised any risks escalated via the risk assessments previously undertaken to ensure appropriate precautions were provided to staff.

217. Where risks for staff were identified, an individual review would be undertaken to try and mitigate the risks, which would include understanding whether the employee can adhere to standard precautions that are already available, find solutions to reduce the risk of unprotected exposure to COVID, safely utilise PPE or be redeployed to a lower risk area.

218.

219. The Trust's People Services Operational Group had senior representation from EDI. As part of the Trust's Frequently Asked Questions for COVID, a specific section referred to EDI matters. This included providing guidance to line managers to support them having thorough, sensitive, and comprehensive conversations with BAME staff to identify any existing underlying health conditions and consider the feeling of colleagues, especially regarding safety and mental health. Furthermore, a platform for staff to escalate concerns was provided, via email and phone-call.

220. There was also EDI representation as part of the Trust's Tactical COVID Group and EDI was considered in policy development and risk assessments. For example, the effect of the uptake of the vaccine amongst BAME colleagues.

221. One of the key themes of Trusts' COVID Post-Peak Survey reviewed whether or not staff felt the communication arrangements were an effective way of sharing information across the Trust. Trust-wide communication to staff was offered in a variety of platforms. Primarily, staff utilised the intranet, daily Communications briefings, video messages from the Chief Executive on Friday's as well as health and wellbeing emails and the use of social media.

222. Responses received indicated a broad consensus from staff that the Trust-wide communication arrangements used during the first wave of COVID were well received, with both clinical and non-clinical staff making use of multiple channels. As a result, it was assessed that the communications program should remain largely the same for further waves of the pandemic. Staff also appreciated being informed about how the Trust was responding to the pandemic, as it provided a safer environment to work in, a platform to reassure staff on the direction of travel and the plans that were under development to respond to future potential challenges. While Trust-wide communications were seen favorably, staff indicated that communication at a local level with line managers was less effective.

223. In the event of future pandemics, the Trust would highly benefit from clear and realistic processes to approve and release media statements. Acute Trusts

were required to sign-off any media statements relating to the pandemic with regional and national communications teams. Approvals were often granted with significant delay, resulting in the Trust being unable to provide comments to the media, therefore tarnishing its reputation with local, regional and national media outlets. For future incidents, if a similar model is adopted, the Trust would recommend regional and national teams are adequately resourced to approve local media statements in a timely fashion.

224. Feedback received from the senior leadership teams indicated a delayed response to queries around national guidance and how it should be applied at the Hospital. This included delays in the process for any COVID related communication messages to be approved. Current incident response processes require any communication messages to be approved by the Regional and National NHS England Communications Teams, prior to any statements being published to the media outlets. While the Trust provided adequate time for approval, we often experienced delays in receiving responses, ultimately resulting in no official comments being provided to the media. This led to negative reputational effects with media outlets.

225. Similarly, responses from the national team around the implementation of new or updated guidance resulted in uncertainty on how to apply it within Leicester's Hospitals. For example, the Trust often had to wait over a week to receive responses to queries around the management of patients who experienced adverse effects to the vaccine.

226. In addition, where information requests were cascaded to the organisation, no platform was available to discuss the practicalities of these information requests, and what the purpose of the information request was. A platform to enable two-way communication between regional and local colleagues could potentially streamline a number of data-related queries, reduce duplication of requests and ensure the right information is captured.

227. My reflection is that during the initial phases of the COVID pandemic, national guidance frequently changed and had very a short window to implement.

It was not helpful that changes in guidance were often signaled on the evening national Prime Ministerial briefing before we had received full details.

228. At times, there was also a conflict between national guidance and guidance issued from the medical Royal Colleges and professional societies - this created uncertainty amongst clinical colleagues and led to clinicians raising concerns about national guidance. Examples of this would include what constituted an Aerosol Generating Procedure; and PPE precautions needed during a cardiac arrest situation. I also feel that the whole process around implementation of mandatory staff vaccinations was poorly handled by policy makers at a national level and brought Hospital leaders into conflict with staff.

229. My reflection is that the regional NHS England team supported as best as they were able given the rapidly changing nature of the pandemic, but at times they also struggled to resolve the differences between national guidance and that from medical colleges and professional societies. Whilst at a hospital leadership level we tried to ensure that colleague concerns were listened to and provide clarity on guidance, these differences in guidance created concern and anxiety for colleagues.

**Recommendations**

230. I feel that NHS hospitals remain poorly prepared to cope with a future pandemic - fundamentally the NHS does not have sufficient single rooms or adequate ventilation in its ward stock. Added to this, we have very little redundant capacity with high occupancy and a very pressured system both for urgent and emergency care and planned care. ICU and High Dependency Unit capacity also need to be increased and we need to be prepared to allow some resilience in the system. There needs to be a better way to keep more planned care work going, but again this links back to sufficient infrastructure and workforce to do this.

231. There needs to be a more joined up approach on developing national guidance between national policy makers, the medical Royal Colleges and professional societies.

232. When publishing updated policies and guidelines, national decision makers should consider providing time for local senior decision makers to review guidance, enabling them to adapt that guidance to their clinical settings. In addition, strategic leadership teams should be provided advanced warning of any updates to policies and guidelines prior to them being announced through national media, as this influences the behaviour of staff and public. This would also reduce the perception of changes being implemented at speed. If staff were provided with more time to adapt to different restrictions and guidance, this would lead to more confidence around the decisions being made.

233. A two way communication platform for regional centers to communicate with the Trust's senior leadership team would be helpful to ensure specific points can be clarified where necessary, listen to local areas and pressures and enable organisations to adopt principles based off the local environment. The two way communication would also enable organisations to understand what questions are being posed by the national team, to ensure useful and relevant information is being requested and captured, rather than perhaps duplication of information returns without a clear sense of purpose or direction.

234. The flexibility of policies and guidelines would be helpful. In January 2022, the Trust was requested by NHS England to establish a Nightingale Hospital at the LGH site, as a surge hub to create a contingency bed-capacity as part of the national response to the surge of the Omricon COVID variant. The Hub would have created an additional 100 inpatient beds for use by the Trust, specifically for step-down COVID patients that are waiting for a care home placement or package of care. While the Trust originally paid for establishing the Nightingale Hospital, finances were fully recompensed by NHS England. Due to the specific requirements of the Nightingale Hospital, no patients were ever treated in the Hub,

as neither the Trust, nor the Midlands required the anticipated additional capacity for COVID patients above the surge capacity identified within existing footprints.

**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**: 29 April 2024