Witness Name: Charles Ashton
Statement No.: 1
Exhibits: 4
Dated: 25 April 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR. CHARLES ASHTON

I, Charles Ashton, Medical Director at South Warwickshire University NHS Foundation Trust, Lakin Road, Warwick, Warwickshire, CV34 5BW, will say as follows: -

1. I make this statement, about the impact of the Covid-19 pandemic on the care and management of patients presenting at hospital, as well as on hospital staff, during the pandemic in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 13 December 2023, in relation to Module 3 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

2. I make this statement on behalf of Warwick Hospital, which is part of South Warwickshire University NHS Foundation Trust (SWFT) and confirm that I am duly authorised to do so.

3. I am the Chief Medical Officer (previously the role was titled Medical Director) of South Warwickshire University Foundation Trust. I have been in this role since 2014 and was previously the Medical director in Worcester since 1998 and thus have over 20 years' experience in this role. I am responsible for medical leadership, education, and research. I am jointly responsible with the Chief Nursing Officer for safety and quality. I am the Responsible officer for

Revalidation and the Caldicot guardian. My clinical background lies in Elderly Medicine, Stroke and Clinical pharmacology. I am a Fellow of the Royal College of Physicians and have an honorary Doctorate. Over my many years of medical management I have faced and overcome many operational challenges including the problems associated with influenza and SARS.

Background

4. The Trust as a whole provides a range of healthcare services to around half a million people in Warwickshire, with Warwick Hospital mainly supporting patients in the South of Warwickshire, where the population is 310,000 based on the number of patients registered with a South Warwickshire GP Practice. Warwick Hospital's Emergency Department (ED) does receive a large number of patients who do not live in South Warwickshire and therefore the ED can see in excess of 15% of its ED patients coming from elsewhere.

5. Warwick Hospital Acute services are provided in South Warwickshire, with community services delivered across the whole of Warwickshire. Children's, Young People's and Family Services are also delivered throughout Coventry and Solihull.

6. South Warwickshire has a growing elderly population. This increase in frail patients with complex, multidisciplinary care needs is a challenge for the organisation, but the Trust's Frailty Team continue to work with partners to ensure patients receive treatment in the right place at the right time. Some communities in Warwickshire are extremely rural which leads to difficulties around access to services. 43% of the population live in rural areas compared with the England average of 18%.

7. The Trust operates from a number of sites including: Ellen Badger Hospital, Leamington Spa Hospital, Stratford Hospital and Warwick Hospital. Warwick Hospital is the Trust's largest site and the majority of the Trust's acute services are provided there. These include emergency, diagnostic and pathology, diabetes and audiology amongst a range of other services. Intensive care,

cancer care and coronary care are all delivered in dedicated units and surgical procedures are carried out in main and day theatres. Warwick Hospital also has a labour ward, special care baby unit and midwifery-led birthing unit called the Bluebell Birth Centre.

8. Warwick Hospital employed approximately 3,200 members of staff during the relevant period. There are 37 Wards at Warwick.

Staffing capacity

9. In relation to staffing capacity throughout the relevant period, the circumstance that affected most whether the hospital was short-staffed or experienced temporary staff shortages was self-isolation. This had the biggest impact, with 738 staff (approx. 15% of the workforce) required to self-isolate in April 2020. This did reduce over time but with another spike in January 2022.

10. ICU was significantly impacted; however, we were able to redeploy Theatres staff to provide support. Our designated Covid-19 ward was also heavily impacted with staff being unwilling to be redeployed there due to worries about contracting the virus.

11. All staff in patient-facing roles were impacted significantly. Non-patient facing staff were able to work from home with suitable arrangements implemented very quickly.

12. During the first wave of the pandemic vacancies and staff shortages actually fell quite dramatically. The reasons were due to less demand through our Emergency Department which in turn led to fewer non-Covid patients. In addition elective work was stood down and staff were redeployed to areas where needed. In addition we had a huge increase in the number of people wanting to join the NHS and at Warwick in particular. This included Clinical Staff who had recently retired or left the Trust as well as new people who wanted to help in the Covid response.

13. Staff shortages were felt in certain areas including our Intensive Care Unit (ICU) and others and this was due to pre-pandemic vacancies, staff who needed to self-isolate, staff who were shielding etc. but during 2020 it was minimal.

14. When we got to 2021 and through to the beginning of 2022 fatigue and stress started to set in which meant vacancies, staff shortages and turnover began to increase. In addition those staff who had returned after retirement and those staff who postponed their retirement made the decision to leave which increased our vacancies. We worked very hard to cover those vacancies and shortages and during the middle and end of 2022 vacancies began to fall back to below pre-pandemic levels.

15. The introduction and availability of Covid-19 diagnostic testing for staff did not necessarily impact the hospital's workforce capacity. Testing of symptomatic staff commenced on 1st April 2020 via a swabbing hub, initially at University Hospitals Coventry and Warwickshire (UHCW) and subsequently on-site at SWFT (from 9th April). Results were communicated via Occupational Health and a spreadsheet retained within Human Resources (HR) for correlation against Covid-19 sickness absence. Sickness absence peaked in April 2020 with 386 staff absent; however, this dropped significantly to 125 in May 2020.

16. Commencement of routine Lateral Flow Test (LFT) testing for asymptomatic staff in November 2020 correlates with a significant increase in the number of staff required to self-isolate.

17. A further peak was seen in January 2022 although this does not appear to correlate with diagnostic testing. We do not have a definitive reason for this peak, however, it does correlate with a peak in Covid-19 in the general population which is likely to be linked to social gatherings over the Christmas period; it can be assumed that that also caused the peak in NHS staff absence. There were no specific outbreaks or other incidents at Warwick Hospital to cause this peak.

18. Processes for staff to return to work were in line with government and PHE guidance.

19. Antibody testing commenced on 29th May 2020, with 4834 staff tested in total. It was a complex operation for all staff to be tested and to have results communicated to them. The results had no impact on staff absence as the detection or non-detection of antibodies did not change the requirement to self-isolate etc.

20. The effect of temporary registers for doctors, nurses, midwives and pharmacists to enable trainees and retired staff to work in these roles did have an effect on workforce capacity as it enabled retired staff to return quickly. I would say this was felt mainly within Nursing colleagues as these were the largest numbers of people who returned. I would say that although this did help the teams within the hospital worked very hard to enable staff to return following retirement whilst still following all national guidance.

21. The main constraints for Warwick Hospital to increase staffing capacity were related to current vacancy position at the time the pandemic started; as the pandemic progressed many staff were required to shield as they were extremely vulnerable and staff that contracted Covid-19 needed to isolate and were therefore unable to work, both of which affected our staffing capacity.

22. We used redeployment measures to alleviate staffing shortages. Staff from non-essential services where services had either been reduced or stood down were placed on a list to be redeployed. These staff were asked their skill set and asked to move to areas where they could assist. This was both for clinical and non-clinical services. Furthermore, basic Clinical Support Worker training was provided for all staff that were being redeployed including student nurses and student doctors and those providing basic nursing care. All staff were inducted into the new areas of work. These measures were effective in that it meant that staffing numbers were increased which helped with patient safety and also with staff stress levels and health and wellbeing.

23. In addition to redeployment of staff and upskilling of staff, we also ran a successful vaccination programme which resulted in reduced effects of the virus

should staff catch it hence reducing staff sickness levels. Our vaccination programme included vaccinating Volunteers and social care staff as well as NHS workforce. We used the 15 minute wait time as a health and wellbeing opportunity for staff to signpost to further support if required or just to check in with them.

24. I am not aware of any measures put in by regional NHS Bodies.

25. We utilised temporary registers brought in following new legislation passed by Government which alleviated staff shortages. The Nursing and Midwifery Council (NMC), the Health and Care Profession Council (HCPC) and the General Medical Council (GMC) initiated a temporary register for staff which increased the workforce number, thereby alleviating staff shortages.

26. There was a national agreement with NHS England and Health Education England around student deployment for payed placement as this would bring them under T&C of workforce. SWFT had a deployment process led nationally for students by NHS England and worked with Higher Education Institutes; this was not mandated and could only be 2nd and 3rd year/final year students; the 1st years were paused.

27. Staff worked flexibly during the pandemic and supported departments that were under increased pressure. Critical care in particular required increased support as they had to increase capacity and extended the intensive care unit into another area. Nursing staff and allied health professionals were redeployed from theatres as well as doctors from anaesthetics and orthopaedics. They assisted trained critical care nurses within ICU. The staff who were redeployed always worked with staff who were trained and used to working in this area to ensure they were supervised and supported as best possible. This did create extra workload and responsibility for the substantive members of staff as well as created stress for some of those staff unfamiliar with the environment in which they were working.

28. No SWFT employees were redeployed to other hospitals.

29. A number of non-essential SWFT staff (e.g. community staff, therapists and senior staff) were sent to the Nightingale Hospital for training but were never required as the hospital did not open.

30. In relation to redeployment of staff and the practical effects, staff were affected; their wellbeing, morale and burn out. Having to work in other, unfamiliar areas did cause stress to staff. We increased our wellbeing support as a result.

31. There has been a small number of staff members who have suffered from Long Covid but this has ultimately resulted in dismissal due to an inability to return to work. This has had a life-changing impact on those individuals, with applications for ill health early retirement refused by the NHS Pensions Agency due to a lack of knowledge about the long-term effects and likelihood of recovery.

32. No members of staff died from Covid-19 at Warwick Hospital, however we did sadly have one member of staff who was based at our Royal Leamington Spa Rehabilitation Hospital pass away due to complications of Covid-19.

33. In relation to the proposed regulations for Covid-19 vaccination as a condition of deployment ("VCOD") for healthcare workers at Warwick Hospital, we checked and documented the vaccination status of every member of staff with assessment undertaken by area of work to assess the likely impact of VCOD on capacity. The highest impact was likely to be on Children's Services with 59 of the 187 staff who were not fully vaccinated working within that area. Particular areas of concern were Health Visiting and School Nursing, both of which are areas that are difficult to recruit to.

34. 130 staff were in patient-facing roles and due to be dismissed due to non-vaccination. This represented 2.6% of the overall workforce (including those in non-patient facing roles). A further 57 staff had had one dose of vaccine more than 8 weeks previously but had not received the second dose and therefore were also potentially at risk of dismissal. This represented 1.1% of the overall workforce.

35. The impact of VCOD cannot be underestimated, particularly the damage to the HR teams who were facing the prospect of dismissing long-serving, caring, compassionate members of staff. The moral injury caused to HR professionals was huge.

36. The impact on staff morale was also huge, causing considerable upset for those staff who, for whatever reason, chose not to be vaccinated. Whilst all conversations were approached sensitively and with compassion, offering support and 1:1 conversations with a clinician to address any questions or concerns about the vaccination, there was significant damage to employee relations and for some individuals this has not recovered.

37. There were a number of managers who refused to have conversations with their staff members, instead insisting that this was done by HR, as they fundamentally disagreed with the government approach.

38. Due to the very late decision to repeal VCOD, potential applicants for vacancies had already been turned away as they had indicated that they were unvaccinated.

39. We did not produce a VCOD Policy but we did develop a SOP. This outlined the procedure that we would follow. We also produced guidance for managers, both on the process and also on having supportive conversations with staff. We decided to do this on the basis that we needed clear, simple advice for staff and managers on how we were managing this and what roles were in or out of scope. As mentioned previously, VCOD caused a lot of distress across the organisation – for unvaccinated staff who were worried about their jobs, for vaccinated staff who were worried about losing colleagues, for managers who were expected to have very difficult conversations with their team members and for the HR team who took the brunt of everyone's upset for a process they did not believe in.

40. Warwick Hospital also had a staffing capacity constraint related to staff of a BAME background once national data referenced them to be at greater risk of

mortality related to Covid-19. We undertook risk assessments on all staff and moved high risk staff to non-Covid-19 wards and departments for their protection. This created some staffing concerns in Covid-19 positive areas.

Bed capacity

41. Bed capacity was high prior to the publication and implementation of the NHSE/I Discharge Policy although had begun to drop prior to the 17th March 2020. The number of occupied beds on general wards dropped significantly once the policy was enacted; this can be seen by referring to the graph at exhibit CA/1 [INQ000427499]. Specifically the graph shows the bed occupancy dropped from approximately 90% early to mid-March 2020 to below 50% by the end of March 2020. This goes hand in hand with a drop in ED attendances, admissions and admission rates from ED. Furthermore, elective work slowed and then halted for a short period which also affected bed occupancy. Also related, is that the discharge process as a whole was simplified so took less time and length of stay reduced as bed pressures reduced to a core of non-Covid-19 patients and a steady stream of Covid-19 patients. ITU capacity on the other hand rose from 50% early March 2020 to greater than 100% by the end of March 2020.

42. Following a national request the Trust executive team asked the Critical Care team to prepare and reallocate all equipment to create the maximum number of ventilated bed spaces possible with the equipment the Trust could source. Regional network submissions were also required to establish regional capacity. Requests were facilitated by the following actions related to location and equipment.

43. Please note that at no time was this level of provision staffed by ICU nurses and no minimum/ alternative staffing levels had been defined. It is important to note at SWFT each of these areas were physically separated so effectively all requiring ICU competent staff in each individual theatre location.

44. Funded ICU capacity for SWFT was 5 level 3 beds plus 24/7 Outreach
    - Week commencing 23/03/2020 NCEPOD theatre was moved to day surgery.
    - Week commencing 30/03/ 2020 - all elective operating cancelled.
    - Critical Care Training for Theatres and anaesthetic staff commenced with resources materials and videos produced for teams.

- The conversion/ set up of 5 operating theatres, ventilators and anaesthetic machines to support the equipped provision of 30 ventilated spaces. This space/ capacity was not requested to be used.
- The ICU environment between March 2020 until September 2021 had 1 ventilated side room and 2 partitioned pods plus 5 open beds to accommodate all Critical Care admissions. 8 bed spaces in total within ICU footprint equipped to take level 3 patients pre refurbishment and during the relocation to Willoughby.

45. Theatre 6 was used on 3 three occasions outside of ICU footprint for infection prevention purposes (i.e. not mixing Covid-19 & non-Covid-19) prior to refurbishment and side rooms.

46. On 3rd July 2020 ICU relocated to Willoughby ward for the ICU refurbishment in order to create improved ventilation and side room facilities. Willoughby had 8 level 3 beds set up there in three bays to accommodate – no regional capacity was lost during this refurbishment.

- We moved back into the unit with 5 side rooms - 2 open beds - total 7 beds on 30/09/2020
- On 12/01/2021 we put patients back into theatre 6 and then made the decision to transfer 3 patients to theatre 6 and split our critical care work force accordingly.
- Peak of the surge for SWFT ICU was 22/01/2021 with 10 ventilated patients until we moved out of theatre 6 on 13/02/2021 but maintained a workforce to manage a dependency of 7 for the rest of February 2021, this was not needed as our dependency never went above 6.
- In the whole surge period we only had 3 non clinical transfers and they all occurred between January – March 2021.
- We supported network/ ACCOTS requests for clinical transfers in.

47. Anaesthetic staffing and emergency shadow rotas were commenced 20th May 2020 to support split location working for Critical Care teams.

48. Theatre staffing shadow and support rotas were commenced May 2020 to support ICU staffing dependency.

49. Outreach continued to run and support was provided by the ICU/ Anaesthetic teams for the respiratory/ CPAP patients.

50. Orthopaedic doctors supported ICU teams with one doctor per day Monday to Friday. Doctors, nurses and allied health professionals from anaesthetics, theatre, outreach, alongside nurses with prior ICU experience; who had other roles within the Trust, also returned to ICU to support.

51. The response of individuals within these teams also varied based on risk and health assessments as a number were excluded from clinical duties based on assessments.

52. Hence SWFT provided capacity as requested Nationally and regionally throughout the duration of the pandemic to 120% funded capacity (Surge) increasing to 160% (Super surge) of funded capacity limited by its locations, physical sizes and workforce.

53. Transfer requests were managed by the regional network in conjunction with the Consultant responsible for ICU 24/7 on a daily basis.

54. With regards to the statement that one of our intensive care doctors made, I think this is a misleading account. Staff worked their standard hours during the pandemic albeit in very demanding conditions. Within high stress environments staff often rely on peer support to rationalise and decompress after a stressful shift. This is often as simple as a 'coffee room chat' or a meet up after work. Unfortunately, due to the infectious nature of SARS-CoV2 this prevented the coffee room camaraderie and any after work events. Having spoken to colleagues most staff wanted to remove their PPE and leave work as soon as possible after their shift had finished; this meant they would deal with the day's events alone or with family support. The doctor's media report was highlighting the frustration with the situation and explaining the impact it is having on staff

with the hope it would encourage the public and policy makers to make decisions that would reduce the transmission of SARS-CoV2.

55. Training modules were created in line with the level of training required and all training materials were uploaded onto the hospital intranet so staff could review it when necessary. MSTeams channels were created with training material attached and the ability for specific questions to be answered by subject experts. Bespoke training was created for the first week of lockdown to go through donning, doffing, guide to proning and to familiarise other staff with ICU equipment. Feedback was obtained from attendees who confirmed the training was well received and they felt supported.

56. The pandemic has undoubtedly had an impact on staff. Within critical care this impact was most felt by staff who helped work in ICU but weren't members of the regular critical care team. Several clinical teams particularly theatre teams and orthopaedic surgeons helped on ICU during surge 2. Critical care is quite a unique environment and very different to that seen in other areas of the hospital. Most staff members are not exposed to this environment during their career so when they came to assist in ICU it was a significant culture shock, being exposed to critically unwell patients many of whom didn't survive. Support, including psychological was offered to staff but this was via self-referral. Unfortunately the resourcing was not available to provide all the support we wished we could have done during and subsequent to this period.

57. We all worked collegiately to increase ICU capacity within the hospital. To maintain capacity within ICU we converted bays on the respiratory ward to provide continuous positive airway pressure via portable machines. This was overseen by the respiratory multidisciplinary team; close collaboration occurred with this team and the ICU team to ensure availability of suitable beds, personnel and equipment. Regular meetings were held with all key stakeholders including nursing, medical, procurement, estates and Electro-Biomedical Engineering (EBME) to ensure supplies were available and machines were working effectively.

58. The ICU team increased capacity as able, during the pandemic. This was done on an agile basis dependant on local clinical need. At the beginning of the pandemic we made suitable provision to increase capacity by 100% and utilised these plans to respond to the national/ regional requirement as necessary. At the height of surge 2 we had expanded to 150% capacity utilising an operating theatre to expand into. Nursing provision was provided by our own staff as well as critical care trained nurses who had left critical care to work in other areas prior to the pandemic. All areas were managed and overseen by a substantive senior critical care nurse. During surge 2 nursing colleagues, anaesthetic colleagues and orthopaedic colleagues helped on ICU providing care within their level of expertise.

59. Safety was maintained throughout by ensuring substantive staff were always caring for patients alongside staff from there areas. Whilst shifts were busy and stressful colleagues did not report concerns of any major safety issues.

60. We accepted patients into the hospital from other ICUs when capacity allowed and utilised support from other hospitals when required.

61. We are part of Midlands Critical Care and Trauma Network. We transferred 3 patients to another ICU for capacity reasons during the pandemic.

62. We had a small number of patients transferred to the ICU from a different hospital during the relevant period; however data is not stored in such a way for us to be able to provide an exact number – this may be held at regional transfer level.

63. The Critical Care Network within the West Midlands was very proactive during the pandemic creating a transfer team as well as hosting daily Teams calls to check on capacity and strain across the network. All transfers into and out of Warwick Hospital were within our network.

64. We did not have any shortage of ventilators in our ICU; by coincidence we had just accepted delivery of new replacement ventilators for our ICU prior to the pandemic. This meant we could use these in addition to our old ventilators.

65. We were an early adopter of CPAP delivery for these patients. This was delivered by repurposing sleep apnoea CPAP machines which we obtained. Consumables and circuits were made up in advance and regular meetings were held between procurement, clinicians and EBME to ensure we never ran out of stock.

66. Oxygen delivery was never a problem. At the start of the first surge, one of our clinicians worked closely with estates to ensure we had an up-to-date map of pipework around the Trust. Diversified flow was calculated for each ward and individual wards were assessed for escalating should high flow oxygen devices be required. These wards were stress tested with high flow devices before patients were admitted, to ensure calculations worked. All oxygen driven devices e.g. anaesthetic ventilators were swapped to air. Ground work and pipe work was rapidly arranged and completed to enable a portable Vacuum Insulated Evaporator to be installed immediately in another part of the site should it be required. Oxygen utilising was recorded on every bed space across the site and this was disseminated to key personnel so they were aware of any impending problems.

67. We had no problems with the provision or renal replacement therapy machines.

68. We had problems with supply of some medicines, but only in line with National problems and there was no patient impact as we increased internal support to manage the response.

69. The Trust with support of our ICB worked with the private healthcare sector (IS) to maximise the capacity during the pandemic. The Trust, and the private health care sector met weekly to plan the resources required both human and physical and to understand the demand and capacity. Weekly activity meetings were in place. Quality and safety meetings were also established and a suite of KPIs

developed. Covid-19 policies and procedures were shared so that staff were working to common guidance.

70. Staffing capacity was used mainly to recover the elective activity with honorary contracts in place for clinicians who did not normally work in the IS.

71. When elective activity was initially stood down across the NHS equipment was transferred from the IS to the Trust, fortunately this equipment was not required and was returned to the independent sector.

72. Capacity was used in the IS for diagnostics such as imaging and endoscopy and cancer. From April 2020 we moved a number of our cancer services off site to the independent providers. The whole breast cancer service moved to the Nuffield Hospital, plastic surgery and urology also moved. Gynaecology capacity was identified at the BMI Hospital in Coventry and this was co-ordinated by the Integrated Care System with one link person within the Trust.

73. To ensure patient safety we moved our own IT systems to the independent provider to ensure continued access to health care records, access to the Trust's diagnostics systems and to ensure communication with patients and GP's remained at the same level as pre-pandemic and the move of service.

74. When elective activity was re-established there was a strategy across the Trust and IS to use as much capacity as possible across the IS to address the long waits, cancer and clinically urgent that could be carried out in the different IS settings, including outpatients pre op, screening and diagnostics. This was monitored weekly via a joint meeting and capacity flexed and expanded to accommodate the demand.

Infection prevention and control (IPC)

75. We followed National Guidance in relation to IPC, as a minimum requirement; however on occasion (April 2020 for example) we did deviate in response to wearing of PPE by staff, when we went above the national guidance. We

implemented wearing of universal PPE for staff before it became a mandatory requirement.

76. With regards to covid testing guidance we followed the national guidance on testing.

77. The Trust held daily Silver Command meetings where any change in guidance was raised. Alongside clinical and operational representatives, the corporate communications team attended every meeting and supported with information sharing. To reach as many staff as possible at times of changing guidance, we utilised 'all staff' emails, a closed staff only Facebook group and also delivered messages directly to inpatient areas through the senior nursing structure. The Trust's governance lead also attended meetings and took responsibility for managing documentation and ensuring version control. The most up to date guidance was available on the intranet for all staff to access.

78. On occasion some IPC guidance was issued late on Friday afternoons which did put pressure on our IPC Team to review the guidance, firstly to establish what the changes were, and secondly, to determine how significant the amendments were and how urgently this had to be communicated to staff.

79. When implementing IPC guidance there were certain challenges which we encountered and we had to implement different ways of working to address. Such examples include the requirement to meet the distancing between beds; as such we had to physically remove some beds from 2 wards as they were small wards and the beds could not be sufficiently spaced out; we had a similar situation in our Special Care Baby Unit (SCBU) with the requirement to distance the cots; many of the staff rooms were small and it was difficult to accommodate the 2m social distancing rule; consequently staff had to manage their shifts and stagger their breaks to ensure this was complied with. We implemented a sign in/sign out sheet so as to be able to facilitate contact tracing if any staff member did test positive for Covid.

80. Prior to the pandemic there was only one ambulance entrance in to ED. To manage flow and to protect patients and staff we had to change the flow of patients and develop a different pathway; a second entrance was created and ED patients were split by respiratory and non-respiratory.

81. Our vulnerable, delirious patients found it difficult to wear face masks which was difficult to overcome increasing the transmission risk.

82. The hospital estate consists of buildings constructed over many years and thus had different layouts, ventilation and ability to be reconfigured. We mapped those wards that were most suited to being utilised for high flow oxygen delivery and stress tested these when not in use. Our estate team constructed 'Airlock' anterooms on Covid-19 wards to reduce transmission and enable donning and doffing of PPE. We mapped all our ventilation throughout the Trust and set out with a series of works to optimise those areas that had reduced air changes. We used the ventilation map to allocate certain patients to those areas with the best ventilation and calculate downtimes for those patients who were having aerosol generating procedures performed.

83. We swiftly created separate wards for Covid-19 patients and non-covid patients. Due to the incubation period of the virus and infectivity patients would develop Covid-19 in non-covid areas; this meant we had to be very dynamic and work closely with our site team creating cohort contact areas as well as hot and cold areas. This created great complexity in the patient flow and also meant teams were having to move around the hospital as their patients were not always located on their base wards.

84. We also created a green pathway project to allow surgery to recommence safely. We made one ward a 'super green' ward where all patients were swabbed and if appropriate depending on current evidence shielded prior to admission. They would then go from here to our elective surgical theatre area. We have two theatre blocks geographically separated within the hospital and we dedicated one to elective super green surgery and the other to non-elective surgery to ensure patient safety.

85. The ED department at Warwick Hospital was redesigned in its layout to segregate patients with respiratory viral symptoms and those without. This expended the footfall of ED and therefore the requirement for staffing. In addition there was an impact and requirement for additional staffing related to patients being cohorted in bays with the door closed and the need to don and doff PPE; this reduced the flexibility and responsiveness of staff hence we needed a greater number of staff.

86. Some parts of the SWFT estate are old and not necessarily designed with infection prevention in mind (Charlecote, Squire and Malins wards), with smaller bays and no en-suite facility in the bay; this was not conducive to good IPC practice; as such we would not choose these wards to manage covid patients in, but by default, e.g. during a Covid-19 outbreak, it was sometimes necessary. Although we had a large number of side rooms, these were spread across the whole Trust; as a result, it made sense for both the care of the patients and the staffing to cohort covid patients and create solely covid wards e.g. Farries and Avon, and titrate up and down dependant on need. A negative consequence of this was however that some of our wards with the better layout and suitability to manage covid patients (Farries and Avon) were specialty wards and these patients had to be moved to different wards. These wards were built as response to previous SARS infections and alongside Beauchamp ward the hospital was able to provide side room capacity for isolation or protection for vulnerable shielding patients

87. Based on available evidence several staff members were concerned about the nature of Sars-Cov2 transmission particularly with regards to aerosols. Both published evidence and lived experience within our own hospital led to concluding aerosols may play a part in outbreaks and infectivity. A programme of works was commenced across the Trust to increase ventilation of clinical areas. Solutions included mechanical air handling units as well as simple air extractor fans and natural ventilation.

88. With regards to testing as an infection control measure, we followed national guidance. Once guidance was released we aimed to discuss it at our next Silver Command meeting and implement as soon as possible after - often the same day. We began swabbing asymptomatic staff and patients on 8th April, from our own local facility as the main swabbing facility locally did not have sufficient capacity. This was particularly aimed at individuals who were 1-3 days since the onset of symptoms or live with someone who has had symptoms for 1-3 days (but where the staff member was asymptomatic).

89. SWFT received communication from NHSE/I on Saturday 25th April 2020 asking organisations to expand testing to all non-elective patients admitted to organisations that require a bed overnight, effective from Monday 27th April or before. This was discussed at the next Silver Command meeting held Monday 27th April where it was agreed to roll out that day.

90. Communication received 24th June 2020 requested that 'surplus NHS testing capacity should also be used for testing non-symptomatic staff (in addition to all patients and symptomatic staff) working in situations where there is an untoward incident or outbreak or high prevalence', which we implemented. Further to this, from November 2020, following National Guidance, we rolled out LFT kits for optional asymptomatic staff testing.

91. Patients with symptoms and relevant travel history were first tested in January 2020 in line with national guidance. Case definition was updated nationally on a frequent basis and we started testing symptomatic patients, irrespective of travel history in early March 2020.

92. We did not suffer from a shortage of test kits, reagents or other testing supplies during the relevant period. We were never unable to provide LFT kits for staff and patient use, as a supply was always available. The issue was more related to the testing capacity at UHCW. At the beginning UHCW were setting up their analysers and deciding which swabs etc to use and we were limited to only 6 swabs per day. This did increase dramatically with time, but was an issue early on.

93. At the beginning of the pandemic there was a 5-6 day delay on receiving test results back from PHE; the negative consequence of this was around the delay in being able to make a clinical diagnosis for the patient and to be able to establish the best treatment plan; the delay did not particularly cause onward transmission within the hospital as we kept our patients isolated until results were obtained. A consequence of the delayed results however was the unnecessary blocking of our isolation facilities.

94. On 29th March 2020 a communication sent to NHS Trust chief executives from NHSE/I asked that Trusts start to identify staff in priority groups (including critical care and EDs) who were unable to work because of the 14-day self-isolation rule. On 2nd April 2020, an email from NHSE/I Midlands Region, stated there was a national drive to test staff for Covid-19 and this was of particular importance in the Midlands as the region had the highest level of staff absence through Covid-19 symptoms and/or isolation in England. As such we prioritised testing staff working in ICU/HDU and ED who were in their 14-day self-isolation period. Following this, if staff were deemed to work in 'essential' roles, absence from which would disrupt the running of the service and risk patient safety, they were also prioritised for testing. This included consultants who were prioritised for testing due to their presence being critical in ensuring patient safety.

95. In May 2020 NHSE/I advised Trusts to test all patients on admission and for those who tested negative, a further single re-test should be conducted between 5-7 days after admission'. This new operating framework was discussed at our Silver Command meeting on Monday 18th May and we opted to perform a 7-day re-swab, to be implemented from Thursday 21st May 2020.

96. On 15th February 2021 we produced a document (CV19-125 SARS-CoV-2 PCR testing frequencies for In-patients and Staff) which sets out following admission, if a patient tested negative, they would be re-swabbed Days 3, 6, 9 and 12 post-admission and continue to be swabbed every 3 days until discharge or until positive swab. Also, patients being discharged to Care Facilities, including

SWFT community beds or home with packages of care should also be swabbed within 48hrs of their expected discharge.

97. Immunocompetent staff and patients who have tested positive for SARS-CoV-2 by PCR should be exempt from routine re-testing by PCR or LFD antigen tests (for example, repeated whole setting screening or screening prior to hospital discharge) within a period of 90 days from their initial illness onset or test (if asymptomatic) unless they develop new Covid-19 symptoms. This increase in testing frequency was brought about due to updated advice from NHSE West Midlands, and in addition to this, learning from the Covid-19 outbreaks witnessed at SWFT, has demonstrated that regular and on-going swabbing of patients who test SARS-CoV-2 (Covid-19) negative would reduce risks of cross-infection and subsequent outbreaks.

98. In the maternity department, as outlined in SWFTs 'Lateral Flow Testing for Covid-19 in Maternity Services (including SCBU) (CV19-123 February 2021), all women must have a PCR test completed on admission. Postnatally, all women must have a PCR test completed every 3 days whilst an inpatient. All parents attending SCBU must be offered a LFT every 3 days. All women must have a PCR test completed on readmission.

99. Hospital policy did not differ from national guidelines and we followed national guidance at all times.

100. We experienced a number of nosocomial outbreaks of Covid-19 infection and we implemented many steps to reduce the impact of this and also to improve our learning. When an outbreak was determined, the first step was to close the ward to further admissions and to move the positive patient away from contacts. We would continue with universal PPE and introduce enhanced cleaning.

101. All ward areas and departments were risk assessed with regard to their level of ventilation and clinical risk to patients; due to the age of parts of our estate we were aware that some ward ventilation systems that did not allow for high levels of air exchange posing a higher risk for infections.

102. We also established a new process to allow completion of routine swabbing to be monitored to ensure swabbing was not missed.

Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE)

103. A summary of practical tasks as part of our Procurement PPE emergency plan during the pandemic are highlighted below.
    I. Manage the PPE stock centrally.
    II. Scope out mutual aid.
    III. Attempt to source supply directly.
    IV. Identify and escalate supply issues in the Sit Rep.
    V. Escalate the severity via the National Supply Disruption Route.
    VI. Continue to complete the Sit Rep/Foundry – updating consumption rates and highlighting National Supply Disruption Route (NSDR) number as applicable.
    VII. Integra Inventory Management module used to track, manage, and issue PPE.

104. The first step involved the removal of PPE from Wards and Departments to a secure central location, which was then managed and monitored daily by Procurement.

105. In March / April 2020 we set up a Covid19Procurement inbox to capture all PPE and Covid-19 Procurement related requests.

106. Resilience was built into the Procurement team and a working from home rota was started to build contingency into the team, should staff be affected by Covid-19. A weekend rota was agreed for the Stores function and the department had volunteers via redeployment supporting over the first few months, March 2020 - August 2020.

107. Following the removal of PPE from the NHS Supply Chain catalogue, the Procurement team developed an internal logistics process for getting PPE out

from Warwick Hospital Stores to Stratford Hospital, Leamington, and Ellen Badger in addition to provisions for the 60+ community sites.

108. Seven PPE Hubs were created in the Community setting. Min/Max levels were agreed with the Hubs based on who they were servicing and Procurement co-ordinated weekly requests. PPE was picked and packed at Warwick Stores and weekly deliveries were made by the Volunteer 4x4 drivers between March and August 2020 before it was brought inhouse.

109. In April 2020 the Procurement team started offering a 7-day service, opening Stores at the weekend for Push Pallet deliveries and to continue pushing PPE out to wards/departments. At this time the levels of PPE coming via Push was often only 2-3 days' worth of stock and so we couldn't push out more than daily amounts at this time.

110. We were directly sourcing respiratory and CPAP products, hoods, respirators, and visors as supply was limited via the push pallet.

111. Working with the Chief Nursing Officer (CNO) and IPC the Procurement team reviewed the anticipated burn rate of PPE based on Wards (by beds), staff numbers by shift and the number of patient contacts. This was in line with the PPE guidance at the time, to plan and manage the daily consumption demands. PPE was ring fenced in preparation for the potential Theatres and ICU surge (April 2020); this was specifically focused on FFP3 masks given there was no supply of fit test solution and models that staff were fit tested on were depleting.

112. Internal meetings, namely PPE Covid-19 Procurement catch ups, occurred daily and Procurement attended the daily Silver Command meetings to provide a RAG status on PPE supply.

113. On the 17th March 2020 we received communications via the Midsincident NHSE advising of the significant demand for PPE and to prioritise requests; Trusts were being asked to complete a PPE capture template. This was supplied.

114. On 25th March 2020 we started contacting local dental surgeries to see if they could support with PPE requirements. Schools were contacting Warwick Hospital with offerings of visors.

115. On 28th March 2020 the Procurement team was contacted by a representative from Arden Gem CSU asking for a daily Sit Rep of PPE by 10am. This was optional and we questioned with the Emergency Planning Lead why there was not a formal national sit rep via the EEPR channels. It did not appear joined up.

116. On 6th April 2020 3M 8833 FFP3 masks were delivered into Warwick Hospital Stores, and it was noted that they were past their expiry dates. On seeking clarity for their use, Warwick Hospital were informed by 3M that the product should not be used as they will no longer offer the required level of protection. Meanwhile, PHE issued a response to the Hospital to say that all expired stock had been quality checked and extended the expiry dates. The reason the labels were not updated was apparently down to time.

117. On 16th April 2020 a formal sit rep was enacted daily and this linked to daily deliveries of PPE via a 'Push Pallet' model.

118. In early April 2020 we started engaging with Jaguar Land Rover who were keen to support Warwick Hospital with the production of visors. Given the visors we had received to date via the push pallet were deemed not fit for purpose by Infection Prevention & Control (IPC), we worked with them on the design of a visor. We also sourced further supply from a local graphic arts supplier.

119. A PPE Task & Finish Group meeting commenced on 30th April 2020 (Integrated Care System members represented). This started as a daily call to support each other with mutual aid, reducing to twice weekly calls. Mutual aid was also sought from outside of this group, for example the Birmingham region, as well as Herefordshire and Worcestershire.

120. From 16th April 2020 the centralisation of the PPE/RPE supply was delivered based on the sit rep submitted the day before. Daily burn rates for each item of

PPE for Warwick Hospital resulted in managing PPE based on 'just in time'. As soon as stock was delivered into the Hospital it was shipped out to the end users. There was no contingency stock within the organisation.

121. Between 23rd March and 19th May 2020 Warwick Hospital Stores received 417,700 IIR Fluid Repellent Masks via the Push Pallet from Public Health England (PHE).

122. 350,500 masks were received in the first 6 weeks (23rd March to 1st May) of the pandemic. Based on the daily stock issued, the Trust was running at a consumption rate of approximately 8,345 per day over this initial 6-week period.

123. By 1st May 2020, the Trust started to experience its first Type IIR mask supply issue and struggled to fulfil demand, consistently reporting red/amber on the PPE Sit Rep once the weekly community stock was issued.

124. The delivery of masks from PHE between 1st and 19th May was 67,200, whilst the actual issued out stock was 138,600. The shortfall was made up of mutual aid, donations, and escalations for emergency supply. The PHE deliveries suggested a consumption rate of 3,536, whilst the rate within this period was significantly higher at 7,294 per day. As such, Warwick Hospital started requesting mutual aid from 1st May onwards and escalating via the NSDR (National Supply Disruption Route).

125. A funding request for masks was taken to Silver Command on 2nd June 2022 to request funding to purchase 500,000 Type II R masks. The decision was made to approve the purchase of Type II R face masks when the burn rate and delivery did not meet demand.

126. In early June 2020 Procurement went live with Integra Inventory Management module to electronically manage and issue PPE. This made tracking the PPE by Ward/Department much more efficient, particularly in the event of recalls.

127. Centralisation of PPE did positively affect supply in terms of quantity, however, in some instances the quality of the PPE supplied was problematic. For example, visors were flimsy with gaps and inappropriate gloves, (vinyl instead of nitrile) were supplied. Warwick Hospital had many examples of receiving Type IIR masks that were questioned in terms of quality but were informed that all quality assessments had been conducted and so to proceed with use, only to be later recalled based on not meeting the standards of splash prevention.

128. Table 1 below shows a summary, by product, date and case reference, when National Supply Disruption Route's (NSDR), also known as 'Emergency Request System', were raised, along with the outcome.

129. **Table 1**: Summary, by product, date and case reference, when National Supply Disruption Route's were raised.

Date	Item	Ref No CPC	Outcome	NPC
13/10/2020	Sterile Nitrile Gloves	39494	Non available	*
14/10/2020	IIR tie back masks	39541	200	BWM296
15/10/2020	Gloves - non-sterile - Nitrile	39541	5,000	FTE2470
15/10/2020	Orange Clinical Waste Bags	39621	400	MVN493
15/10/2020	IIR tie back masks	39815	200	BWM296
23/10/2020	Surgical Reinforced Gowns XL	39898	60	BWK2104
23/10/2020	Surgical Reinforced Gowns XL Long	39898	60	BWK281
28/10/2020	Sterile Nitrile Gloves	40024	Non available	*
04/11/2020	Non-Sterile Gloves Large	40268	50,000	FTE2544
05/11/2020	Non-Sterile Gloves Medium	40315	20,000	*
19/11/2020	Surgical Reinforced Gowns XL Long	40710	504	BWM1105
24/11/2020	Fit test solution Sour	41052	30 bottles	BTB168
01/12/2020	Clear view face mask	41279	30	MTKC9999
03/12/2020	Fit Test Kits - Bitter	41378	10	BTP203

24/12/2020	Body Bags	41829	50	VMS002
05/01/2021	Clear view face mask	42004	Non available	*

130. There are several occasions when the hospital was provided with PPE that was unsuitable. The Hospital always presented new brands of PPE to IPC for review. If they were unsatisfied, Procurement escalated to the regional incident team / PHE.

131. Examples are set out below for recalls of PPE where quality was deemed an issue.

- Easimask masks were not suitable for clinical environments (11th -14th May 2021). We received communications of unsuitability on 25th May 2021.
- Obisk facemasks. 13th January 2021 Warwick Hospital reported 12000 Model IR099 Obisk Type IIR masked that had not been passed by IPC. This was escalated. An email response from the Regional Head of Procurement for NHEI stated that any items released to Trusts for delivery are approved for quality assessment and so Trusts' IPC cannot just disregard as inappropriate. The Trust were advised to offer as mutual aid if the Trust did not want to use them. However, 22nd October 2021 the Trust received communication to say that the Obisk facemask may not meet technical specifications for splash protection. This was 9 months after Warwick queried and were told to use them.
- On 26th May 2020 an alert was received to isolate Cardinal IIR Masks as there were reports the stitching was coming away.
- On 31st May 2022 Hunan EEXi inherent Type IIR mask were recalled as they fell short of the required standards for splash resistance.
- In December 2020 Royal mint visors were recalled due to a latex warning
- Tiger googles recalled.
- Drager FFP3s masks withdrawn.

132. Pre March 2020 the Infection Prevention Team were responsible for staff Face Fit Testing. During the pandemic, due to the increased number of staff requiring face fit testing and the number of different disposable FFP3 masks being delivered via the National push pallet, the Learning & Development Team undertook the majority of Face Fit Testing for both hospital and community staff, (along with some specialist areas who had face fit testers e.g. ICU and IPC staff).

133. NHS England then provided additional Face Fit Tester support and this resource was only removed in March 2023. More SWFT staff were also trained to undertake face fit testing.

134. The Face Fit Tester provided by the external company would not fit test staff on the 3M disposable FFP3 masks or the half face masks, therefore this was undertaken by SWFT staff (trained face fit testers).

135. Post March 2023 Wards and departments trained fit testers undertake the face fit testing of staff.

136. There was persistent concern about the quantity and quality of PPE available. Advice changed on a regular basis, giving no assurance that it was proportionate and maintaining staff safety.

137. Warwick Hospital did not experience shortage of PPE or RPE, although there was anxiety that we might; however as previously stated some PPE was of poor quality. We implemented a system where any new item was risk assessed by our IPC team to ensure it was suitable prior to it being implemented.

Visiting restrictions

138. The national visiting guidance was applied at Warwick Hospital, by firstly reviewing and developing our own guidance documents based on the national guidance but more encompassing of other patient groups and scenarios where we believed visiting should be allowed i.e. breaking bad news, cognitive impairment, disability etc. We then approved these guidance documents through our daily Silver command meetings and then made the practical arrangements needed to implement them such as additional PPE for visitors, iPads for all wards, booking systems for visitors to ensure social distancing etc. We then sent the guidance to clinical teams both through our daily communications and in our professional meetings and put them on social media platforms and the Trust internet site for the public to view.

139. We developed our own visiting guidance at Warwick Hospital, which was based on the national guidance. We wrote a document specific to inpatients and accompanying patients in outpatient settings, one for visiting at End of Life in ICU, one for parental visiting in our Special Care Baby Unit and one for our

Maternity Unit. The aim being to minimise the risk of infection, whilst also facilitating visiting in certain circumstances, with the appropriate preparation and precautions.

140. On occasion, we did exercise our discretion as this felt the right thing to do. The CNO informed Ward Managers to use their own initiative for permitting visiting and being responsive to patient's individual needs, particularly if they were end of life, needed additional support because of cognitive impairment or were receiving life changing news. Staff were known to move a Covid-positive patient from a cohort bay into a side room to facilitate a visit, and then move the patient back again.

141. When facilitating visiting we arranged for visitors to be provided with and taught how to donn and doff PPE safely.

142. If unable to visit, staff used iPads and telephones to give patients opportunity to contact their relatives. On occasion, ward staff used their own phones before iPads became available. Relatives were also encouraged to write letters and cards to be given to patients so virtual contact was maintained.

143. Our internal processes for inpatient visiting and outpatient accompaniment was prioritised for patients suffering mental health issues such as dementia, a learning disability or autism, where not having visitors would cause the patient distress. People who were in attendance to support the needs of the patients, for example a familiar carer/ supporter or personal assistant, were not counted as a visitor. Patients were permitted to be accompanied where appropriate and necessary to assist with the patient's communication (for example patients with communication difficulties, cognitive impairments, or with limited English) and/or to meet the patient's health, social or spiritual needs.

144. At Warwick Hospital we frequently reviewed our visiting guidelines at the Daily Silver command meetings. This was always done whenever the national guidance changed but also when the numbers of patients who were Covid-19 positive reduced between the different waves of the pandemic.

145. Visiting for some patients and not others was often difficult to manage for the ward teams who needed to explain the reasons for the difference without breaching confidentially.

146. It was also very difficult to manage the public behaviour in terms of PPE when they did not believe Covid-19 existed or did not believe in the rules.

147. I do believe restricted visiting had a negative impact of patient experience with patients feeling isolated from their social support. This impacted them psychologically which did add to the workload of the healthcare team in trying to keep them positive and cheerful. It also impacted on the relative(s) in that they were very anxious about their loved one in hospital and the separation made that worse. Warwick Hospital did implement a policy whereby the clinical team would endeavour to contact a relative for each patient every day to update them on their relative's condition and progress.

148. Our Maternity Service feels that restrictions on visiting caused a negative impact on women and families by removing choice as partners, loved ones and family members did not feel as involved or connected; however the service undertook to not always follow national guidance, in order to minimise the negative impact while protecting staff and patients.

149. Visiting restrictions were implemented outside national guidance to allow a birth partner for Induction of Labour/ Labour and the initial postnatal period. A Doula was also allowed in during labour. At the time, this concession was considered to be working well for families. This increased visiting however, which was more than most other organisations were offering, did cause significant anxiety to some staff at the time due to an increased risk of exposure due to being in contact with more people.

150. Specifically in our Special Care Baby Unit (SCBU) we found visiting restrictions to have very negative experiences for families. We had to limit visiting, so at the beginning of the pandemic only one parent at any one time was allowed to visit

and we could also only have one set of parents at one time in SCBU; as such there had to be on a timetable to restrict visiting; this will no doubt have caused a negative experience for the parents. This would especially have impacted the dad's if a baby was being breast fed as it would only be the mother who was allowed in to do the breastfeed; consequently this is likely to have impacted the breastfeeding rates.

151. Parental access to babies in the High dependency (HDU) was sometimes restricted because if there were 2 babies from 2 different families receiving ventilation in HDU neither family could enter the room. This was an infrequent occurrence, less than once a week, but it was nevertheless very distressing for families.

152. At times during the pandemic schools were closed which meant children were at home which will have affected the ability of parents to visit and when.

153. I think generally visiting guidance did strike the right balance but there could have been more emphasis in the national guidance related to using discretion. Also the national guidance was very focused on end of life care initially which was not the only reason to let visitors attend; learning disability, cognitive impairment, birthing, breastfeeding, psychological support when making difficult decision or hearing bad news should all have been included.

Patient treatment and care

154. As per national guidance elective activity was ceased other than Pathway 1 and Pathway 2; where Pathway 1a is categorised as when an Emergency operation is needed within 24 hours or 1b which is where an urgent operation is needed with 72 hours, and Pathway 2 which is where surgery can be deferred for up to 4 weeks. Cancer work continued although based on risk assessed approach along with national guidance on the risks of elective surgery during Covid-19. Patients were given a choice to wait or proceed based on their risk as per guidance. Non elective activity continued on a risk benefit basis.

155. Elective activity followed the national guidance and was dictated to by national time frames.

156. The Trust tried to protect elective bed capacity; this along with the patient pathways allowed us to provide elective care safely. There were challenges due to reduced capacity and for some services the delay to recover was longer due to the type of procedures delivered.

157. From a practical level moving a cohort of patients and staff to other sites did have some logistical challenges but this was all completed safely.

158. Another challenge was our staff as some fell into the vulnerable group so had to shield; although they continued to work virtually this did place extra pressure on those staff who were able to attend site.

159. We reduced outpatient and theatre list templates to ensure adequate time between patients for cleaning and reducing numbers in waiting areas; this had an impact on the delivery of the pre-pandemic patient numbers which contributed to the backlog more significantly than the short suspension of services as this continued throughout the pandemic and for the early recovery stages.

160. Virtual outpatient appointment became routine; these were an effective way to continue care, although not all patients fitted the criteria. Triage of patients to send them onto a direct to test pathway were also adopted quickly, this reduced the visits to the acute site.

161. We also changed some of the medication routes for long term conditions so that patients did not have to come to the acute site so often; this was managed carefully with regular virtual follow up.

162. We identified green pathways for all patients so that ring fenced wards, pathways clinics etc could support early return to re starting or continuing care and treatment. We worked with community and social care providers to innovate across discharge pathways and step up and down care, maximising virtual ward

opportunities. There was also System working to tackle waiting lists and cancer treatments.

163. We also utilised early development of health inequalities tools. At SWFT, the operational and informatics teams worked together to come up with an approach whereby a 'risk stratification score' was developed. This was made up of a four digit number, where the lower the number, the higher the "risk". These included clinical prioritisation, duration the patient had already been on the waiting list and information relating to level of deprivation taken from the patient's current residential address. We continued to focus on dating patients in order and tackling the long waiters and not lose sight of clinical priority. We then spent a lot of time analysing the data to better understand our demographic. Having a score has meant we can better understand the patients who might 'Did Not Attend (DNA)' or cancel more than once. We now need to refresh the approach but it was a good place to start.

164. There are a few other measures we put in place such as any patient with a learning disability flag is proactively dated, regardless of waiting times. We also have veteran aware status and are working to improve access for veterans.

165. Virtual cancer MDT's remain in place which has reduced the travelling between sites and has helped facilitate more effective specialist MDT with our tertiary partners.

166. Elective procedures were paused following National guidance and due to conflicting guidance from Royal Colleges. At the start of the pandemic there were a number of different definitions from societies and colleges regarding the definition of an aerosol generating procedure. This was recognised and a definitive evidence based list was created by NERVTAG and a statement produced regarding cardiopulmonary resuscitation.

167. We believe the right decisions were made at the right time based on the evidence available to us at the time.

168. The problem was ensuring that we had suitable plans and escalation procedures in place to prepare for potential overwhelming of services by Covid patients. Allowing a very short break in elective work to create local plans for escalation, when to stop services and when to recommence may have been better. This way the correct teams, often those having to manage Covid patients, e.g. ICU and anaesthetics would have had the time and space to strategize better. Creating bespoke plans for local areas and supporting the local network may have been a better strategy than blanket rules.

169. We maintained our cancer and urgent elective care by a mix of virtual appointments and increased infection prevention measures which were quickly implemented.

170. We recommenced elective care on site in May 2020 and moved services off the acute site to maintained services, with reduced capacity but we restarted as soon as the evidence became available and in a measured and safe way.

171. At the start of the pandemic period there was much uncertainty as to the impact and infection risk. The services were paused appropriately until more evidence became available. Once we had more evidence the Trust recommenced as much elective activity as possible. We protected our cancer patients and maintained cancer diagnosis and treatment. Making the early decision to move our chemo unit away from the acute site ensured we maintained chemotherapy treatment throughout the pandemic.

172. We created very robust green pathways within the Trust to ensure elective work could be safely delivered. Our ventilation strategy was a key tenet to this and was implemented and enacted very early on. As stated earlier the key is in planning for the potential problems so stopping services for a short period and then creating bespoke plans may have been better. All predictions end up in a counterfactual discussion as had lockdowns occurred differently, or footfall stayed the same within hospitals transmission could have been a lot greater. Also with published CovidSurg data it was clear operating on patients who had Covid

carried considerable risk, so any activity that was likely to increase transmission in the perioperative period was likely to result in patient harm.

173. We have learnt a lot about maintaining all our services should another pandemic or similar incident happen again, of course it would depend on what that was. We moved quickly to safeguard our most vulnerable patients by moving services to "green sites" we implemented "green" elective pathways and the importance of maintaining the integrity of our elective wards, this has continued through the ongoing rise in demand for emergency care and the recovery and reduction of waiting list backlogs.

174. We understand how important communication with our patients has been and we have processes and policies now in place to ensure that happens, including a patient portal where we can get messages to patients about their appointments, diagnostics and surgery.

175. The governance structure and daily management of pressures is robust and lends itself to swift communication which we would retain in the face of a future pandemic.

176. Using the experience from Covid-19 we would prepare in advance and risk assess using the tools and knowledge gained. Further to this we would re-establish known pathway if they needed to be re-established alongside implementation of IPC guidance etc.

177. To support women and their families, South Warwickshire's maternity services created online parent educational "classes" via YouTube for women to prepare for life after childbirth; the parent education programme pre-covid was already partially online but it was moved fully online in Summer 2020 due to social distancing guidance; it was available on multiple platforms for all women. We also set up dedicated and secure Facebook groups for pregnant women to help reduce pregnancy related anxieties by being able to provide regular and timely updates, as well as offering a platform for peer-support.

178. Maternity care was moved to a hybrid system of some virtual appointments and face to face appointments. This was done for the benefit of patients and staff.

179. Patients who did not have access to Facebook were provided with the key maternity-related information in other ways i.e. during their appointments, be that face to face or virtual.

180. Early on in the pandemic (23rd March 2020) all children's centres where antenatal services and postnatal clinics were run out of closed with immediate effect. This meant we lost 8 venues from which we ran our services. SWFT had fantastic support from Barnardos, who are our host organisation for the children's centres, and they kept one hub open; so all antenatal outpatient appointments had to be run out of one centre; this now amounted to one day a week for each team. This will have created difficulties and some accessibility barriers for some parents. However, of note, SWFT did not receive any complaints from women about having to relocate their antenatal appointments, which would have meant a lot more travelling for some women; for example those travelling from Alcester and Stratford then had to travel to Lillington or Bluebell Centre at Warwick Hospital. Antenatal care followed the same principle and the decision for location was made based on clinical requirement and social need.

181. The women's needs both social and clinical were considered in location for appointment.

182. The potential increased risk of poor physical/ mental health for the pregnant woman was recognised and it was mitigated where possible. We individualised care and considered adjustment for high risk women and babies, e.g. through more frequent contacts to suit the needs of the woman and facilitate place of birth.

183. To minimise such barriers and risks we considered each family individually and worked with the multidisciplinary teams and external services.

184. We created our own guidance for Maternity Services provided in the hospital. The first version was published on 16th April 2020 and there were 14 versions in total, with revisions taking place as required, throughout 2020, 2021 up until the latest publication, version 14, on 14 July 2022; the latest 2 versions of the document had had a complete refresh as we transitioned in to 'business as usual'/ living with Covid-19. Version 12 of the guidance document is exhibited to this statement as CA/2 [INQ000427500] as the table at the front clearly documents the amendments made and the dates published.

185. Guidance from the Royal college of Midwives and national covid guidance from PHE were used to inform the above mentioned document. As were Royal College of Paediatrics and Child Health, Doctors of the World.org and International Confederation of Midwives.org.

186. Other than visiting restrictions as mentioned previously, the national guidance or guidance from the Trust was followed.

187. The feedback received was that the women felt confident in the Service as the guidance was clear, updated and readily available for families. The Service had women transferring care to Warwick from their local service as they considered it to be safer and enabling more choice.

188. Women were asked to submit their positive stories on social media and many women shared their stories supporting other women to feel confident in birthing during this time.

189. During the pandemic it is clear that ambulance handover times changed; this is demonstrated in exhibit CA/3 [INQ000472501]. It can be observed that at the start of March 2020 the ambulance handover averaged 17.8 minutes to handover, which slowly increased to just over 19 minutes by November 2020. The most pronounced increase was from August 2021 where the figure increased to 28.8 minutes and peaked at 38.5 minutes in October 2021; then reduced and averaged at 29 minutes across the remainder of the period.

190. Reasons for the increase were down to overcrowding in ED due to segregation of Covid-19 confirmed or suspected patients in to red zone and non-suspected in to blue zone. These zones would be flexed up or down depending on the proportionate of symptomatic patients.

191. Rapid testing greatly enabled flow by confirming diagnosis within 2 hours rather than 48 hours and so patients could be moved from ED safely.

192. During times of pressure and excessive waiting times for ambulances during the relevant period we enacted our own Ambulance Escalation policy document which was effective in reducing pressure and increasing capacity. It is not unusual for ED to be under pressure outside of a pandemic and having to deal with escalating numbers of ambulance attendances and capacity issues and these are managed as 'business as usual'. However, under greatest times of pressure, additional escalations are put in place. During the pandemic, these included transferring referred/specialty patients to the ward prior to clerking or senior review. The most senior ED Doctor in the department would review these patients prior to transfer and a checklist was used to support safe transfer.

193. In addition to this, 'One-up Boarding' was utilised whereby a patient is admitted to a ward that has a definite discharge identified. The patient awaiting discharge is sat out of bed and the new patient is admitted into the bed space.

194. When pressures increased further later in the pandemic, the ambulance escalation procedure was updated with additional measures to relieve pressure and create capacity. These included implementing rapid Cepheid PCR testing for patients in the department (November 2021). If they are Covid/Influenza/RSV negative, they could be moved out to create capacity for ambulance patients with suspected Covid/respiratory illness.

195. Further to this, the SWFT 'Emergency Department Full Escalation' Protocol was enacted. These actions include; Switchboard to activate Internal 'ED Full' Escalation Protocol; all speciality On-call consultants to immediately attend ED to support ED and clinical work; ward allocated Consultants to identify patients on

pathway '0' to 'Discharge at Risk' or into Virtual ward; ED to identify Consultant or Registrar to initiative Rapid Assessment and Treatment process and speciality in reach to pull from ED; Emergency Division Matrons to attend ED to oversee quality and safety within the department.

196. In relation to escalation of care decision making within the hospital, no concerns were voiced by clinicians in the hospital regarding the absence of a national decision-making tool for rationing care.

197. We created our own policy document 'for assisting with level of care decisions in the Covid-19 crisis in the presence of limited resources'. This was written by me, as Medical Director after consultation with senior physicians and intensivists and is exhibited to this statement as CA/4 [INQ000421763]. This was done in the absence of national guidance as a contingency plan was required because during the Covid-19 crisis it was likely that the demand for intensive care would exceed the resources available and prioritisation decisions would need to be made. No changes were made to this policy and it was never required to be used.

198. SWFT does not have an ethics panel or committee and therefore not involved in formulating the document.

199. We did not change our admission criteria for ICU. All potential admissions were reviewed by an ICU consultant and decision to admit was based on whether treatment was likely to benefit a patient.

200. We were early adopters of CPAP for Covid-19 patients. We had minimal change in our practice other than keeping in line with national guidance.

201. We did not need to ration care throughout the relevant period.

202. The Trust already used the ReSPECT process ahead of the pandemic, it was fully embedded and we continued it use throughout. Decisions around recommendations for cardio-pulmonary resuscitation (CPR) were made on an individual basis, following conversations with patients and in consideration of

their clinical condition. Decisions relating to CPR were not used as an indicator as to whether a patient was admitted to ICU – this decision was based on whether it was in the person's best interests, and whether further treatment options may have been of benefit. Patients continued to receive oxygen therapy as required – even if there was a recommendation not for CPR.

203. There has been a previous awareness from research that in some areas patients had not been admitted to ICU as they were not for CPR. This has been shared within training (and prior to the pandemic) and staff informed that a DNACPR recommendation does not mean not for ICU admission. The fact that a patient may have a DNACPR recommendation is not and has not been an influencing factor as to whether the patient was for escalation to ICU. Consideration is and was given as to any potential benefit to the patient from an ICU admission.

204. During the pandemic there was increased focus on having ReSPECT conversations and completion of ReSPECT plans – with a number of those plans completed for those patients identified as 'for CPR'. This level of information supported the modelling required in the Trust to ensure adequate provision of equipment such as NIV – as those that may benefit had been identified. Further equipment was procured to be able to meet the expected increased demand.

205. With regard to DNACPR decisions we use the ReSPECT process and have since 2017. ReSPECT is based on a conversation with the patient (where possible) alongside their clinical condition which informs the recommendations made. We do not have 'DNACPR notices' at SWFT but make recommendations as to what appropriate levels of care would be in an emergency situation, including CPR. We do not routinely scan ReSPECT plans as they are discharged with the patient, as they extend in to community care. However, there will be a record of discussions/ decision making within the healthcare record, as a ReSPECT plan is a summary document. Incidentally, there will be a number of scanned ReSPECT plans on the Electronic Patient Record which relate to plans that have either been rescinded and/ or updated, along with the plans for patients that have passed away during their admission.

206. Warwick Hospital witnessed some potential impact on patients with protected characteristics due to the measures adopted as part of our response to the Covid-19 pandemic. These included patients who were hard of hearing and not being able to lip-read due to the masks that staff were wearing. Patients with cognitive impairment, or patients who were IT illiterate would potentially have struggled with remote outpatient clinic facilities.

207. During the recovery period Warwick Hospital prioritised elective procedures for patients who were higher risk, including those with a learning disability.

Impact on hospital staff

208. The impact of the pandemic on staff morale and on their physical health and mental wellbeing changed throughout the pandemic. Initially staff were very fearful and were concerned not only for their own safety but also of the potential impact on their families if they were to take the virus home with them. As time went on and more became known about the virus, morale improved with staff pulling together to support each other. There was also significant public support for the NHS at that time with staff feeling valued and respected for their hard work.

209. As the pandemic continued, staff became physically and mentally exhausted. They were working long hours in large amounts of PPE and were unable to draw on their usual coping strategies, spending time with friends and family as this was not allowed. The moral injury felt by staff was significant, feeling that they were not delivering the standard of care that they would aspire to.

210. As the pandemic drew to an end, morale became even lower. There was no respite for staff with the focus immediately falling on elective recovery and no time for staff to decompress and reflect on their experiences. They also went from being regarded as "heroes" by the public to "villains", facing abuse about waiting times and delayed treatments.

211. Multiple wellbeing offers were implemented and these were shared with staff through the daily briefings. The support offered focused on physical, mental and financial wellbeing with a range of offers dependent upon individual circumstances.

212. During the restoration phase, the Trust utilised Schwartz Rounds and Team Talks to enable staff to share their experiences and receive support from peers and qualified mental health professionals.

213. IPC measures and effective PPE were assessed and discussed daily as part of the Silver Command meeting. The focus was very much on keeping all staff safe and well.

214. There were a number of staff who struggled with respiratory difficulties having contracted Covid-19 and a Post-Covid Respiratory Support Team was implemented to provide physiotherapy support and treatment.

215. Occupational Health provided advice and guidance throughout the pandemic, as did the HR team, based on the constantly evolving national guidance.

216. Wellbeing initiatives were primarily focused on mental wellbeing, particularly for frontline workers who were directly dealing with the effects of Covid-19. The Psychology team were allocated wards to connect with in order to offer psychological input. The Chaplaincy team were also very visible in clinical areas, not only offering spiritual guidance but also comfort, support and a listening ear for those staff who were struggling.

217. Multiple regional and national initiatives were quickly established to support staff mental wellbeing.

218. National initiatives were welcomed; however, staff felt more comfortable accessing local services. The national offers were more helpful to local health and wellbeing teams to identify options to support staff.

219. We very quickly established Coffee & Connect, a weekly virtual catch-up for anyone working from home. It was an unstructured opportunity for people to have a conversation with others in a safe, supported way.

220. Wobble rooms were established, offering quiet safe spaces for reflection and decompression. They offered wellbeing resources, e.g. drinks and snacks, and were well-received by staff.

221. The Post-Covid Respiratory Support team was established, offering physiotherapy advice and treatment for sufferers of Long Covid. Unfortunately, after some time, staff were dismissed where there was no prospect of them returning to work in the near future due to the debilitating effects of Long Covid. This position was exacerbated by their inability to be eligible for ill health early retirement as the long term effects, and therefore likelihood of recovery, was unknown.

222. Risk assessments were introduced on 18 May 2020, 2 months after the pandemic began. Many staff felt that it had taken too long to implement. There were also concerns that the original risk assessment, based on the framework developed and published by the Faculty of Occupational Medicine did not specifically identify ethnicity as a risk factor, despite early evidence to the contrary.

223. Risk assessments had little impact on staff deployment as conversations had already taken place to identify those staff at higher risk, prior to the implementation of formal risk assessments.

224. We did not carry out Equality Impact Assessment (EIA) in respect of IPC guidance, fit testing or risk assessments during the relevant period. With regards to fit testing, no staff were treated differently because any staff member cannot be face fit tested for a disposable FFP3 or half face mask if they have facial hair so in these circumstances if an individual has facial hair and doesn't want to, or can't shave due to religious reasons, then an air fed respirator and hood is

provided. Likewise if a staff member has a failed result for a disposable FFP3 or half face mask then an air fed respirator and hood would be provided.

225. Throughout the pandemic we did not complete a risk assessment for mask wearing as the Trust were pre-empting, following and going beyond National guidance. This is now being kept under review at our daily Silver Command meetings.

226. At the start of the pandemic all managers were told to risk assess each staff member and implement necessary control measures. This was thought to be the appropriate response due to each individual staff having their own specific risks related to their own personal risk factors and circumstances. These risk assessments were repeated during the relevant period.

227. Some issues were identified concerning unequal impact of measures adopted in response to the pandemic on hospital staff. There was very little support for staff with caring responsibilities for clinically vulnerable family members. The advice was that sharing a home with somebody who was clinically vulnerable was not sufficient reason for the staff member not to work within a known Covid-19 environment, which caused significant distress to staff who were placed in this position.

228. Warwick Hospital is situated in an affluent part of the country with a less diverse patient population and workforce. Having said that, the psychological impact of Covid-19 was significantly greater for BAME staff. There were also higher levels of vaccine hesitancy amongst our BAME workforce.

229. The communication at Trust level was constantly reviewed and improved on the daily Silver meeting which was a conduit for this alongside the comms that followed after each meeting. All new guidance and decisions were included as were the minutes of the meetings. The meetings were also recorded on MSTeams for other staff to watch after each meeting. The Trust responded to questions via our rumour mill and Q&A sessions on MSTeams. Recorded messages were sent out from Executives so they could be shared across teams.

The CNO set up a weekly meeting for all senior nurses and AHPs to cascade messages and answer any concerns.

230. Our CEO attended a series of engagement events via MSTeams with regional and national leaders. Informal discussions also occurred, facilitated by NHS providers. A wide range of issues were discussed. Whilst these occurred at a senior exec level many senior staff felt that their frontline experience wasn't always being heard.

231. The local ICU network, which was well established prior to the pandemic, set up daily meetings with representatives from all ICUs across the region so they could support one another, share learning and help arrange transfers when hospitals were reaching capacity. Later into the pandemic they created a dedicated transfer service. This regional support was invaluable. Occasionally other regional/ national bodies such as NHSE would try and intervene with this process in terms of transfer etc. This occurred on several occasions creating unnecessary work and stress for the teams on the ground.

232. Other networks were established as the pandemic progressed e.g. IPC regional forum where all the IPC leads could share experience and produce real world workable solutions.

233. It was these networks that provided the most peer support and an ability to share solutions in a rapidly evolving situation where no one person or team was an expert. The networks were forums where colleagues could feel heard and ask each other for advice, guidance, and support. Having these established networks will be invaluable should another similar situation arise and are a much quicker way of getting subject experts together rather than with a traditional command and control structure.

234. Whilst National guidance was well intentioned, it was felt that it hadn't always been created with enough contribution from operational teams with extensive experience of how to implement this within various NHS settings. Guidance was often published late on Friday giving operational teams very little time to enact

before the weekend, this created confusion amongst staff and the public. If guidance had been discussed with regional clinical networks and then agreed upon before being published this is likely to have achieved a more collegiate and workable real world solution.

235. It was perceived the support from national bodies etc was not as extensive as required. Many colleagues felt that the ask was mandated, and support was minimal. Again, far more support, discussion and sharing came from the regional networks. In a rapidly evolving situation, it was unsurprising that confusion could occur, and many national bodies, colleges and organisations had differing and sometimes contradictory guidance.

Recommendations

236. We have held a multi-disciplinary discussion to establish what our recommendations to other hospitals would be to improve the way they respond to a future pandemic and suggestions which may improve the way national decision makers for the healthcare system respond to a future pandemic.

237. First and foremost we would recommend that hospitals held daily Silver Command meetings with the correct attendees. One thing we did well and that benefitted us was to hold daily Silver Command meetings. Although this was mandated as part of the Emergency Preparedness, Resilience and Response (EPRR) response to the pandemic it is our understanding that not all organisations held these daily. These had representation from across the whole site and were multi-disciplinary, with staff at the front line and feet on the ground. Our meetings took on an unusual flattened structure, unlike many whose were hierarchical and with staff who were not necessarily able to relate to the discussions taking place. Amongst others, we had representative from executive directors, Infection prevention, HR, medical staff, nursing bodies, AHPs, Finance, Estates, Governance, Communications, and Procurement etc. Staff felt heard. Their knowledge and expertise in their areas counted, and although at times this may have been challenged, it provided for very useful debate. Discussions at Silver Command meetings were around the risk at that time, and decisions were

made there and then. This was putting in to place the EPRR framework and using it in the manner for which it was intended i.e. Silver Command to be used for decision making at a tactical level and therefore operates by providing resilience and sound decision making during the ever evolving situation. This could only happen because the right people were 'in the room'. Related to this, we also agreed the actions required behind these decisions and written processes (standard operating procedures (SOPs)) were developed and published very quickly – our set up allowed us to be very responsive; SOPs were frequently turned around within 24 hours; meaning staff were not 'paralised' with indecision.

238. The traditional blocks and delays in getting decisions made were not a factor. The usual rules on spending money were not a feature hence there was more freedom on expenditure; however, at our Trust this took place in a considered manner though with good governance and discussion between the right people in the room. Although there were fewer spending rules to be abided by, we were still reserved in what we spent funds on. This would be a recommendation for other Trusts to take note of; just because there was a freedom it should not be abused. This has left us in a better financial position than many post-pandemic. Examples of this include that we were considerate to what PPE was required based on staff need and risk assessments which were discussed and agreed at Silver Command and as such we have not ended up being left with large amounts; we purchased in a structured, well thought-through manner. We didn't purchase lots of CPAP machines; instead we repurposed some of our sleep apnoea machines which were already in our Trust.

239. We put out a daily communication to all staff so staff were aware of what was going on. These contained the current national guidance, recently approved and published SOPs, signposting to staff health and wellbeing support etc. Communication also included the scale and size of the pandemic and its impact on the organisation so staff were fully informed.

240. We have continued our Silver meetings ad-infinitum and it is run as a very useful operational meeting that continues to this day.

241. With regards to procurement, we were very quick to centralise our stocks from wards and departments and discussed burn rate very early on which allowed us to manage our stocks.

242. Another recommendation would be to keep business continuity plans more up to date. It is difficult to write and prepare for every eventuality especially if you don't know what is coming; but it is fair to say our business continuity plans are more robust post-pandemic than pre-pandemic having now been through it and lived some of the unexpected scenarios that wouldn't previously have been considered.

243. Having been through this pandemic, we now see that it would be necessary in a future pandemic to take a step back early on, acknowledge it's coming, and prepare early. Just because we may be being told everything is ok and it won't come to anything is not necessarily a reason to just continue and hope those 'above' are right. Having the ability to recognise the need to possibly stop something for a day or so, establish the facts, review business continuity, make a plan, and then pick back up whatever we stopped in a day or 2, could potentially lead to better outcomes. This would not only benefit at a 'hospital level', but potentially at a 'national decision-maker' level too.

244. In addition to the above, we had key members of staff taking on roles who were heavily involved in making early decisions early on. There was a very collegiate feel. This again, from liaising with colleagues elsewhere was not the case. In the early days, it was reported that many hospitals had problems with ventilation and oxygen flow possibly because they didn't have the right people involved in the discussions and making the decisions. We on the other hand did not have these same issues as we had the right people in our discussions from the start.

245. A recommendation for national decision-makers would be to give organisations more autonomy to own their own risk and make more of their own decisions. We had the ability to recover quickly and restarted surgery sooner than many others, because we did our risk assessments and took control. Therefore, related to this

is a recommendation for hospitals to remember what their key function is – which is to provide healthcare. Don't be afraid to take control of your own risks.

246. Making decisions at the top and feeding down did not always work. National decision-makers should have left it for the clinicians at the front line to make certain decisions as they are the ones who deal with this day to day and know the best way to manage it. For example, consultant to consultant in ICU to decide who goes to theatre, based on evidence, not from what they are told from those 'above'.

247. A further key recommendation to the government would be to better consider the timing of when national guidance documents were issued. Sending documents out late on a Friday afternoon for implementation the next day for example was very unhelpful and made it difficult to review, communicate and implement changes at short notice. Often national documents had been published prior to them being sent out to Trusts, which gave us no time to respond as there had been no forewarning. Our own staff then saw us as the policy makers and led to an element of backlash from staff. It would be much better to give organisations the autonomy to take the rule or must do and deal with it in their own way as a sovereign organisation; but to be clear what the 'real' must dos are and give us more notice and time to develop our response.

248. With regards to the national decision-makers making rules, in future, we feel it would lead to a better outcome if those who are going to be impacted by the rule were consulted with at the beginning. One example of this is mandating vaccinations. If anyone in government had spoken to those involved, they would have been told immediately that the policy would not have results in mass staff coming forward to be vaccinated; it was always going to result in hundreds of healthcare staff being lost.

249. Another recommendation for the national decision-makers would be for them to put in place better processes to prevent some of the issues hospitals faced as a result of some of their decisions. An example of this would be to perform better quality checks on PPE before it was sent out to hospitals. As a result of being

sent PPE that our own IPC team assured us was not fit for purpose, as a Trust, we made the decision to isolate and store it and keep only use if we became desperate. As such we had to foot the cost of this storage as we were not prepared to use it. We were then told 9 months later by PHE that it was being recalled as it was now established that it was in fact not fit for purpose; this whole time we had had to foot the cost not only of storing it while not using it, but now to dispose of it ourselves. All along we were having to assure clinicians PPE was fit for purpose when we did not necessarily believe it ourselves; we lost the trust of many clinicians because of this.

250. We recognise that the national decision-makers clearly had some very tough decisions to make. We feel that in future a better narrative should be given on some decisions. For example, we feel that the government should have acknowledged that some of their decisions were not necessarily the best thing for healthcare, but were the best thing for the country as whole at that moment in time. Being honest with the nation would have made some of these decisions more palatable.

251. The decision relating to mass discharge from hospital into care homes and the mandated way in which it was expected to be carried out, not based on a true risk based assessment needs a consideration for future pandemics. Funding should be considered moving forward to right size the social care and out of hospital capacity to prevent this occurring again in the future. The Trust responded well to this based on the relationships that were already existing across the System and the integrated working across health and social care. This lead to a whole System management of risk and speedier recovery post Covid.

252. Lastly, a general recommendation for the future would be to think more about staff early on. Initially thinking was focused on protecting patients but thoughts on protecting staff should have been implemented sooner.

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: 25 April 2024