Witness Name: David Sulch Statement No. 1 Exhibits: 22 Dated: 4 June 2024

COVID-19 PUBLIC INQUIRY

WRITTEN STATEMENT OF DR DAVID SULCH

I provide this statement on behalf of Medway NHS Foundation Trust ("the Trust") in response to the request under Rule 9 of the Inquiry Rules 2006 dated 13 December 2023.

I, David Sulch, will say as follows: -

Introduction

- A My full name is Dr David Sulch. My date of birth is **Personal Data** My professional address is Dartford and Gravesham NHS Foundation Trust, Darent Valley Hospital, Darenth Wood Road, Dartford, Kent, DA2 8DA, where I am a Consultant Stroke Physician. Concurrently, I am also a Medical Examiner at Medway NHS Foundation Trust, Medway Maritime Hospital, Gundulph Trust HQ, Windmill Road, Gillingham, Kent, ME7 5NY. In my previous role, I was the Trust's Chief Medical Officer, during which time I sat on the Trust's Board. I was appointed to this role on 1.9.2018.
- B I have been asked to respond to a Rule 9 Request sent to the Trust's Chief Executive in my capacity as former Chief Medical Officer during the relevant period. I note that Alison Davis replaced me as the Trust's Chief Medical Officer, and my last date in this role was 30.11.21. The contents of this statement will therefore cover the period from 1.3.20 to 30.11.21, where I provide my account of the matters relevant to the Inquiry as set out in the Rule 9 letter dated 13 December 2023.
- C This statement has been prepared with information gathered from across the Trust andI have consulted with a number of individuals who were in post during the relevant

period to inform this response. It should be noted that a significant number of those in leadership roles at the relevant time are no longer in post at the Trust (there are only two individuals who remain in post at Executive Board level now who were in post at the relevant time) and this has hampered my ability to provide comprehensive answers in relation to some questions.

D I have prepared this statement using terminology that refers to "Waves", "Covid-19" and "Variants". For clarity, Wave 1 refers to the period from February – July 2020, and Wave 2 to the period from October 2020 – March 2021 (the Trust started to see a rise in admissions between October 12 and October 19). During Wave 1, I refer to the infection of "Covid-19", and during Wave 2, the virus was widely referred to as the "Kent" or "Alpha" Variant, and I have adopted these terms in the paragraphs below to reflect these variants over the relevant period. As the "Delta" Variant was not established until May 2021, this has not been referred to in my statement.

1. Background:

1.1 General profile information about Medway Maritime Hospital has been provided separately by Alison Davis, current Chief Medical Officer at Medway NHS Foundation Trust.

2. Staffing Capacity:

2.1 As Covid-19 symptoms began to spread initially, and generic guidance was issued regarding isolation prior to Covid-19 testing becoming available, there was an increase in workforce sickness absence reported. Staffing shortages occurred across all areas, however as services were stepped up (e.g. critical care level 3 beds), or stepped down (elective surgery, face to face outpatients etc), staffing shortages were mitigated wherever possible through staff redeployment. This was based on a personalised risk assessment of the staff member and acknowledgement of their previous and current work experience/skill set. Whilst capacity levels were easier to manage during Wave 1 because of low bed occupancy in the Hospital (as low as 50-60% around Easter 2020), there wasn't the same drop off in occupancy during Wave 2 (November 2020 to March 2021, and consequently, this was much harder to manage as a result. This was particularly the case given that Wave 2 came before the vaccination programme was rolled out nationally (the first staff to be given their first vaccine was in December 2020 and this was delivered to priority high risk groups initially).

- 2.2 The Trust's maternity-managed acute and elective activity during the pandemic established and monitored staffing levels over the relevant time. Staffing shortages identified were mitigated by moving staff to areas of high acuity and implementing an on-call roster. Our midwifery students also provided support worker cover across the Trust. There was a number of maternity staff who had clinical isolation during this period, but they were utilised providing support from home with virtual clinics and patient helplines.
- 2.3 In relation to the Trust's Critical Care staffing ratios, these were set by Guidelines for the Provision of Intensive Care Services (GPIC), providing a 1:1 nurse to patient for level 3 and 1:2 for level 2. During the COVID-19 pandemic, adjusted guidance was released by the Critical Care National Network of up to a 1:5 nurse to patient ratio. Due to the increase in critical care bed capacity, staffing was risk assessed and allocated daily. Redeployed staff, such as Operating Department Practitioner's, Anaesthetic and Theatre nurses and staff with a background in critical care, supported the substantive critical care nurses with their cohort of patients. Nursing ratios within ICU were maintained at 1:2 for the majority, with a few occasions of 1:3 of lower acuity level 3 patients.
- 2.4 With reference to our HR data, this monitors staff absences by reference to their specialities and groups. It should be noted that the absence data provided includes those pandemic-related absences, but also any other absence unavailability due to maternity, adoption leave and other non-Covid-19 related illnesses. This data set out below identifies staff shortages over the relevant period where such shortages reflect a +15% shortfall in staff capacity, over two or more successive months.
 - 2.4.1 Specialisms: Cancer unit (five months over 15%); Outpatients Nursing (ten months over 15%); Phlebotomy (15 months over 15%); Staff Nursery (four months over 15%); SMART team (six months over 15%) Clinical Site team (six months over 15%); Patient catering (seven months over 15%); medical assessment units SAFU and Lister (average 8.5 months over 15%); ED paediatrics nursing (seven months over 15%); Frailty wards (average 7 months over 15%); McCulloch ward (ten months over 15%); Acute Response team (12 months over 15%); HDU nursing (seven months over 15%); ICU nursing (five months over 15%); Day case Theatres (11 months over 15%); Paediatrics (five months over 15%); NICU nursing (eight months over 15%);

2.4.2 Staff groups:

Support Workers: peaked in April 2020 at 11.1% absence rate and December 2020 at 15.7% absence and January 2021 at 11.9%. Average % over the relevant period was 11.2%. The average absence rate for 12 months pre-Covid-19 was 8.6%.

Estates and ancillary: peaked April 2020 at 11.1% and December 2020 at 11.2% and October 2021 at 7.5%. Average % over the relevant period was 7.3%. The average absence rate for 12 months pre-Covid-19 was 6.5%.

Medical and dental: peaked April 2020 at 4.1% absence rate and December 2020 at 5.6% and December 2021 at 4.4% and March 2022 at 4.9%. Average % over the relevant period was 3.7%. The average absence rate for 12 months pre-Covid-19 was 2.4%.

Nursing and midwifery registered: peaked April 2020 at 10% and December 2020 at 14.1% and July 2021 at 9% and December 2021 at 11.6% and March 2022 at 10.6%. Average % over the relevant period was 9.4%. The average absence rate for 12 months pre-Covid-19 was 7.2%.

Months with significantly higher gaps (vacancies and shift cover requests) Included April 2020, September 2020, April 2021, June 2021 and May 2022. This is particularly difficult to assess as underlying budget changed through this period usually in April and May every financial year. Overall contractual staff in post increased through the period. Vacancies are similarly difficult to assess as we had contractual vacancies and also significant change to the bed base which wasn't reflected in the budget.

- 2.4.3 Actual worked Full Time Equivalent (FTE) is presented as Exhibit DS/01 INQ000427380 demonstrating the total amount of worker FTE worked in each month excluding sickness and maternity but would include isolation.
- 2.4.4 A graph depicting Absence Reason Trends both before, during and after the relevant period is shown at Exhibit DS/02 INQ000427382.
- 2.4.5 A spreadsheet depicting Staff Absences throughout the relevant period by reference to specialisms are shown at Exhibit DS/03 INQ000427383.

4

3. Staff Shortages:

- 3.1 Staff vacancies presented some challenges prior to the relevant period. As shown in Exhibit DS/04 INQ000427384 which depicts the monthly average of all Trust sickness between 2018 and 2023, the pandemic exacerbated these shortages, reaching its peak in December 2020.
- 3.2 Staff shortages also existed due to ward configurations. An example of this was the medically led high dependency unit (6 beds) which was moved into a 10-bed surgical high care unit with the staffing from both units combining. The Intensive Care Unit (ICU) expanded into Theatres and Recovery, with an expansion of at least 4 times our normal ICU bed base. Staffing as a result was seriously overstretched. As Wave 2 progressed, it became clear that we were being overwhelmed for several reasons. Firstly because of the sheer numbers of patients and secondly because the virus was more infectious than the first variant, and many staff were going off sick. It was at this time when the Alpha Variant became the dominant variant that we requested that the situation be declared a major incident, and that staff might be deployed from other Trusts, but no such support was available.
- 3.3 By January 2021, many staff had large amounts of annual leave which had accumulated over the preceding year. This required the Trust to consider how this could be taken and whether a dispensation to carry it forward to the next year should be agreed.

4. Workforce Capacity and Diagnostic Testing:

- 4.1 The introduction and availability of diagnostic testing resulted in clearer processes for staff and departments to follow.
- 4.2 Whilst it is accepted that there were longer term gains, diagnostic testing for staff did, however, have the effect of increased absence from work. This was because we had to release over 100 staff who elected for Diagnostic Testing from clinical duties over the relevant period to go to Occupational Health for testing at a time when the clinical workforce was already stretched.
- 4.3 Antibody testing did not affect staffing to the same extent, except to release staff for a short period of time to attend Occupational Health, which was staggered to minimise overall impact on staff numbers.

4.4 Maternity had support from 2 retired midwives who supported the unit by undertaking suturing during the height of the pandemic.

5. Constraints to increase staffing capacity:

5.1 As a Trust we continued with our temporary staffing processes – bank and agency bookings to cover designated areas. However, the labour market of agency staff was minimal and as a result we did not see agency staff as a source of additional staffing capacity at any point during Covid-19. The Trust engaged with the national volunteers, return to practice processes and increased capacity through medical support workers, although these were relatively small numbers. The Trust received direct support through the military with 46 Military Medical Technicians who provided direct care across our Emergency Department function. As a system, NHS trusts and Medway Community Healthcare (CIC) agreed to Mutual Aid processes to support the movement of staff across organisations in a safe and secure way. Ultimately, the labour market contracted significantly, as did our internal supply of labour with shielding and absences, and this effect was replicated across other healthcare providers seeking labour.

6. Measures taken to address/alleviate staffing shortages:

- 6.1 Please see response set out in paragraph 5.1 above.
- 6.2 In general terms, we implemented significant changes to medical working patterns during Wave 1. Ward based consultants moved to a full 7 day working system, with appropriate junior staffing to provide support across the whole week. We decided on this approach at the outset of Wave 1, when the drop in bed occupancy had not yet occurred, as we felt that robust consultant-led decision making 7 days a week discharges would be necessary to maintain patient flow and create capacity. We were unable to implement the same model in Wave 2, with excessive patient numbers and staff sickness compromising this option.
- 6.3 Staff ratios were routinely reviewed throughout each day, 7 days a week by the Command Centre and senior leadership team. Decisions were logged by the Command Centre on any changes in areas such as ICU, and escalation areas. The Board stood up a review committee to involve clinicians in shared decision making, particularly within areas such as ITU. This worked well in the Trust, but we would benefit from a structured system response in future scenarios. A challenge that we identified was the conflict between operational demand (COO), and quality of care (CNO). The dominant factor for this was that the CNO had previously implemented rigorous processes and systems

in response to an earlier CQC Report issued in April 2020, in which it highlighted deficiencies by the Trust for its lack of compliance with policies on the Dickens Ward. This led to the Trust taking the decision before Wave 1 to close the Dickens Ward temporarily whilst it addressed these issues. During the pandemic, the CNO felt that these processes and systems were being circumvented by the operational need to increase bed capacity and this understandably created tensions between the COO and CNO. Once Wave 2 hit, the operational and tactical teams led by the COO tried to put in place systems to deal with the significant upsurge in cases, but the CNO was concerned that this would put patients and staff at risk. This was particularly the case where the COO sought to reconfigure wards to increase bed capacity. The CEO at that time noticed these tensions and reminded all colleagues of the importance of decision making via the Command Centre and also of collective responsibility.

6.4 In respect of workforce profiling, The Trust had a very good workforce tool, which projected staff sickness by staff group and area with a 7 day look forward. This approach was limited to the Trust, and a potential recommendation may include an ICS approach to workforce profiling and mobility. This was lacking throughout the pandemic, and Trusts were often left to manage the workforce issues themselves with little or no support.

7. Staff redeployment:

- 7.1 As an overview, the Trust undertook a number of methods to support redeployments, this included reviewing continuity plans and minimum staffing for administration areas, identification of potential available FTE for redeployment to support demand areas, individual risk assessment consideration, training requirement to be redeployed and other requirements, such as DBS checks. New ways of working and redeployments resulted in significant working from home (guidelines developed and published by the Trust throughout Covid-19 including wellbeing at home) and different ways of working. An example of this was the Virtual Bed Bureau which changed the way ward clerk roles were delivered in a part remote arrangement. Nursing teams used a tiered redeployment approach, deploying different layers of corporate nursing to front line as required by demand.
- 7.2 Deployments were commonly seen in areas having the highest need such a Critical Care, whilst ensuring that we considered the vulnerability status of the staff member concerned. Where staff were known to be in a vulnerable position, they were moved to

a work-from-home post, or placed in a low-risk area, and within the parameters of their previous/current skill set.

- 7.3 In Critical Care, redeployed staff, such as ODP's, anaesthetic and theatre nurses and staff with a background in critical care, supported the substantive critical care nurses during COVID-19. Redeployed staff were inducted and given basic competencies to ensure safety. Staff were identified to support critical care based on a Covid-19 risk assessment of their health, risk factors and their prior experience within the acute care setting in critical care particularly. Staff members that had previous experience of critical care, that may have moved onto specialist nurse roles were redeployed and supported a substantive critical care nurse with their allocated patients. The critical care PDN team supported with any competency updates required. Redeployed staff were clear on their roles and understood their scope of practice and limitations. Redeployed staff worked alongside critical care staff and were supervised and "buddied-up". To support the phases of a critical surge, a Workforce and Deployment Model was established for nursing to ensure that redeployment remained within the relevant professions. This Model was developed and additional training was coordinated via the Workforce Hub. Going forward, a skills inventory for all staff will be developed and held centrally to ensure relevant training for clinical and non-clinical staff. In terms of wellbeing generally, a significant number of Wellbeing initiatives were implemented to maintain staff morale as set out in paragraphs 42.6-42.20 and to manage the increased risk of burnout. For those working in critical care specifically, there was a Wellbeing Room set up within critical care that staff could use as a breakout area. The critical care counsellor was available for staff if required and the Matron made reasonable adjustments for redeployed staff such as flexible working. There was extra consideration for staff redeployed into critical care specifically for those experiencing added stress of working in a new environment. The wellbeing of staff was priority and any staff members struggling with the impact of the COVID surge were offered time out and wellbeing support as stated. However, during this time there was a great sense of teamwork and camaraderie, it is now that the critical care workforce is experiencing burnout.
- 7.4 During Covid-19, the Trust set up a forward look supply report as depicted in Exhibit DS/05 INQ000427385 which tracked staff groups and care groups based on known and estimated return to work for those on isolation, this was triangulated with daily staffing demand and daily safe staffing huddles and provided valuable projections to help us manage staffing during the relevant period.

7.5 I am not aware of anyone redeployed to a different hospital (including a Nightingale Hospital) during the relevant period.

8. Long Covid:

8.1 During the relevant period, we have had 172 individuals leave via ill health retirement, voluntary health reasons, or capacity – however, we are not able to report on those where Covid-19/long Covid-19 was a factor. I can confirm that our HR department can identify three individuals who have had sickness periods of over 100 calendar days with the sickness reason listed as Covid-19; of this number, two were clinical support workers and one was a registered nurse.

9. Staff Deaths from Covid-19:

- 9.1 The Trust sadly experienced three staff deaths directly as a result of Covid-19 and we were able to successfully support the families with the NHS & Social Care Coronavirus Life Assurance (England) Scheme applications. Two staff were Staff Nurses, and one was a Specialty Administrator. We linked the affected departments with the Wellbeing Team.
- 9.2 Colleagues who worked most closely with the staff who we lost were very badly affected. The staff who died worked in departments that were already under great pressure resulting from workforce issues, COVID-related absences among the senior medical workforce, and intense scrutiny because of concerns over quality of care before the pandemic. I provided support where I could to colleagues in what were very difficult times.
- 9.3 Staff were offered support through the Trust's wellbeing initiatives, as set out at paragraph 42.6-42.20.

10. Covid-19 Vaccination as a Condition of Deployment ("VCOD"):

- 10.1 The Trust prepared a report on the final position of VCOD just before the Government made the announcement not to proceed. We have been unable to locate the document at this time, but it was ultimately not implemented as a Policy due to the reversal of Government Policy as a mandated requirement.
- 10.2 The vaccine wasn't available to staff until December 2020 and most staff did not start to receive their second dose until March 2021, after the Wave 2 had subsided. It was noted that by the beginning of August 2021, there was still around 10% of Hospital staff who

had not yet had their Covid-19 vaccination, with specific focus on BAME communities who were at higher risk of infection.

11. VCOD Policy:

11.1 Please see comments set out in paragraph 10.1 above.

12. Other concerns or issues related to staffing capacity:

- 12.1 From those on the ground, the general view was that staffing was very stretched over the pandemic, with high-risk staff deployed away from critical care, increased sickness/absence of staff and increased bed base. However, staffing was made safe on a daily basis, risk assessed, and Mutual Aid sought through the CC3N where possible.
- 12.2 Staffing was reviewed formally on a twice daily basis for day and night shifts and was reviewed further on a local basis as further sickness absence was reported. Temporary staffing (bank and agency) was utilised to mitigate where possible. Both staff off sick (long and short term) and staff actively working were supported in a reasonably practical way.
- 12.3 There were 13 final year medical students who stepped up into Foundation Year 1 (junior doctors) type roles to support the medical staffing during Wave 1 until July 2020, after which they took up their FY1 posts at other hospitals. We had strong and enthusiastic support on the respiratory ward.
- 12.4 The Trust considered whether 3rd year nursing students could support the staffing issues it faced during Covid-19, but it was decided at Strategic Group meeting that it would not be in the best interests of the students and would not provide any real benefit to the service. Students would be offered bank contracts outside their educational hours if desired.

13. Bed Capacity and National Guidance:

13.1 The Trust collated information about bed capacity in respect of open beds, occupied beds and available beds for both general wards and ICU during the relevant period. This document, attached as Exhibit DS/06 INQ000427386, established that on the date when the NHSE/I Discharge Policy was issued, there were 81 available beds in general wards and 17 available beds in the Hospital's ICU. The Trust continued to monitor average bed capacity and availability on a monthly basis and whilst there was a slight increase in bed availability during March 2020 (reflecting the periods both before and after the

NHSE/I Discharge Policy was issued), there was marked increases (more than double) in bed availability in April 2020 across both general wards and the ICU. ICU in particular, had increased its intensive care bed capacity from 28 to 58 by 9.4.20 with additional capacity to take this to 72 if needed.

- 13.2 The Trust made the decision in Wave 1 to stop elective care which meant that staff could be reassigned from Theatres to assist in ICU which was hit hard. Internal communications between the various groups within the Trust meant that it was able to get more accurate data than that which the government were providing on projected cases. This gave the Trust a sense of assurance through both waves that they could trust in the people to make the right decisions on the basis of information gathered by its own teams.
- 13.3 By August 2020, the Trust restarted it programme for elective care and in October 2020, in preparation for Winter, the Trust undertook a further assessment between emergency and elective beds. The Trust implemented a number of changes at this time to move services around the Hospital to facilitate "green" elective surgery wards.
- 13.4 However, the availability of beds was put under extreme pressure during peak periods in Waves 1 (limited to critical care) and Wave 2 (across the Hospital). For example, in November 2020 Exhibit DS/07 INQ000427387 shows that the Trust was experiencing a number of challenges with the then Chief Executive stating in a staff communication that the Trust was facing a surge in ambulance arrivals to the Emergency Department, and this combined with high levels of staff absences created a very difficult bed position.
- 13.5 In terms of steps taken by the Hospital prior to the issue of the Discharge Policy on 17 March 2020, it was identified early on that there were key areas of risk to be managed, and that this included an urgent need for significantly more medical equipment and beds. A decision was taken by the Accountable Emergency Officer and the Emergency Planning Officer that the scale and potential longevity of the Covid-19 pandemic meant that the Trust's standard recognised structures for dealing with incident control would not be sufficient. Strategic Groups were therefore set up with trained level leads in which the Trust established three main tactical groups, namely, Medical Tactical, Nursing Tactical and Operations Tactical. All three Strategic Groups were set up to allow professional leads to escalate and disseminate requirements at speed and were involved in preparing for increased demand in the ICU. An assessment of building requirements emerged in which the Hospital assessed the need for separation of clinical

cohorts of patients. This ultimately led to a separation of the site to clean elective pathways whilst acknowledging that Covid-19 was a dominating factor of the patients we had in Trust beds.

14. Increasing ICU capacity:

- 14.1 Following the formation of the Strategic Groups, ICU bed capacity was assessed daily and was recorded in Exhibit DS/06 INQ000427386. In terms of increased ICU bed capacity, please see my response set out in paragraph 13 above.
- 14.2 A Covid-19 Flow Pathway was implemented on 18.3.20 to ensure that patients were treated appropriately and a bespoke ITU/CCU flow pathway highlighted the circumstances in which ITU beds would be allocated where identified as a referral. Where appropriate, patients would be directed to specialist and non-specialist respiratory flow instead of ITU where this was not considered clinically necessary.
- 14.3 Daily tactical updates by the Strategic Group monitored availability of ITU and HDU beds. This highlighted each day the capacity of both hot and cold ITU and HDU and assessing if staff ratios were being met or whether these fell outside ICS recommendations. Decisions were then taken to assess what could be done to increase capacity where these reached critical levels.
- 14.4 One obstacle we faced to increasing ICU capacity was the designation of "hot" and "cold" areas in the Hospital. This reflected patients who were placed in wards which were either hot or cold according to whether they were Covid-positive or Covid-negative. One of our major challenges in Wave 1 and for most of Wave 2 was the time it took to receive test results back and the impact this had on these designated areas, particularly where patients who weren't presenting with Covid symptoms were placed on cold wards. Positive test results following delays caused cold wards to be re-identified as hot. This is explored further at paragraph 24 of my statement.
- 14.5 A Critical Care Surge Plan was devised using data from Waves 1 & 2. This is made up of 5 distinct phases and addresses how the demand for red and green capacity would be managed (Covid-19 Policy 2022). On 22.2.22, the Trust also implemented a Statement of Work (SoW) which comprised Action Cards to be used in any future event which puts pressure on ICU beds. Specifically, Action Card 2 provides a critical care ward decision tool and escalation plan, Action Card 3 provides for the expansion of ICU utilising Theatre space to accommodate further ICU beds, and Action Card 4 sets out

Mutual Aid support and the process of transferring critical care patients to other centres with ICU capacity. This decision tool was devised with the intention to support increases to ICU capacity.

14.6 I and my colleagues identified in our efforts to increase bed capacity, that it was difficult to achieve social distancing without removing beds which was counterproductive to our ability to maximise bed spaces. If we had met the national recommendations in terms of spacing between beds, we would have lost a third of our inpatient bed capacity. This was a very significant challenge in coping with the pandemic on a site with many old wards in poor condition, several being configured in a Nightingale style without bays, which added to the risk of spread of infection.

15. Hospital's ICU capacity:

- 15.1 ICU bed capacity was monitored and assessed daily in Strategic Group meetings during both waves. In terms of increased ICU bed capacity, please see my response set out in paragraphs 13 & 14 above.
- 15.2 Patient safety was not compromised due to bed capacity. ICU capacity was risk assessed and allocated daily. Nursing ratios within ICU were maintained at 1:2 for the majority, with a few occasions of 1:3 of lower acuity level 3 patients.
- 15.3 Critical care beds were extended into the Theatre Department and Recovery Area adjacent to the ICU. Daily meetings with the Clinical Care Network identified staffing and bed capacity and availability of Mutual Aid. Patients were transferred to other ICU'S when needed, if safe, and this was facilitated by the Sprint Transfer Team.
- 15.4 Having checked our records, 13 Level 3 patients were transferred from the Trust to other hospitals as Mutual Aid requests and 13 Level 3 patients were transferred from the Trust for more specialist care (ECMO) where this involved severe respiratory failure with potentially reversible causes. This occurred predominantly during Wave 2 of the pandemic. Of the Level 3 patients transferred, 23 of these were transferred within the hospital's Critical Care Network.

16. Critical Care Network:

16.1 The Hospital was part of a Critical Care Network for Kent, Surrey and Sussex which comprised our Hospital, Dartford and Gravesham Hospital, Maidstone and Tunbridge

Wells Hospital and East Kent Hospitals, together with those Trusts located in Surrey and Sussex.

- 16.2 Daily network meetings took place to support the Trust and other organisations and to provide Mutual Aid. This was instigated in Waves 1 & 2 across Kent and linked into the regional response by the Integrated Care System (ICS). It was considered in the aftermath of Waves 1 & 2 that the critical care network across the southeast worked very well, and Medway Maritime Hospital gives particular mention to East Kent Hospitals who provided us with assistance upon the onset of the Alpha Variant by taking transfers of patients which was invaluable to this Trust.
- 16.3 Outside the critical care network, Spire Alexandra, Chatham and KIMS (Kent Institute of Medicine and Surgery) were also utilised for periods when capacity increased at the Trust. Spire had a clean unit for cancer patients but was available to support demand from Covid-19 for acute, cancer and urgent operations. This was provided in two phases, the first to increase Theatres from 1 to 2 per day from 11 May 2020 and the second was to reconfigure the Hospital's operating centre at the Trust to create a cold elective unit to undertake cancer and emergency procedures. This support maximised the availability of essential anaesthetic and critical care staff at the Trust.
- 16.4 Please see paragraph 15.4 in relation to patients transferred from the Trust to other ICU's. The Trust received 2 Level 3 patients from other hospitals as Mutual Aid requests during the relevant period.

17. Medical Equipment/medicines Shortages:

- 17.1 As an overview, and as a regional and national consideration, the Trust Estate in Medway was not designed to deliver the quantities of oxygen required by the Covid-19 pandemic. The Estate has limited capacity oxygen delivery systems.
- 17.2 The Oxygen Gas Team was formed in January 2020 and was the Hospital's response to a significant concern about oxygen consumption at a point where it started to reach critically high levels. This was led by the Chief Pharmacist and backed at executive level by the Director of Estates & Facilities. This group was a true multi-disciplinary cell with leads from EPRR, Estates, ICU and anaesthetic consultants, Clinical Engineering and Nursing as well as bi-analysts.

- 17.3 One unexpected challenge to our oxygen capacity came during Wave 2 with the reduction in the number of patients needing intubation, and the increase in the number managed with approaches such as high flow nasal oxygen (HFNO) in an HDU or acute respiratory setting. The presumption is that this relative reduction in demand for ventilators resulted from the treatments identified for COVID during Wave 1 (most importantly dexamethasone). HFNO is a much more oxygen hungry treatment method than ventilation (there is no leak of oxygen into the surrounding air with a ventilated patient who is on a closed circuit).
- 17.4 It was identified in a report titled Cell: Medical Gases dated 8.1.21 "situation given the unprecedented demand for non-invasive ventilation (NIV) to support patients with the respiratory symptoms of Covid-19 and the staffing required to deliver it safely there is a risk that the Hospital will reach the limits of its current capacity to treat patients with this therapy. This will also impact on our ability to deliver to fully ventilated patients." The Medical Gases Group issued a Medical Gas Response Plan which implemented measures to address these concerns and instigated actions to improve system resilience.
- 17.5 At one point, piped medical oxygen was at 87% on the Hospital's demand against capacity.
- 17.6 The Oxygen Gas Team stepped up in February 2021 with an accurate forecast usage model that was run on a daily basis to predict capacity and usage of oxygen. This involved a multi-disciplinary team (MDT) which focused on the use of oxygen concentrators and worked very well. The Hospital's Business Intelligence Team created a dashboard to assist swapping usage of oxygen and PPE. Mutual Aid requests were managed well and supported by a dashboard for procurement, NIV capacity and oxygen.
- 17.7 With regard to oxygen, there was some rationing during peak times, but the anomaly between consumption figures measured and those supplied by NHS England did cause the Trust an issue. NHSE figures showed maximum consumption, but not typical consumption. This would have significantly reduced the amount of equipment which could be used, for example a Drager v500 adult ventilator has a maximum oxygen consumption of 40 litres per minute. A typical tidal volume would be 7-12 lpm, at 60% would use 3.5-6 lpm, rather than 40 litres. The Medical Gas Committee devised a Response Plan, in which we calculated the consumption of devices at typical setting

which our business intelligence used to calculate our flow rate, limited at the Vacuum Insulated Evaporator (VIE) at 2800lpm, on a daily basis. The Response Plan can be made available upon request.

- 17.8 The availability of equipment was collated as a list of available items. We monitored Datix, as this would show any shortages, however, those individuals involved don't recall there being any. There were no shortages of medical devices for CPAP, ventilators, haemofiltration or infusion during the relevant period. In terms of medical equipment, we were well equipped and at one point were assisting Darent Valley Hospital in Dartford with infusion equipment. An itemised list of equipment procured, and equipment deployed is held by the Trust and can be made available on request.
- 17.9 In relation to anaesthetic and palliative care drugs, we were in a fairly good state as our pharmacy procurement team was on top of supply issues and kept our supplies coming in when other Hospitals around us were struggling to procure some drugs, in particular, propofol and analgesics.

18. Private Healthcare Sector support:

- 18.1 As an overview, I recall that although discussions were held over the use of the private sector for elective work, the very tight restrictions on which patients could safely be treated in private provider settings meant that in practice it was very difficult to move many patients into this treatment and care environment. Staffing was also an issue as local private hospitals are largely staffed (from a medical point of view) by NHS staff working in local hospitals. While surgeons in specialities such as Trauma & Orthopaedic and ENT may have been available to operate, our anaesthetists were very busy supporting the ITU and respiratory units and providing rapid support to deteriorating patients within the acute hospital site. We therefore had minimal availability of anaesthetists to support elective work on the private sites.
- 18.2 East Kent Hospitals did provide us with assistance upon the onset of the Alpha Variant by taking transfers of patients and KIMS and Spire Alexandra, Chatham were also utilised for periods when capacity increased at the Trust. Spire Alexandra had a clean unit for cancer patients but was available to support demand from Covid-19 for acute, cancer and urgent operations.
- 18.3 During the height of the pandemic, some staff requested that the situation be declared a major incident, so that staff might be deployed from other trusts, but no such support

was available, other than to provide the support set out in paragraph 18.1 above. Accordingly, senior leaders took the decision not to declare a major incident, as it was widely considered that this would not produce any additional benefit to the Trust. This was due to the fact that everyone was already stretched and such a declaration would not have made any difference.

18.4 In relation to medical equipment, there were no shortages of medical devices for CPAP, ventilators, haemofiltration or infusion during the relevant period. In terms of medical equipment, we were well equipped. Please see my response at paragraph 17.6 in relation to PPE/RPE.

Infection prevention and control ("IPC")

19. IPC National/Local Guidance:

- 19.1 The Trust largely followed National Guidance but did make some adjustments based on a view on staff welfare and the rationality of the Guidelines. For example, we allowed full PPE for staff managing COVID patients who were not undergoing aerosol generating procedures before the national recommendation supported this. We also continued to recommend that staff wore full PPE for all Cardiopulmonary Resuscitation (CPR) activity, regardless of the patient's COVID status (this was in line with the Resus Council recommendations, but not in line with national IPC guidance).
- 19.2 The Trust's local (internal) guidance policies and standard operating procedures are set out in Exhibit DS/08 INQ000427388 (highlighted in yellow) which were prepared during early March and April 2020 and extended during both waves of the pandemic.
- 19.3 In September 2021 the Trust implemented a Covid-19 Policy. This was built on National Guidance but also included an internal review of Waves 1 & 2 and protocols for addressing winter capacity and demand planning in advance of a Covid-19 Wave 3.

20. Dissemination and implementation of IPC guidance:

20.1 Weekly staff communications highlighted IPC guidance with links to relevant national, local and Trust Policy documents. These were delivered electronically to staff email accounts and were issued more than once weekly. During Wave 1, these occurred every few days and were either a) weekly staff messages, b) important staff messages or c) messages from the Chief Executive. Each staff message contained an index so that staff could see what information was to be given priority which ensured that IPC

guidance at national and local levels would present first. Other sources of information were provided in:

- Daily verbal updates from Head of Nursing and PPE steward sessions.
- Infograms were also used to help staff to understand how to implement IPC guidance.
- Escalation plans and operating procedures were prepared and provided to staff via and protocols were established across the Hospital.
- · Action cards were prepared to support staff.
- · Staff internal comms, forums and meetings
- 20.2 During Wave 1, I especially (early March 2020), there were frequent changes to IPC guidance regarding PPE requirements as more was understood about the virus and its transmission. As part of the incident management there was a daily communications summary, and any PPE changes were communicated through this medium.
- 20.3 When the government issued the living with Covid-19 White Paper on 23 February 2022, an implementation plan was developed to reflect the changes in the Trust's Covid-19 Policy. There was a plethora of SOP's and flowcharts created throughout this period supporting any IPC specific changes and a Covid-19 page was added to the Trust's intranet to allow easy access to the relevant document.

21. Difficulties encountered in disseminating IPC guidance to staff:

21.1 We identified that some staff do not routinely access NHS.net emails in the course of their work and others were working at pace and would not have easily seen the changes and information sent out through our staff communications. Microsoft Teams had only just been launched and adopted for videoconferencing and was not being used widely by some clinical teams. Consequently, our Heads of Nursing within unplanned and integrated care were aware of this, so they implemented a daily huddle for all the divisions ward managers to attend. This was either in the corridor or outside in the dementia garden as weather permitted to facilitate social distancing. We used this huddle to go through the updates in the communications as well as discussing any changes to PPE. It was a way for the ward managers to remain in communication with each other and to provide a collective support. Staff could then ask questions, raise concerns and issues and talk through how they were feeling. Similarly, for planned care, information was disseminated from IPC meetings via matrons on the wards and any new

information was shared during medical and nursing handovers, safety huddles and on staff WhatsApp groups.

- 21.2 There were weekend calls for Covid-19 (Strategic Command weekend calls) and any guidance that was issued by Government on a Friday was discussed in these calls to see if they needed urgent action or could wait until the following week. The majority of guidance was actioned in the weekdays when a full complement of managers, leaders and stakeholders were present, but on occasions this required urgent staff communications be raised to address anything which would not wait.
- 21.3 Where guidance was changed late in the day or on a Friday afternoon that could not wait until the following week, this was challenging to implement. It was decided during Wave 1 at one of the Tactical Groups that the Matrons from across the Trust would become PPE champions. They were rostered to early or late shifts to walk around the wards supporting staff with correct PPE, update the latest guidance and to challenge staff not following guidance. Changes were easier to manage as an ADIPC when restrictions were easing as there was a timeframe to work to not an immediate need for change.
- 21.4 The Trust developed a log of concerns from staff in relation to PPE/RPE/IPC so that issues could be tracked and addressed by team leaders. This provided the Trust with a strong indication of the effectiveness of its communication strategy in relation to IPC guidance. Where messages were not getting through to staff, ward managers held morning briefings to address staff concerns and to escalate to Tactical Groups where further support was needed. The ward manager was tasked with reviewing IPC practices and encouraging compliance amongst staff.
- 21.5 So as to ensure that all staff received information sent via weekly staff communications, and to counter against the work pressures staff were under, these messages were also printed off and distributed to staff in their area of work and discussed in meetings at ward level.
- 22. Examples of difficulties encountered when implementing IPC guidance and how we responded to those challenges.
- 22.1 It would be fair to say that the major news stories over issues with PPE availability (and some near misses when we nearly ran out during Wave 1), did lead to staff cynicism

that the national guidelines had been written partly to ration PPE use, rather than truly being appropriate for the infection risk faced by them. This led to some staff members persisting in overusing PPE in contravention to the guidelines. This was a practice we largely tolerated as we did not wish to be punitive with staff who were continuing to work despite being very concerned for their own safety.

- 22.2 There were some staff during Wave 1 who obtained their own PPE advice and procured some PPE themselves. Feedback from staff identified that there was a lack of IPC guidance generally.
- 22.3 One example of this was a concern raised about ward signage being updated and the importance of this being done. Staff were prompted by ward managers to ensure that ward signage needed to be completed. Other examples were:
 - Non-use of aprons where required;
 - Clarification of maximum wear time for surgical masks and which way round masks are worn; and
 - Sharps bins overflowing.
- 22.4 In March 2020 it was also identified that staff were eating and drinking, often because they were very busy and were grabbing food where they could. The IPC lead advised that this needed to stop, and mealtimes would need to be managed in a safe way.
- 22.5 The Trust identified in early May 2020 that some confusion over which masks should be worn in different areas of the Hospital. A global communication was agreed which would clarify this for staff.
- 22.6 There were also challenges in maintaining social distancing guidelines which required Hospital trusts to maintain the 2-metre rule even though National Guidance for the general public had reduced to one metre plus from 4 July 2020. Regular staff communications were issued to remind staff about this, and the Trust appointed social distancing stewards at entrances to the Hospital to manage flow of patients and visitors. Where it was important to reinforce messaging about IPC and social distancing, walkabouts from senior and junior doctors worked to strengthen resolve and underpin messages.

- 22.7 Leaders wanted to ensure that the same messages were going out consistently but efforts to use WhatsApp and emails did not work well in Wave 1.
- 22.8 It also became necessary to remind staff to use a mask when entering the Hospital at the start of a working day. Social distancing stewards at Hospital entrances were handing out approximately 300 masks daily to staff who hadn't brought one to wear on arrival. Staff were reminded to carry a mask with them at all times and to plan ahead.

23. Difficulties in implementing IPC guidance due to the physical condition and layout of the Hospital Estate:

- 23.1 The Hospital owns its own land and buildings and has its own estates and facilities staff, but there was little expansion room within the existing Hospital infrastructure to adapt at pace to meet Covid-19 requirements. There was also little capacity for the internal Estates Department to work at pace to develop solutions in response to the changing requirements of the Hospital. There was also a lot of competing demands and directions being pulled between senior colleagues, notably the Chief Nursing Officer, Chief Medical Officer and Chief Operations Officer for the support services to deliver on.
- 23.2 One major challenge was the use of the Nightingale Wards Wakeley, Keats, Will Adams and Jade. These wards have no bays, with only dividers (non-full height) between blocks of beds. In Wave 1 we concluded that these wards could only be used for COVID negative patients, because of the obvious risk of transmission. The bed occupancy was so low during Wave 1 that these wards often only housed 33-50% of their normal number of patients, reducing the risk of cross infection.
- 23.3 However, the increased infectivity of the Alpha Variant in Wave 2 led to multiple outbreaks of hospital associated COVID infection in these areas, starting with one significant outbreak on Will Adams which led to regulatory action. The emergence of the Alpha Variant had not been appreciated at that time. The ongoing delays in getting results of COVID tests on new patients (as further described in paragraph 24 below) meant that patients with COVID were inadvertently admitted to these ward areas and had often infected multiple other patients by the time their positive status was identified. As a result, it was agreed during Wave 2 that these wards could only be used for COVID positive patients, and that became an absolute criterion for admission to those ward areas.

- 23.4 Following a meeting on 26.3.20 the EPRR and Estates teams devised a map of the Hospital to identify which wards were Covid-19 wards, and the IPC/Estates leads would take the steer on any wards that were "flipped". This meant a change in designation of the ward from a Covid positive ward to a Covid negative ward (or vice versa). Covid-19 wards were then mapped out and signs placed on doors into wards to identify them as either Covid-19 or non-Covid-19. Staff communications were stepped up over the coming weeks to inform staff about this process. It was also noted that there were no plans yet to convert any nightingale Hospitals in Kent.
- 23.5 It was noted by the Strategic Group on 1.5.2020 that separation of Covid-19 and non-Covid-19 was more challenging in HDU/CCU areas. Because there weren't enough "clean" critical care beds in HDU, this meant that patients had to be sent to CCU and discussions took place about the most suitable location for ICU were had.
- 23.6 As the Hospital considered ward configuration, it was deemed necessary for acute specialities to be near the Emergency Department and surgical wards to Theatre. One suggestion made was to remodel non-clinical areas to clinical wards and changing the location of outpatients to other areas. Discussions were had about using KIMS for non-patients (hip related). The IPC also needed to consider the space each area provided and whether it would be more difficult to transfer patients to and from these new locations. An example of this was the respiratory ward which moved on 5.4.20 as the acuity of the patients in that ward increased dramatically and four patients required intubation and ventilation. It was felt that the ward was too far away from ITU with an increased risk of transferring those patients between the two areas. This risk led to the respiratory ward moving into an empty ward opposite the surgical HDU and nearer to ITU.
- 23.7 There were also discussions about capacity for clean (i.e. non-Covid-19) respiratory patients on general wards and whether there was scope to place these patients on a "hot" Covid-19 ward if there was medical capacity for this and the extent to which this could be done safely where bays were segregated by double sets of doors.
- 23.8 Challenges were identified as to how quickly a "hot" Covid-19 ward could move to cold and then be re-classified later as hot again. Patients on cold wards continued to be swabbed and where they weren't deemed as Covid-19 risks, they were moved to cold wards. This constant changing and re-classification of wards raised concerns from nurses about Hospital layout and new ward configurations which they struggled to keep

22

up to date with in a fast-changing environment. This was identified as creating additional risks of infection and required the clear Policy and procedures to deal with this issue.

- 23.9 "Flipping" a ward from hot or cold also took time and required the input from all relevant areas and functions to ensure smooth transition and turnabout. As such, mobilisation often took a week.
- 23.10As a consequence of measures described in 23.6, Hospital acquired Covid-19 was identified and ward moves and transfers meant that patients moved between hot and cold wards creating more infection. This was tracked to monitor infection rates and sources.
- 23.11After Wave 1, the Hospital then moved to red wards which were Covid-19, amber which were emergency admissions and green for electives as the Trust moved into the recovery phase post Wave 1.
- 23.12The Trust restarted elective and diagnostic services on 22 June 2020 by making changes to way people access the building and move around the Hospital. The nature of the Hospital site presented challenges to restricting movement and access points. From 22.6.20, the main entrance of the Hospital was used for visitors only. All staff were required to wear face coverings and entered and exited the Hospital only via the departure lounge entrance or brown zone level 1 entrance/exit. These measures helped contain the spread of infection.
- 23.13There were a limited number of single rooms to enable isolation. Spaces were created in the Hospital using clear screens and curtains which were not approved for us by the Chief Nursing Officer.
- 23.14Ventilation in the Hospital was limited to natural ventilation, particularly in the original Hospital build areas, and little ability to add in any mechanical solutions. There was no ventilation committee in place that I recall. In the respiratory ward during Wave 2, this was concerning as ventilation in that area was below the recommended 10 air changes so a risk assessment needed to be completed to ensure the area remained safe with clear plans to close beds when the level reached unsafe levels.

24. Testing as an infection control measure:

- 24.1 As an overview, testing for COVID was a massive issue for the Trust. The National Policy changed after Wave 1 (when testing was not undertaken unless patients were symptomatic) to an approach where all admissions needed to be tested. However, as the other comments point out, it took 48-72 hours or more to get results back from COVID swabs during Wave 1. The Medical Tactical Group identified rapid COVID testing as a critical part of the management of a future wave of COVID, and we started to make enquiries about rapid testing systems (such as the SAMBA machines) and requests to the Regional Team to support with these machines as early as July 2020. However, the pace of discussions over procurement of these machines was very slow (and we were told by the Regional Team that we must not try and procure our own machines under any circumstances). The result was that when Wave 2 hit in November 2020, we did not have capacity to test all patients with a fast turnaround test. We were still validating SAMBA machines on 22.11.20 and by early December 2020, we still had inadequate equipment to test all admissions. Even when SAMBA machines were provided, we had limited reagent available meaning that we were limited in how many tests we could carry out per day.
- 24.2 Following the notification from NHSE/I and PHE in January 2020, the Trust issued a staff communication message to all staff on 23.1.20 advising that sampling of suspected cases would be tested by PHE and to identify possible cases for isolation. The Hospital first started testing symptomatic patients for Covid-19 around 6.2.20 when pods were set up and patients were brought in for testing and then sent home. There was a change in National Guidance in March 2020, and a further update on 12.4.20 for tests to be carried out to NHS staff and household members, and this guidance was implemented by the Trust. By 1.5.2020, a plan was approved, and sop created to swab all patients admitted into the Trust.
- 24.3 By a communication on 25.6.20, all staff and inpatients were to receive antibody testing. Antibody testing for staff was offered around the beginning of July 2020. Staff communications contained a link to a booking system which staff could then use to reserve a slot for testing.
- 24.4 In relation to test kits, these were allotted on the basis of staff numbers, together with a surplus. For the most part, there were more than sufficient numbers for staff, not only frontline as initially indicated, but for all staff across the Trust. Any shortfalls that did exist was the result of staff not using the tests correctly or using sooner than advised (such as asymptomatic testing daily, multiple times a day or utilising for symptomatic testing).

There were also some issues around staff seeking multiple boxes for home and work usage and sharing with family and friends.

- 24.5 In terms of the test results, North Kent Pathology Service (NKPS) which managed this service, operated to a 72-hour Standard Operating Procedure but this was from the time that it was received at their lab in Dartford. Many other trusts by comparison were working to a 24-hour turnaround. When testing first commenced, this was very problematic as it took 4 days for the test results to be returned and then a further day before the results could be uploaded to iLab. Consequently, staff had to check every person's record that had been tested until such time as the result was visible. Over time, this turnaround time was reduced to 48 hours with a handful of occasions where the time would increase again due to issues such as machine failure or a national shortage of reagents. There are some cases reported on DATIX raised by Theatre where test results went missing once they went to NKPS, and this might have been due to testing outside recommended times (i.e. 48 hours prior to procedure rather than 24 hours or because results were being chased early).
- 24.6 In terms of staff and patient testing, another challenge for the Trust was around screening, especially when the guidance moved to screening on day 1, day 3, day 5-7 and then weekly. Some of the complaints received within specialist medicine raised screening and Hospital acquired Covid-19 as an issue. In some areas, particularly wards that had both red and amber bays and the nightingale wards, the decision was made that they were required to test all patients daily too. Staff were confused at which point they should be screening and by December 2020 there was often incidental findings of positive results in asymptomatic patients. It was at this time that IPC instigated a review of the testing, particularly where wards were testing daily to ensure National Guidance was followed.
- 24.7 By early December 2020, staff were being asked to collect lateral flow tests to test themselves twice a week and upload results to the portal. A cell was implemented to replace the nursing tactical group and it was here that uptake of testing was discussed and monitored in respect of updated numbers of staff testing.
- 24.8 As the Hospital geared up to Wave 2, lateral flow testing kits continued to be made available to staff to carry out home testing and a Covid-19 Mobile Testing Unit was deployed on site to enable screening of staff in early December 2020. Staff were being asked to collect lateral flow tests to test themselves twice a week and upload results to

25

the Portal. A cell was implemented to replace the Nursing Tactical Group and it was here that uptake of testing was discussed and monitored in respect of updated numbers of staff testing.

24.9 By 4.1.2021, changes to swabbing were implemented, and all patients would be swabbed on arrival and then again on day 5.

25. Nosocomial Outbreaks of Covid-19 infection affecting patients and/or staff:

25.1 There were challenges with bed spaces in many of the wards during the relevant period. It was difficult to achieve social distancing without removing beds. This was not possible during Wave 2 when the Hospital was under pressure and often at capacity. Two of the wards were nightingale wards and in Wave 1 these were protected as cold wards. During Wave 2 when the Hospital was at critical capacity, this became very difficult to manage and there were several outbreaks within these wards as once a patient had Covid-19, it would move through the ward with increased nosocomial transmission. Each time this occurred, the ward would close to admissions and once the patients had been discharged or moved elsewhere then the ward would be deep cleaned and then reopened. Early in Wave 2, the decision was made to convert the Nightingale wards to red wards as the closure of the beds and the management of contacts was reducing Hospital capacity. On other wards with bays, this was easier to manage.

<u>Personal Protective Equipment ("PPE") and Respiratory Protective Equipment</u> ("RPE")

26. Steps taken to obtain PPE/RPE:

- 26.1 As an overview, local procurement teams worked tirelessly, but there were challenges accessing PPE, difficulties caused by changes in National Guidance on the use of PPE and variations in advice to different organisations, and challenges presented by the need to "fit test" a wide range of different face masks.
- 26.2 The Estates & Facilities Directorate ("Estates") which was responsible for procurement of PPE, mobilised the senior management team very quickly in response to Wave 1 and stood up key areas of risk to be managed. Early on, Estates identified the urgent need for significantly more medical equipment and beds.

- 26.3 With the government's relaxation of the procurement rules which came into effect in March 2020 (Information Notice PPN 01/20), this enabled the Trust to quickly progress medical equipment purchases which was a significant benefit to the Trust. Whilst the whole Covid-19 environment was a pressurised one over an exceptionally long time, the Trust teams felt empowered to make the decisions it needed to, and the strategic oversight meetings kept the pace going. The Trust was well organised and, for example, was able to support local trusts with shortfalls in equipment.
- 26.4 The Trust did not differentiate between NHS and non-NHS suppliers. Given the urgency with which PPE was required, we procured from wherever the stock was available.
- 26.5 The Trust had a robust stocktaking process which was updated daily to identify were shortages were within the Hospital. This process was coordinated through the operational group and was recorded in strategic and daily tactical group updates, an example of which is set out in Exhibit DS/09 INQ000469931. A master list of stocktaking was also compiled setting out stock levels from 17.4.20 until 31.11.21, an example of which is shown in Exhibit DS/10 INQ000469927. From this monitoring, the Trust could determine at any time during the relevant period critical levels of stock by reference to the number of days remaining before that item would run out.
- 26.6 Stock was ordered through the PPE portal ("push stock") in accordance with National Guidance. The Trust submitted a weekly stock take and run rate to the PPE portal and we would then receive a delivery of products that we needed. Generally, this took 24-72 hours for PPE to arrive once an order was placed although at the most critical times in Wave 1 in mid-March 2020 when there were critical shortages of visors, ffp3 masks and gowns. It is also noted that the operational group was concerned about the allocation and sharing of PPE between departments which needed to be addressed.
- 26.7 Due to the urgency and need to maintain adequate levels of PPE and RPE, most requests for equipment were made by phone. This was the most effective way of getting what the Trust needed, particularly during Wave 1 in March/April 2020. Later, these requests started to come through our EPRR team.
- 26.8 In relation to the bigger regional picture, it was identified that the community trust did not have a central supply, ordering system or delivery point and the Hospital rapidly set up different ways of ordering and distributing PPE with the commission, build and set up of a delivery hub which took over the ground floor of our head office. Daily situation reports

for PPE helped the Trust make decisions as to whether it could give Mutual Aid to other organisations who requested it.

- 26.9 The Trust did not make any requests to other Hospitals or NHS trusts for PPE, but we did support other trusts who made requests using Mutual Aid channels. A small number of requests were also made by email, but urgency often dictated that the majority of requests were made verbally.
- 26.10It took 24-72 hours generally for PPE/RPE to arrive via push stock during the relevant period. Whilst we don't have specific information on timings, it may be that the DHSC or Palantair could provide this.

27. Use and Effectiveness of Emergency Request System to request PPE and RPE:

27.1 The Trust did not request products using the Emergency Request System and cannot comment on the effectiveness of this system.

28. Provision of unsuitable PPE and / or RPE:

- 28.1 There were a number of incidences where the PPE/RPE was not suitable. For example, we identified that some guidance was needed at a national level for people with beards. This was particularly the case in relation to some individuals where we needed to ascertain whether there were any religious factors involved and how to cater for their needs. Some people who fit tested on every type of mask still failed because the type and shape of face. These staff require a different type of apparatus completely.
- 28.2 Another product that we received which was not suitable was a type of gown which was basically see through. It is further noted that tiger eye protective goggles and frames were removed from the national supply chain as they did not have the necessary level of splash protection needed for aerosol generating procedures. Staff were advised to return the tiger eye goggles to store and to use other forms of PPE instead.
- 28.3 In June 2020, NHSE had issued new ffp3 respirators manufactured by Cardinal Health which would become the first line model used. This meant that all staff already fit-tested for other masks would need to be re-tested for this model which was time consuming and placed the Hospital under additional pressures in relation to staffing capacity.

- 28.4 By a communication to staff on 3 July 2020, staff were also advised about a product recall in relation to large bioplus gloves with instructions to return these to stores as they contained latex.
- 28.5 In a PPE Incident Log of concerns developed by the Trust, a record on 26.6.20 found that surgical gowns provided for surgery were "entirely inappropriate". The record concludes that, due to the Covid-19 crisis, a selection of Chinese manufactured surgical gowns were delivered instead of the usual gowns. Specifically, the largest gown was large, and this was still too small and were ill-fitting and the user was unable to close the back of gown. Please see paragraph 30.3 for further details about this issue.
- 28.6 The Hospital was able to reuse some PPE and in the case of some goggles and visors, a 1-page wrap around communication was issued to staff to notify them about the reusability for this item.
- 28.7 Where these issues with PPE/RPE equipment arose, the Hospital followed National Guidance and made adjustments to ensure that staff were trained in the most suitable PPE/RPE available at the time.

29. Practical arrangements for fit testing of PPE for healthcare workers:

- 29.1 At the beginning of Wave 1 of the pandemic there were some difficulties in relation to fittesting for certain PPE items. One product which was particularly challenging was the ff3p mask as only one person was trained to undertake fit testing of this type of mask. This impacted the number of staff who could use the ffp3 masks. This galvanised our response to run training sessions on ffp3 mask fit testing and soon had approximately 15 staff trained to do this. Fit-testing trained staff worked via rota to provide this service which was overseen by an interim governance support individual.
- 29.2 By March 2020, and in response to the risk identified above, a risk assessment for fit testing RPE's was completed. This document recorded that there was a lack of accredited fit testers at the Trust to ensure staff were compliant with wearing suitable masks. By this time, there were only 2 trained RPE fit testers with 130 staff assessed as competent to wear them. This confirmed the need to increase trainer numbers and to ensure all staff were fit tested. When the risk assessment was reviewed again on 22.5.20, the Trust had increased this number to 64 trained fit testers. Further service modelling and monitoring was also carried out by daily reporting, daily safety staff reviews and Trust incident reporting. By November 2021, a rounded picture of maskfit

training across the Trust was held and maintained on record. Further details of this may be provided on request.

- 29.3 Action log entries compiled by the operational group confirm that there were issues with high fail rates with fit testing on 13 March 2020 and that there was a lack in staff confidence in the use of facemasks. This would be addressed with further fit testing in high demand areas and an action plan was prepared by the director responsible for infection prevention & control (IPC) to ensure further testing of staff for PPE was implemented.
- 29.4 One example of where fit-testing was problematic was in the respiratory ward. Here, many of the staff were not fit-tested and when this was flagged to nursing tactical, an external company was brought in (Ashfields) to train staff to be testers. One of the heads of Nursing ensured that two of the respiratory ward staff and respiratory physiotherapist was trained as testers to ensure that training took place quickly.
- 29.5 A further issue that arose in relation to fit-testing was that the housekeeping team were not prioritised to be fit-tested. Consequently, they would not go into bays with Covid-19 positive patients which meant that nursing staff would have to clean those areas. The training of staff was imperative to resolving this problem.
- 29.6 A register of all staff ffp3 mask fit tested was maintained and the Trust's HR function have the records of these. Due to a dependency on 'push stock' as our primary source of PPE, many staff members had to undergo further ffp3 mask fit testing for each new model type of ffp3 mask issued. All staff who worked in aerosol generating procedures (AGP) or potential AGP environments (where certain clinical procedures caused the release of airbourne particles from the patient's respiratory tract) were required to undertake ffp3 mask fit testing or were relocated to an area in which ffp3 masks were not required.
- 29.7 Staff communications then notified those staff members who had been fit tested on the new non-valved ffp3 1863 mask, that this mask should be worn rather than the valved ffp3 883 model so that the Trust could reserve the valved models for fit testing at times when stock was low.
- 29.8 A further issue identified was in relation to the Trust meeting the religious requirements of some of the teams. These were met by the HR Director, who issued the equipment

directly due to the exceptionally high cost of this equipment. The Trust also developed a PPE steward rota at the beginning of April 2020 which was inspired by the breathing apparatus entry control officer role in the UK Fire Service, and implemented by Gloucester Hospital NHS Foundation Trust to give reassurance and security to staff at a very uncertain time. The steward role profile is set out at Exhibit AD/01 INQ000469932 (contained in the statement of Alison Davis). Stewards were available to staff at ward level with the addition of a drop-in facility for mask fit testing by trained testers and Q&A sessions.

30. Shortages of PPE and RPE:

- 30.1 During the peak of Wave 1, (March/April 2020), PPE shortages reached critical levels. When these shortages were identified, they were escalated to the IPC lead, and this would result in rationalisation of stock into a central location for redistribution within the Trust. Once these efforts were exhausted, shortages would be raised with NHSE/I to access national stockpiles.
- 30.2 The Trust developed a log of concerns from the PPE steward sessions from staff in relation to PPE/RPE so that issues could be tracked and addressed by team leaders.
- 30.3 An example of this can be found in the PPE Incident Log dated 18.4.20 which reported that nursing staff on a hot Covid-19 ward were wearing thin isolation gowns in place of the fluid repellent long sleeved gowns due to concerns with lack of PPE within the Trust. This was escalated to the Medical Tactical Group and declared as serious incident. Action was taken by PPE stewards who removed inappropriate gowns from these wards.
- 30.4 Another example was a record on 26.6.20 stating that surgical gowns provided for surgery were "entirely inappropriate". The record concludes that, due to the Covid-19 crisis, a selection of Chinese manufactured surgical gowns were delivered instead of the usual gowns. Specifically, the largest gown was large, and this was still too small and were ill-fitting and the user was unable to close the back of gown. No other gowns were available but as staff were undertaking a clean procedure, which was not sterile, it was used. It was noted that the procedure next week would be sterile, and the surgical team would not proceed and cancel the case if the appropriate gowns weren't made available. This issue was referred to the Planned Care Management Team who ensured alternative gowns were on site and sent to the Operating Department that morning.

- 30.5 A PPE incident log dated 13.3.20 records that staff working in the Will Adams ward started CPR on an unresponsive patient with a surgical mask and ordinary aprons and gloves which were unsuitable. On arrival to the ward, the arrest team ordered all ward staff out of room due to inappropriate PPE.
- 30.6 In another Incident Log dated 30.3.20, staff refused to work, and one left their ward due to concerns expressed over PPE. The log makes the recommendation that all agency staff be asked to attend training and that PPE was available and had been ordered.
- 30.7 An Ethics Group meeting dated 20.4.20 states "current PPE supplies (gowns do not mask at present) running low. Immediate decision taken to halt all elective work for the next 72 hours to allow prioritisation of PPE for staff looking after patients in Hospital." This was associated with an acceptance of a need to reduce the number of staff seeing each patient and the number of times a patient was seen.
- 30.8 The Ethics Group acknowledged that gowns were not always needed more aprons and gloves would be suitable for some areas, but this would need to be risk assessed urgently. It was agreed that emergency work would still be done, and 72 hours was unlikely to cause initial harm but could be if stocks remained low in the longer term.
- 30.9 A document titled "Covid Risk" which was prepared in advance of Winter 2021/2022 and records risks identified over the relevant period. An entry on 31.8.21 states in relation to PPE shortages a "potential for increased risk of patients and staff outbreaks could have an impact on Trust's ability to deliver services". This risk is described as due to "non-compliance with PPE, hand hygiene, screening and multiple ward moves. As the Covid-19 numbers increase in the Hospital, there is an increase in demand on bed capacity, resulting in multiple ward moves. Where ward teams are not consistently compliant with screening, this increases the risk of infection...[and] impact on all wards and waiting lists." In response to this risk, mitigations were put in place for prevalence scoping and local controls in line with National Guidance.
- 30.10In terms of PPE shortages affecting other Trusts in the region, email requests for Mutual Aid were received around mid to late March 2020. During this time, we received requests from Medway Community Health (MCH) and Medway CCG seeking PPE from Medway Tactical Command. The Trust was able to support MCH but an urgent request from Swale CCG for fit testing kits and swabs could not be provided by the Trust, East

Kent or Medway Tunbridge Wells in April 2020, with a meeting note recording that the Trust was "*not in a position to help other trusts*".

Visiting restrictions

31. Visiting Restrictions:

- 31.1 Visitor Guidance was put in place by the Trust in line with March 2020 National Guidance and updated periodically in August 2020, and April 2021, and March 2022. This was disseminated to staff through our usual communication channels (see paragraph 20.1 for further details about this).
- 31.2 The Trust produced its own Visitor Guidance and took the approach of making Wardspecific updates.
- 31.3 The Trust also set up a separate email address (medwayft.patientexperience@nhs.net) for patient family members to email in messages that would be passed to patients. This addressed the need to help keep everyone safe, by considering other ways of keeping in touch with patients such as telephone calls and video messaging.
- 31.4 Although visiting was restricted during COVID-19, critical care visiting was permitted in exceptional circumstances, based on each individual need. Telephone and virtual Skype calls were used to facilitate contact between patients, their loved ones and the nursing/medical teams. iPads were used for the Skype calls that were received from a central team. Virtual visiting in particular was implemented daily and at speed, and Skype calls were scheduled in with families of patients and facilitated by a team of staff designated for this role.
- 31.5 Medical staff called the nominated next of kin for each patient daily with an update. 2 nominated family members were able to attend face to face, for end-of-life patients. All visiting individuals were made aware of the risks of entering a COVID-19 area before they made a decision to visit. Families visiting were asked to wear PPE, and this was provided, and families were able to attend the designated family room to receive updates and communication from the medical and nursing teams. Bereaved families were contacted within 2-4 days after the death of their loved one, and a letter sent to explain the new bereavement processes due to the pandemic. The follow up bereavement calls included offers of support, opportunity to answer questions, locating property etc. Friendship bracelets and knitted hearts were provided as a matching pair that one kept

with the patient and one with the family. Memory boxes, locks of hair and handprints were offered to bereaved families. Virtual bereavement counselling was offered to bereaved families, although there was a low uptake for this service. A COVID-19 critical care bereavement support group was set up, facilitated by critical care nursing staff and a critical care Counseller, the uptake was good, and the support group continued to form a network between themselves as bereaved families.

- 31.6 Where a visitor needed assistance on grounds of compassionate circumstances, such as end of life care or for patients with dementia, the Trust permitted additional visitors at the discretion of the Ward Manager. This was set out in the Trust's Policy dated 16.3.21 in which it stated that *"Patients may be accompanied where appropriate and necessary to assist their Communication...and/or to meet their health, emotional, religious or spiritual care needs."*
- 31.7 In terms of specific issues about the implementation of visitation, restrictions were put in place swiftly, however there was some variation across the Hospitals within the Integrated Care System. Maternity (and ante-natal) was a good example where there appeared to be inconsistency, which led to media articles, and emails to the then CEO asking why our Hospital was different to others in the region. It would therefore be helpful in future scenarios, if all Trusts agreed and stuck to the same principles in areas such as maternity.

32. Visting Restrictions and patient experiences:

- 32.1 Generally, visiting was restricted to nil on the wards at the height of the pandemic and one birth partner for labour and birth only.
- 32.2 Between 16.03.20 25.10.22, the Trust records patient / patient family complaints at 64 complaints relating to visitation restrictions out of approximately 450 total complaints listed. Examples of some of these complaints is as follows:
 - Patient's sister emailed, he is currently on **I&S** ward after having had an amputation and she is concerned about the lack of physiotherapy and the effect on his physical and mental health, and because she is unable to visit due to the ward being in Covid-19 lockdown, she is unable to speak to anyone about her concerns.
 - Patient's daughter emailed very distressed as her mum has dementia and is hardly eating anything but there have been delays in getting a dietician to see her and now she has been moved to Pembroke ward and she is unable to visit due to Covid-19.

- Pts next of kin called in very upset that when she went to visit her dad she was told that there was a COVID-19 outbreak on the Ward and that he has been moved to a different ward. He was upset as they let her on the ward and then told her he was moved. She said she should have been told at the door.
- Patient's daughter emailed in as she would like her mother moved off a Covid ward to a non-Covid one so she can visit her.
- Patient emailed in to say that he would like more information on the Maternity COVID 19 visiting policies as he is angry that he will not be with his baby when born.
- Patient emailed in to say his daughter has been transferred to our care, but he isn't allowed to visit, and the communication hasn't been that great. The baby is only a couple of weeks old, born at 29 weeks and was born with COVID-19.
- Patient's son called, he would like a consultant to call him about the plan for his father's care and they would also like to know whether he is now testing negative for Covid-19 and can be taken out of isolation and receive visitors as he is in low mood and not eating.
- Patient is currently on **I&S** Ward. Her daughter is keen to know why her father was told by track and trace that patient had been near someone with Covid-19. She would also like more visits to see her mother on the ward as she is getting depressed not seeing her family.
- Patient has just told that she has been tested positive for Covid-19. She has dementia and her daughter is concerned that she is being left in a side room alone due to the no visitors protocol and would like her father to stay with her while she is here.
- Patient's wife called very upset that she wasn't allowed in with her husband to his preassessment. He is hard of hearing and also does not retain a lot of information so wanted to be with him.
- Patient is very frustrated as his father has been in Hospital for 5 weeks and it is so difficult to get through to the ward to speak with him. He tried 27 times today before he got through. He would like to know why the management have not arranged for more phonelines and more staff to help with communication during COVID-19 when relatives are not able to visit.
- This lady is concerned about the lack of communication and miscommunication from ward staff during her mother-in-law's stay in Hospital. She feels there should be more admin staff on the ward to answer the telephone and help keep families informed during Covid-19 when no visiting is allowed.

33. Did Visiting Restrictions guidance provide the right balance to minimise infection and enable patients to benefit from the support and comfort of visitors?

- 33.1 I think this is a really difficult area. I completely understand why the visiting restrictions were introduced: they were important not only to protect visitors themselves from acquiring COVID, but also to prevent visitors inadvertently bringing COVID infection into the hospital. However, it is my personal opinion that the restrictions were excessive, particularly given the fact that we had a much bigger issue with the Alpha Variant in the Autumn of 2020, and this led to significant problems in a range of areas. The complaints and communications in this section give a flavour of this. As a care of the elderly physician, I particularly worried about the impact on the elderly and those patients with confusion (not just dementia but delirium), who had nobody to highlight unusual issues with their loved ones to the staff. I also worried about the experience of death for patients without their families with them, and how this will have impacted on grief reactions and bereavement for the families concerned.
- 33.2 The psychological impact of separating loved ones was similarly noted by staff in relation to patients and their families.
- 33.3 Due to the variation of visitation across different Hospitals, this led to some confusion and upset due to inconsistencies in applying the National Guidance. Clearer advice with a consistent approach would have been preferred to strike a better balance and to gain better public support.
- 33.4 The decision to allow visitors visiting end of life patients was discussed at strategic level while the Trust grappled with the need to protect patients and staff while addressing the situation in an empathetic and sensitive way. It was agreed that visitors could visit end of life patients where full PPE was worn, and this would strike the right balance of all concerned.
- 33.5 The feedback from some teams suggest that virtual ward visiting was very frustrating. It was largely dependent on patients having iPhones and being able to use their phones correctly in order to have virtual visits. It was also noted that there was a general view that Wi-Fi should have been made more readily available, sooner.

Patient treatment and care

34. Patient Treatment and Care for non-Covid-19 Patients:

- 34.1 The structural layout of the Hospital and departments allowed for some elective surgery to continue in a non-Covid environment during the relevant period. This was achieved with a separate day surgery unit. Emergency surgery remained possible whilst minimising risks to staff and patients by creating Covid and non-Covid areas which allowed for much of the emergency procedures to continue. Elective cancer care continued with the support of 2 local private sector Hospitals, namely KIM's and the Spire Alexander which helped us with our elective surgical work. There were certain times during the relevant period when it was necessary for the Hospital to suspend some elective and non-urgent surgical procedures. The context for this is set out at paragraph 34.2 below and was done to protect the safety of Trust staff (in the case of PPE shortages) and to ensure that PPE and staff could be redeployed where they were most needed at the time. When elective surgery was cancelled, plans were put in place as quickly as possible to enable Elective Surgery to resume. An example of this was on 20.4.20 when all elective work was cancelled on 20.4.20 due to low PPE supplies (gowns).
- 34.2 The Trust experienced unprecedented numbers of cases during the relevant period. In Wave 1 this saw a peak of 150 Covid positive admissions over a 10-week period. In Wave 2, the Trust started to see a steep increase in positive admissions from 12 October 2020, relating to the Alpha Variant (not identified scientifically until December 2020, but the cause of the major surge in Covid during Autumn 2020). This prolonged Wave 2 lasted for approximately 27 weeks until the beginning of April 2021, with admissions peaking to over 300 by the end of December 2020. This placed significant pressure the Hospital's ability to provide care and treatment for non-Covid patients where Covid-19 cases increased both in staff and patient numbers, and it was necessary to redeploy staff where possible to cover staff sickness and staff who were shielding.
- 34.3 There were some challenges for the Hospital seeking to provide care to non-Covid-19 patients where those patients were not supportive of IPC guidelines. An example of this was in relation to patients who are Covid-19-sceptics and who refused to be swabbed prior to treatment in circumstances where the treatment might be life-saving (such as chemotherapy). Failure to adhere to Trust Policy presented risks to Trust staff and other patients if the patient was Covid positive or a "super-spreader". This presented a challenging environment for nursing teams to deal with.

- 34.4 In terms of changes to care and treatment pathways, and also local innovations employed, the Trust followed guidance from NHS England in the management of cancer patients generally and the Hospital ensured that essential and urgent cancer treatments continued. Cancer specialists across all modalities did discuss with their patients whether it was riskier for them to undergo or to delay treatment during the Covid-19 pandemic with the understanding that where referrals and treatment plans departed from normal practice, safety netting was put in place to ensure follow up for these patients was maintained.
- 34.5 Other changes to care and treatment pathways included an altered pre-assessment and outpatient process to initiate virtual appointments for patients.

35. Maternity Services:

- 35.1 Acute and Elective Maternity Services continued throughout the pandemic. Some changes were necessary to mitigate against Covid-19 and measures were implemented to support staff and patient safety.
- 35.2 Such measures in relation to staffing shortages included the migration of staff to areas of high risk and implementing an on-call roster. Students also provided support work cover and those maternity staff who were clinically isolating were utilised to provide support from home with virtual clinics and patient helplines. The maternity service also had support from two retired midwives who attended to suturing procedures during the height of the pandemic.
- 35.3 In the Community visits were reduced to the minimum required to reduce contact and telephone triage and virtual clinics were utilised where possible.
- 35.4 Whilst there were some visiting restrictions implemented in August 2020, Maternity was not affected. Visiting restrictions were put in place in maternity from 4 December 2020 so that no patient could be visited on the maternity ward during the height of Wave 2 of the pandemic. From this time, partners were prevented from visiting both antenatal and postnatal wards and one birth partner was permitted for labour assessments and birth only to balance the emotional wellbeing of the patient with the risk of spreading infection. Hospital visits were not reinstated until 14 April 2021.

- 35.5 The Hospital also temporarily suspended the home birth service on 31.1.20 following advice from SeCAMB that they could not guarantee ambulance response times to women who planned for a home birth. The home birth service was reinstated on 2.2.21.
- 35.6 A number of Standard Operating Procedures ("SOPS") and Policy guidelines were developed during the relevant period to support maternity staff, an example of which is attached as Exhibit DS/11 INQ000469928.
- 35.7 Most notably, the Trust developed a SOP for maternity inpatient care on 16.4.20. The purpose of this Policy document was to ensure consistent and effective safe care for maternity patients with suspected or confirmed positive Covid-19 status. This addressed staff shortfalls due to sickness and/or self-isolation by utilising specialist and community staff members to cover where required. It also provided triage for maternity patients, depending upon whether or not they had obstetric concerns, and detailed the requirement for new patients to wear masks until their swab results were known.
- 35.8 Another SOP was also introduced on 16.4.20 to address the transfer of maternity patients to obstetric theatre where the patient was suspected or confirmed Covid-19 patient. Here staff were identified as "clean staff" i.e. those who met patient at entrance to delivery room and "dirty staff" who were those pushing a patient on a bed to Theatre. Dirty staff could only touch the bed they were transporting and nothing else (no doors etc.) and the Theatre team would then take over the management of the patient in the Theatre. This SOP followed the patient's journey from planning and preparation to post-Theatre Recovery for both mother and baby with consideration of oxygen, IPC, PPE and patient care. As an aside, we accepted on reflection that the terms "clean" and "dirty" could be interpreted as pejorative and wish we had used better terminology here. There was local criticism of the use of terms such as "cold" and "hot" wards and the concept of "flipping". The pandemic generated its own vocabulary, and this was not always in the most sensitive manner.
- 35.9 The Trust developed a SOP Maternity Escalation Plan for patients with suspected for confirmed Covid-19 on 31.9.21. This addressed issues such as providing segregated areas from general maternity patients and planning oxygen requirements in advance. The SOP sought to avoid maternal and fetal deterioration and to identify increased risks associated with Covid-19 maternity patients.

36. Overview of ambulance handover times:

- 36.1 During the pandemic I noted that there were inadequacies in addressing pressures across acute sites. Whilst it was generally acknowledged that all hospitals in the Kent and Medway area were in a negative bed position the ability/willingness of the other acute Trusts (and SECAMB) to help by redistributing ambulance flows was in general inadequate, although Maidstone and Tunbridge Wells NHS Foundation Trust were able to accept more patients. As a learning point I would suggest it would make more sense to extend travelling time to another site, if this resulted in quicker offloads and less overall waiting time. This needs to be addressed at an Integrated Care System and Regional Team level in my view.
- 36.2 The Trust experienced unprecedented numbers of patients during the relevant period. The Trust was one of the busiest single site emergency departments even before Wave 1 hit. The Hospital was aware during Wave 1 that flow through the Emergency Department and wider Hospital did not achieve national standards due to the pandemic. Specifically, staffing challenges due to shielding or illness meant that some ambulances waited far longer than they should have to be offloaded as the Trust struggled with available bed space and the demands placed upon it. This was particularly a problem during the CQC inspectors unannounced visit to the Emergency Department in December 2020.
- 36.3 During Wave 2, the Hospital was significantly impaired in its emergency performance, which was impacted by bed availability, particularly as the Hospital had to use beds flexibly in response to changing numbers of positive patients, the flow through the Emergency Department and wider Hospital. The Trust worked hard in a challenging environment to put processes in place to quickly identify patients who were deteriorating so that they could be prioritised.
- 36.4 The Trust monitored ambulance handover times from 4.12.20 until 28.6.2022. Please see chart attached as Exhibit DS/12 INQ000469929 which was prepared from the SeCAMB power business intelligence dashboard. This sets out ambulance handover delays of 30-60 minutes, which peaked at over 500 between October 2021 and November 2021, and handover delays which exceeded 60 minutes which peaked at approximately 375 during the same period.
- 36.5 The Trust has attempted to obtain data for the period from March 2020 until 4.12.2020, but information received was difficult to interpret and not easily transposed. Further

information might be available if required but would require engagement outside the organisation.

- 36.6 Ambulance handover times was noted by senior leadership in an Outbreak Management Meeting on 16 December 2020 when the Trust identified that there were a large range of risks to patients with ambulance and bed spaces which needed to be addressed so that patients would not be left in ambulances. Please see my further comments at paragraphs 46.10, 46.13 & 46.14 about this.
- 36.7 The second Wave to hit the Trust was caused by the Alpha Variant which saw significant numbers of infected patients from the Isle of Sheppey (this being an area which the Trust served). The second Wave saw a much faster and higher escalation in numbers of inpatients with Covid-19. Medway Maritime Hospital was one of the first in the country to experience Wave 2 at a time when the Trust was already attempting to reach the backlog of patients whose elective procedures were postponed during Wave 1. This created a challenging environment for patients presenting at the Emergency Department.

37. Escalation of Care:

37.1 As a general point, it is worth noting that the Trust did not have a formal Ethics Committee in place at the start of the pandemic to consider clinical matters (we did have an Ethics Committee responsible for decisions in relation to Research and Innovation). We stepped up a Clinical Ethics Committee early in Wave 1, with a multidisciplinary membership (including lay members) and found this to be a powerful and influential group when decisions were considered over options in case of the need for care withdrawal or rationing.

In relation to point a:

37.2 A discussion took place with the Nursing Tactical Group about the creation of a decision tool to support the cessation of some nursing care. There was some resistance from the Nursing team who felt that this was not possible, explaining that nursing was not a collection of individual tasks but a complex interdependency of actions which required skilled judgment taking into account the situation as a point in time.

In relation to point b:

37.3 A number of decision-making tools were devised over the relevant period to support teams to make appropriate decisions regarding the escalation of care. In March 2020,

the Hospital devised a decision tool for the Escalation to Critical Care for Respiratory Support as shown at Exhibits DS/16 INQ000421807 and DS/16.1 INQ000421808, which was evaluated against the c19 Ethical Framework. This was formulated with a referral to the Hospital's Ethics' Committee which considered its implications across certain patient cohorts. There were a number of iterations of this decision tool as it was reviewed in consultation with clinical teams and a prevailing view by geriatricians that a frailty score of 4 (rather than 5) would be a more appropriate score. This was on the basis that patients who lived an independent life style would be more suitable for ITU referral and more patients would qualify for critical care. Ultimately, the decision tool was not a strict rule, only a guideline, and there was always scope for clinicians to discuss a case that didn't meet the stated criteria.

- 37.4 A Forward Triage Flow Pathway was devised on 13.3.20 as shown at Exhibit DS/17 INQ000421809, which set out pathways for patients during the relevant period. This included guidelines on ITU/CCU flow and specialist and non-specialist respiratory flow. This document was an early attempt to prepare for the pandemic and was created before Wave 2. It was devised to give the Trust structure in how it would cope with Emergency Department patient flow. Whilst not practically implemented, it did play a part in preparing the Trust for Covid-19.
- 37.5 A Critical Care Triage Tool (as shown at Exhibit DS/18 INQ000421810) was first created on 31.12.2020 and updated on 7.1.21 to assist with decision making around the provision of critical care. It was devised to address a scenario where there was no prospect of Mutual Aid and to give clinicians support in their decision-making. Due to the high numbers of patients, it was considered necessary that a benchmark be set for referring respiratory patients to critical care and the tool would provide this clarity for clinicians. The Triage Tool was a filtering tool based on both numbers and outcomes and was formulated on outcome evidence from Wave 1 and Wave 2. The Hospital noted that critical oxygen levels meant that the Hospital needed to be vigilant in its use and to ensure optimisation for patients that are escalated for care. This issue was considered further by the Ethics Committee detailed in paragraph 37.10 below.
- 37.6 A revised Critical Care Triage Tool (as shown at Exhibit DS18.1 INQ000421811) was built on the earlier version described in paragraph 37.5 and was a response to the management of patients stopped at ward level before referral. The revised document included Intensive Care Guidance on Decision Making in the Covid-19 Pandemic from the Intensive Care Society and Outcomes in Critical Care Data from the Intensive Care

National Audit and Research Centre (ICNARC) in its most recent iteration. I recall that this tool wasn't ever used practically, and we never had to use it to choose between patients. Decisions around escalation from respiratory to critical care were made in a multidisciplinary meeting attended by both the respiratory physicians and the critical care consultants.

- 37.7 A Maternity Escalation Plan for patients with suspected or confirmed Covid-19 was also implemented on 29.7.21.
- 37.8 The Hospital also developed medical Critical Care Covid-19 Action Cards (as shown at Exhibits DS/15 INQ000421805 and DS/15.1 INQ000421806) for staff to use as a decision support tool for Covid-19 and non-Covid-19 patients which was created in January 2021 and implemented in February 2022. This tool provided a mechanism for deciding whether to escalate to critical care and addressed issues such as Trust capacity to accommodate such patients (for example by expanding into other areas of the Hospital) and invoking the Mutual Aid process where there was a lack of ICU beds or nursing capability to safely manage critical care cohort. The Action Cards evolved as changes to the clinical evidence base increased dramatically. As the speed of new and increased evidence intensified, this enabled the Trust to change and optimise treatment on a daily basis. This evidence meant learning experiences of clinicians could be captured and treatments adjusted using the Action Cards to deliver good guidance as we and senior management learned how to treat the disease. The Action Cards were also used to inform changes impacting on other services (such as theatres).
- 37.9 A protocol was also created to support theatre action in the event of a critical care surge, and this was activated at the end of the relevant period on 17.6.22.

In relation to point c:

37.10The Ethics Committee was involved in reviewing a decision tool for the Escalation to Critical Care for Respiratory Support. This was evaluated against the c19 Ethical Framework, and a concern was raised that the tool in current draft could inadvertently discriminate against people with learning difficulties or psychiatric issues who may meet the criteria for frailty. The Committee considered this and referred the document to our Head of Safeguarding to ensure the safeguarding of vulnerable patients under this Policy. The safeguarding response stated that it was reassured that the tool provides for patients to be ventilated whether or not they had a learning difficulty. The response also stated that consideration would need to be given to how this was monitored effectively in respect of complex patients with physical disabilities as their dependency may be higher. It was agreed that where such cases were challenging, support from the safeguarding team would be provided.

37.11The Critical Care Triage Tool critical care triage tool was created in January 2021. The tool was considered by the Ethics Committee because it evaluated the escalation of patients to critical care who would not get better thereby potentially depriving other patients with better outcomes and better use of oxygen which were at critical levels. It was established that the tool would be used as a filtering tool for patients who could not be considered for critical care but also for those that did not need to be considered. The tool placed patients into categories of priority so that a decision could be made regarding the escalation of their care. In relation to patients with learning difficulties, it was noted that this cohort of patients did end up on ITU and had successful outcomes, with decision making aligned with what would have been expected from clinicians.

In relation to point d:

37.12Changes to the tools for Escalation to Critical Care for Respiratory Support and the Triage Tool were made as stated in paragraphs 37.9 and 37.10 above.

In relation to point e:

- 37.13The criteria for admission of patients to Intensive Care altered following the implementation of a number of decision tools as set in paragraphs 37.2-37.10 above.
- 37.14In the second Wave of Covid-19, respiratory teams were overwhelmed due to the volume of patients and rates of staff infection and isolation. No support was available from other trusts during this period and suitability for escalation was based on a clinical frailty score described in decision tool for Escalation to Critical Care. Daily MDT meetings took place between the CCU and the respiratory teams to discuss management strategies and escalation of patients.

38. Concerns or issues in relation to rationing of care:

38.1 During Wave 2, our intensive care bed base was much smaller, and we saw much more significant rationing of care than in Wave 1. The suitability for a patient's care to be escalated was based on clinical factors indicating a poor prognosis (such as a high Clinical Frailty Score). During Wave 2, the critical care unit and respiratory teams instituted a 'COVID-19 MDT' where they met every day at lunchtime to discuss the

sickest cases and decide on management strategies and escalation. Decisions in treatment and care provided, continued to be made in the patients' best interests on a case-by-case basis.

- 38.2 The Hospital sought support from our specialist centre, Guy's and St Thomas (GSTT) on medical therapies, particularly in regard to the use of high dose steroids after the RECOVERY trial and supported the use of dexamethasone in all patients with COVID-19 requiring oxygen. We were also in close collaboration with GSTT in regard to patients who were failing mechanical ventilation in regard to the possibility of extra-corporeal membrane oxygenation (ECMO). Unfortunately, it became clear that those patients who had been on CPAP therapy for more than 5-6 days prior to ventilation had a poor outcome and so were not transferred.
- 38.3 Whilst there is no doubt that there were difficult decisions to be made in relation to admission to critical care, much experience was gained by the critical care and respiratory teams during Wave 1 in managing ventilated patients. During Wave 1, for many colleagues, the decision to place a patient on a ventilator seemed to set in process a train of events which resulted in their death, often after several weeks had passed. By Wave 2 the critical care team were more able to identify those patients who they thought would benefit from ITU admission and ventilation and those who would not. This is of course part of standard critical care practice.
- 38.4 It was discussed by the Ethics Committee that critical oxygen levels meant that the Hospital needed to be vigilant in its use of oxygen, and ensure oxygen was optimised for those patients who were escalated for care. Concern was raised that by escalating people who would not get better, the Hospital was potentially depriving those patients who would improve with access to oxygen. The decision tool referred to in paragraph 37.5 would be used as a filtering tool for patients who could not be considered for critical care, but also those that do not need to be considered. Unlike the earlier decision tool used in April 2020 (as stated at paragraph 37.4), this tool puts people into categories of priority. Regarding those patients with learning difficulties, the Hospital noted that these patients do end up on ICU and have successful outcomes. Decision making in relation to patients with learning difficulties were aligned with what would be expected from clinicians.

- 38.5 Patients were transferred to other NHS ICU's when the need arose and if safe, when the Hospital had no capacity to treat them. This was facilitated by the Sprint transfer team.
- 38.6 Essential equipment such as NIV machines and ventilators were supplied centrally but training support for the new equipment was not as robust as it could have been, however it was safe.

39. Explain whether and how the Hospital used ReSPECT/DNACPR forms:

- 39.1 The Trust already had processes in place for using respect forms and DNACPR notices prior to the Covid-19 pandemic. This was set out in Policy documentation and guidance, the most recent iteration having been in place since 2017. This process continued throughout the pandemic and was considered by clinicians when deciding whether or not to escalate a patient's care.
- 39.2 In the absence of a respect form or DNACPR notice for a patient that required resuscitation, the Trust followed the guidance issued from the Resuscitation Council UK for adult advanced life support for Covid-19-patients in acute Hospital settings. This provided guidance on how to handle the clinical care of Covid-19 patients requiring advanced life support treatment.

40. DNACPR notices:

- 40.1 Currently, paper Treatment Escalation Plan/DNACPR charts are used by the Trust and do not form part of the patient's electronic record. This is in part an evolution, as Electronic Patient Records were only introduced into the Trust in 2022. All patient records before this time and during my time as CMO at the Trust during 2020 and 2021 were paper based. There is a project currently to bring the Treatment Escalation Plan/DNACPR to a digital form which has raised issues about the process of electronically signing the forms, which is ongoing.
- 40.2 No concerns were raised with the Hospital in relation to the issue, use or consideration of DNACPR notices and I refer to my response at paragraph 39.1 & 39.2.
- 40.3 The Trust maintained robust policies and procedures for preparing DNACPRs and engaging with patients and their families to ensure they understood the importance of this document. These policies were accessible to those involved in this process. All clinicians made the decisions in the best interests of the patient, and the decision was

communicated to patients and their families. Family discussions and updates were virtual at the time, and families received daily updates as were appropriate.

- 41. Any potential unequal impact on patients of measures adopted by the Hospital in response to the Covid-19 pandemic:
- 41.1 Face mask guidance was issued by NHSE/I in June 2020, which identified that NHS staff wearing face masks when treating patients with deafness or with impaired hearing would be impacted as they would block the face of healthcare workers and prevent the ability to use visual cues such as facial expressions and lip reading. The guidance suggested the use of clear masks where possible, as well as visual aids such as writing things down, speech to text apps and sign language.
- 41.2 The guidance further stated that the UK government's PPE procurement team had sourced a small number of clear surgical face masks to support communication with this cohort of patients and were working with the regions to identify where they should be best distributed. A staff bulletin dated 24.6.20 advised Trust staff about this and stated that "a fully transparent mask may soon be available for staff to use as part of their PPE".
- 41.3 The Trust's procurement lead has confirmed that the clear masks were never clinically approved by NHSE/I for use in the NHS environment and as such, these were not issued to any staff in the Trust during the relevant period.
- 41.4 The Trust noted that one complaint was received during the relevant period that related to visiting restrictions in place. It is recorded on a complaint log on 30.9.21 that a patient was upset that his partner was asked to leave the department as he was deaf and needed assistance.
- 41.5 However, the Trust did have some success stories and one staff nurse in ITU was commended in a Trust weekly message on 21.8.20 for her treatment of a patient with severe autism, ADHD, deafness and sight issues who was extubated. The staff nurse concerned used sign language to manage the treatment and keep the patient calm.
- 41.6 The Trust operates a BAME network which supports and celebrates cultural diversity of its staff to promote race equality and diversity of its employees.
- 42. Summarise the impact of the pandemic on staff morale:

- 42.1 As a general point, it is widely accepted that the pandemic had a significant impact on the morale, physical and mental wellbeing of all staff during this period. Teams were affected from day one. Where staff worked remotely, they had to cope with the instant transition to remote working and the practical challenges this brought. To counter feelings of isolation, daily team check-ins and routine virtual coffees and other creative ways helped staff to stay connected and motivated. Teams were worried about colleagues in the Hospital who had to be on-site, and this led to a feeling over time of mental and physical exhaustion.
- 42.2 Support networks meant that teams heard harrowing stories of what was happening onsite, and this led to fears for the safety of each other and their families. One account about a nurse tells of them leaving home in the morning, immediately changing at work, donning scrubs and mask, working for 13 hours without a break and changing again before returning home. Once home, they didn't touch anything. Their first child opened the front door, the second opened the washing machine door and they stripped, put the clothes in the machine, showered and finally fell exhausted on the sofa with the children to eat before going to bed and then repeating the whole cycle again the following day. With tears streaming down their face, they were terrified they would take Covid-19 home from work.
- 42.3 One of the biggest challenges that I have been told by staff was navigating the constantly evolving evidence and subsequent offers that were provided as a result. As an example, they received psychological first aid training, mental health first aid, 5-step wellbeing conversations, REACT, LSC and ultimately NHSE wellbeing conversations training. This created anxiety with some staff who felt bombarded with options and weren't sure which ones to choose to deliver the most positive impact and how could it be embedded at pace. There was some concern that this created a shotgun approach which would not provide the necessary focus to deliver.
- 42.4 The Trust understood that there was an urgency during Wave 1 to provide a robust response to the immediate needs of Trust staff. Consequently, the Trust implemented a significant number of initiatives and measures over the relevant period to support staff through the pandemic. Occupational health services continued to be available on-site (July 2021) including access to support from regional well-being hub for staff impacted by Covid-19.

- 42.5 Staff members were FIT-mask trained to ensure their safety and supplied with Personal Protective Equipment although this presented some challenges as described in paragraph 29 above. Team leaders and charities also supported staff with toiletries and food donations. Teams were encouraged to come together as socially appropriate, communicate via telephone and utilise MS Teams to maintain contact. Staff were thanked and appreciated both by the Trust and by the wider healthcare community and general public. Virtual meetings were arranged, and this did help staff to feel engaged but safe and wellbeing spaces were put in place to support staff.
- 42.6 An example of this is that Staff wellbeing support was offered across the Trust and some clinical areas such as Critical Care had a dedicated Wellbeing Room and offer of support from the Critical Care councillor. Staff supported each other, and there was a high level of camaraderie amongst the teams. Staff in distress were given time and flexibility. Whilst morale remained high during the pandemic, the subsequent years that followed appeared to have had more Impact on staff burnout.
- 42.7 In April 2020, a Staff Wellbeing Operational Group was set up between multidisciplinary teams to ensure that our staff were receiving the correct care and support. This was jointly chaired by the Occupational Health (OH) Lead and Emergency Preparedness, Resilience and Response Lead (EPRR).
- 42.8 In May 2020 the Hospital in collaboration with NHS SE, introduced a How Are You? Guide for all staff to follow to support staff during the Covid-19 pandemic. It asks staff look after themselves and the wellbeing of their colleagues. With particular emphasis on leaders and managers, this initiative focused on managing the concerns and fears of the NHS workforce and was well received.
- 42.9 A communications plan was put in place aimed at simplifying the messaging and ensuring staff awareness of health and wellbeing support available. The plan included branding, i.e. "Your Wellbeing", along with consistent and regular messages via the CEO and senior leadership team, COVID-19 bulletins, staff briefings, intranet and other online platforms, printed material, listening events, corporate induction and targeted communications at those in leadership roles.
- 42.10The Trust also introduced the concept of a decompression room, or Wellbeing Hub, and twice weekly Trust wellbeing group meetings took place. This provided a safe, quiet space where staff could "detox" in a positive and uplifting environment. Users were

asked to voluntarily provide a simple tally of their emotional state on entering and leaving the Hub so that its effectiveness could be assessed. Whilst this space was not monitored, from the time they were established in April 2020, until July 2020, 78 staff were noted to be actively using this facility on a weekly basis. The staff using the Hub were predominantly medics.

- 42.11All BME staff were written to, on behalf of the Chief Executive, on 5 May 2020, highlighting the support available (to have a risk assessment, providing additional PPE, providing vitamin D supplements and links to GP vitamin D testing, and the Covid-19 support resource link.
- 42.12The Trust also provided a number of other wellbeing initiatives. A summary leaflet of resources for staff was devised which included details of: Unmind, Headspace, Sleepio, lunchtime walks, Chief Nurse/Chief Operating Officer drop-in sessions etc. and psychological support through the Carefirst (Employee Assistance Programme). This provided 24/7 access to confidential professional counselling services. A report sets out the evolution of the range of support provided to staff at Exhibit DS/13 INQ000469930.
- 42.13This, and other initiatives to support staff was recognised in Jan 2022 when the Trust was presented with the Workplace Wellbeing Award Gold.
- 42.14By April June 2021 a Regional Mental Health and Wellbeing Hub was in place which aided rapid access to psychological support including an on-site provision of a Clinical Psychologist and CBT, two days per week. This was provided in addition to national NHS support services through NHS People and Practitioner Health which was available 24/7.
- 42.15This was followed in October 2021 with the appointment of a dedicated Staff Health and Wellbeing Team comprising a Staff Health and Wellbeing Manager (band 7) and a Staff Health and Wellbeing Coordinator (band 5).
- 42.16With additional support from charitable funding, the Trust also offered the Medway Fitness Hub, an onsite staff gym which was open 24 hours and is free to all staff. Current Membership stands at 1,800 (January 2024).
- 42.17 During Wave 1, some staff turned an unused side room into a wobble room with comfortable chairs, access to a shower and soft lighting. Supported by charity funding,

the hub created a warm friendly environment with soft furnishings, refreshments and a variety of materials and mindfulness activities for colleagues to get some down time away from the 'hot Hospital'. Children from local schools drew pictures which were displayed there and throughout the ward area. There was a psychologist provided to support staff in critical care but there was nothing available for the respiratory ward. The chaplaincy team attended the ward once a week and sat in the wobble room during Wave 2 to be available to staff. During Wave 2, there were more Hospital staff admitted as patients to the wards that were known to the clinical teams.. This took a significant toll on the ward staff as they had to deliver bad news to people they knew and worked with, and their relatives.

- 42.18The Trust also proactively connected with a range of resources and networks that evolved through the period. National programmes were continuously being developed and these were cascaded regionally and locally. For example, NHS England developed REACT wellbeing conversation training and Leadership Support Circles (LSC) which we heavily promoted to help managers be proactive in supporting their teams and enabled managers at all levels to come together, share their experiences and be heard. LSC's helped leaders recognise they weren't alone and gave them practical ways to support their team while also looking after themselves.
- 42.19Where possible and appropriate we made use of and promoted a range of offers from other agencies and initiatives generated from our workforce. These included, for example: coaching for individuals and groups from a variety of sources; a series of virtual cooking sessions led by a clinician; a running club led by colleagues who had joined the healthy workplace champions group; project wingman, a national programme supported by furloughed staff from the airline industry; free mindfulness apps; virtual yoga; free food offers and in person, socially distanced, mindfulness sessions.
- 42.20In terms of physical health, the Trust undertook risk assessments of its staff in Wave 1 which identified those individuals who needed to shield. By November 2020 at the beginning of Wave 2, we again risk assessed our workforce and identified those who were clinically extremely vulnerable under the new national restrictions and requested that those individuals remain at home in accordance with Government guidance.
- 42.21In relation to long Covid-19, this was not supported in a separate way by the Trust than any other long term sickness absence would have been addressed at the time.

43. Covid-19 risk assessments for staff:

- 43.1 A general risk assessment for RPE Fit Testing revealed that there was a lack of accredited fit testers to ensure staff compliance with appropriate PPE. This led to a risk that staff would be potentially exposed to specific airbourne/respiratory infections. Existing measures were the existence of only 2 trained testers, and it was identified that this number would need to be increased.
- 43.2 A Covid-19 Risk Log was devised over the relevant period which identified a potential for increased risk of patient and staff outbreaks which could have an impact on the Trust's ability to deliver its services due to non-compliance with PPE, hand hygiene, screening and multiple ward moves. An increase in bed capacity for Covid-19 patients was also identified as impacting on all wards and waiting lists. In response to this, the Trust put mitigations in place for prevalence scoping and local controls in line with National Guidance.
- 43.3 Many staff on the respiratory ward were keen to make a difference during the pandemic but many were worried. This became more significant during Wave 2 when the effect on BAME staff was more apparent. During this time there was significantly sicker patients remaining on the ward and not transferring to critical care and a lot more patients were dying. This definitely impacted on staff wellbeing.
- 43.4 Once staff had been appropriately risk assessed, many could be redeployed if such redeployment was consistent with their previous and current work experience/skill set. We assessed suitability so that any redeployments would be similar to their practice area and experience already so that much of the work they were doing was familiar to them. For example, cardiac and respiratory specialist nurses were redeployed into cardiac and respiratory wards which they were familiar with. I refer to paragraph 7.3 for further details about this. Where staff could not be redeployed on site, alternative roles and/or home working presented options for staff who presented as high risk. I found that staff were more than happy to step up and do what was needed and this was consistent with the attitude adopted by staff across the NHS. I can't recall if any concerns were raised about staff redeployment to higher risk clinical areas but these are more likely to have been addressed at a local level and talked through. The only specific concern raised was undertaking risk assessments in case this invalidated life insurance.

44. Equality Impact Assessments ("EIAs"):

- 44.1 Whilst issues were raised regarding FIT Testing, I don't recall this being formalised by the preparation of an EIA. However, the Trust followed National Guidance on risk assessments for Covid, which included equality impacts.
- 45. Any unequal impact of measures adopted by the Hospital in response to the Covid-19 pandemic on Hospital staff:
- 45.1 Please see my comments at paragraphs 28.1 and 29.5 regarding this issue.
- 45.2 There were issues initially in getting hoods in for staff of all backgrounds who could not complete Fit Testing using masks.
- 45.3 Whilst it is widely acknowledged that the effect of the pandemic on BAME staff created additional risks for this group, the Trust is not aware of any specific issues relating to the impact of measures adopted by the Hospital in relation to Covid-19. Staff who were considered vulnerable would undergo a personal risk assessment in order to be assessed for working in the specialism to which they were assigned. Where risks were identified as high, staff would shield or be redeployed in line with National Guidance.
- 45.4 During Wave 1, many of the staff on the respiratory ward were not FIT tested and there had been a decision to focus on ED staff and critical care in the first instance. This was resolved as set out at paragraph 29.2. However, there were occasions in March 2020 when there was not enough staff who were FIT tested which put additional pressure on those staff who were.
- 46. The relationship between the Hospital and Medway NHS Foundation Trust, national bodies or other decision-makers within the healthcare system.
- 46.1 As a single site Hospital, there was little distinction in the relationship between Medway Maritime Hospital and Medway NHS Foundation Trust. In terms of decision making, in early 2020, Strategic Groups were set up with trained level leads in which the Trust established three main tactical groups, namely, Medical Tactical, Nursing Tactical and Operations Tactical. All three Strategic Groups were set up to allow professional leads to escalate and disseminate requirements at speed and were involved in preparing for increased demand across the Trust with a focus on ICU.
- 46.2 Prior to Friday 19 March 2020 when the Prime Minister announced that we were going into lockdown, we had been preparing for the potential provision of our services in a virtual environment. This included ensuring we were necessarily equipped to work

remotely and ensure business continuity for the most important of our services, including effective induction programmes for all new staff and the provision of statutory, mandatory and essential training. We recognised the national call for additional staff would increase the demands on these elements of our services. Included within the essential package was Fit Mask, where we worked closely with the Infection Prevention and Control team (IPC) to ensure clinical staff were appropriately trained. At a time when the media narrative was focused on adequate provision of personal protective equipment (PPE), there was growing tension for staff. We also recognised, as workload pressures increased due to Covid-19, our people would need additional levels of wellbeing support, beyond the norm. We were inundated with information about new offers, resources and services, at a national and regional level, on an almost daily basis. Navigating these communications and products, making sense of how best to utilise them and effectively communicating with the people that needed them most, became extremely challenging. Our people were telling us they didn't even have time to read the Covid-19 bulletins and updates which included the developing wellbeing offer, much less access the support available. It was clear early on that there was a need to rationalise the messages and prioritise the services in a way that ensured there was a) awareness of the wide range of support available, and b) people could access the services with the support of their line manager.

- 46.3 During Wave 1, National Guidance indicated that Covid-19-positive patients could be sent to nursing homes after a declared number of days without prior testing for carriage. It was identified within the Trust that this would create risks for spreading infections within such locations, but it was decided that we would follow the Government's directive. One of our leaders did approach a senior figure at NHS England to offer their services and expertise of nursing homes (they were the very first DIPC and the original creator of the post) at this time but other than contacting the local region to link up with him, this offer wasn't taken up.
- 46.4 With regard to support for the Hospital, its staff and management from national bodies and decision-makers, I believe that this question cuts to the heart of the challenges faced by the Trust and its leadership team during Wave 2 of the pandemic. The Trust came out of Quality Special Measures in 2017 but remained under intense scrutiny. However, the Trust continued to face a number of key challenges, some of which had improved significantly with internal changes to operational practice and others which were proving much more difficult to progress. This, in combination with the Trust serving a large,

deprived population with an inadequately sized acute hospital set the scene for likely major challenges during the pandemic relating to demand and capacity.

- 46.5 The NHS, of course, did recognise the potential for services to be overwhelmed by the Pandemic, given the awful scenes playing out in northern Italy in February and March 2020. This was the driver for the creation of the Nightingale units, including the unit at the Excel in London. It was never clear whether Trusts in Kent and Medway would have access to this unit for their patients I recall comments suggesting that if we wanted to move patients to these units, then we would also need to provide staff to help look after them. When we were dealing with the type of staffing challenges detailed earlier in this statement, this did not seem to be particularly feasible. As it turned out though, Wave 1 was managed without need for such facilities, partly because Wave 1 peaked before the large increase in available critical care capacity was saturated, and partly because of the massive drop off in non-COVID admissions, leading to a bed occupancy typically below 70% for most of April 2020.
- 46.6 It always seemed probable that if a second wave of COVID occurred, layered onto normal NHS pressures (and more particularly normal winter pressures) then this would lead to a major issue with demand and capacity within the general bed base.
- 46.7 There was a surge of admissions in October 2020. This is evidenced by Exhibit DS/14 INQ000427381 which shows the percentage of beds occupied by Covid patients in the Kent Trusts up to 10 November 2020 (Graph 1). This shows a significant increase in cases at the Hospital from mid-October 2020, with Dartford and Gravesham, East Kent Hospitals University and Maidstone and Tunbridge Wells Trusts following approximately three weeks later. Graph 2 of the same Exhibit shows the Trust Covid admissions (for patients arriving at the Hospital with Covid, rather than those who acquired it during their stay (i.e. nosocomially) which shows a sustained rise from 26 October 2020.
- 46.8 This surge in admissions in October 2020, coupled with the sudden increase in nosocomial transmission of COVID was interpreted as a sign of failure of leadership and of poor basic practice at the Trust, rather than being an indicator of a new challenge in terms of the Alpha Variant and its increased infectivity. I recall that we had an outbreak on Will Adams ward at the end of October 2020 that attracted the attention of the national IPC Team. Our Director of IPC and others commented at Outbreak Meetings that the virus seemed to be behaving very differently in Wave 2. This was superseded in mid-November 2020 by a further major outbreak on our Pembroke ward, with cases

occurring all over the ward (despite Pembroke being a ward with bays). For those external to the Trust, there was a view that this was a due to increased bed occupancy, the close spacing of beds and the historic substandard IPC practices at ward level. However, the data was available to suggest alternative explanations including the possibility of a new variant.

- 46.9 My microbiology colleagues commented from late in October 2020 that there was something distinctly different about transmission which could not simply be explained by the higher bed occupancy levels and the greater potential for patient-to-patient transmission. The speed with which some outbreaks spread around wards with conventional bays was indicative of this. Consequently, despite the Hospital identifying early on in Wave 2 that there had been a change and increase in viral behaviour and our epidemiological awareness of this, PHE officials did not investigate our report and it was later that PHE declared the emergence of the Kent Variant (subsequently renamed the Alpha Variant).
- 46.10As Wave 2 progressed and spread out into the rest of Kent, all the acute sites began to have severe difficulty in managing patient flow and bed capacity. The issue was less to do with critical care capacity (as I have previously mentioned, the introduction of treatments such as dexamethasone had beneficial effects on COVID mortality and the need for ventilation) and more on general bed capacity. Lack of capacity led to worsening flow in the Emergency Departments, and in turn to delays in ambulance offloads, compromising the responsiveness of the ambulance service. There were a number of national decisions which impacted on this - for example, a view that each region needed to manage its own problems. The potential for Trusts in the London perimeter such as ourselves and Dartford and Gravesham to work with local London Trusts such as Lewisham and Greenwich or Kings was blocked by this decision meaning that critical care transfers, for example had to go to Southampton or Oxford as these sites were within the SE region, and not to the Princess Royal in Farnborough or the Queen Elizabeth in Woolwich. There was no evident ability for LAS to support SECAMB around the London perimeter (or vice versa). The NHS was being overwhelmed exactly as had been predicted in Wave 1, but the support which appeared to be planned nationally in Wave 1 was replaced by a series of unhelpful and critical discussions over bed capacity and patient flow.
- 46.11This negativity particularly affected Medway. I recall a story that a fellow operational manager at another Kent Trust criticised Medway staff during a sector operational 'gold

command' meeting for 'failing to go the extra mile' in managing their patients. The fundamental challenges facing the Trust based on its unwell and deprived population, its historic demand and capacity mismatch and the presence of the Alpha Variant were simply not appreciated. I began to spend significant parts of each day dealing with regulatory scrutiny rather than supporting the local teams. I have mentioned in a previous answer that our response in Wave 2 became stalled by increasing layers of governance process.

- 46.12The height of this critical landscape was the CQC's visit in December 2020, at which the Emergency Department (ED) was rated as 'inadequate'. I would not disagree that the care being provided was far from the level we would have wished to provide in normal circumstances, but these were far from normal circumstances. It is my opinion that the CQC judged the department against the standards they would have expected to see in 2018 and 2019, with no regard for the extraordinary pressures that the Emergency Department faced at that time. The rating of 'inadequate' was a massive blow to the morale of the entire organisation, but most specifically to the staff in the ED who were doing their best in appalling circumstances to keep patients as safe as possible.
- 46.13Crowding in the ED was caused by a fundamental mismatch of flow into the department (driven by ambulance traffic, with no clear overarching strategy by colleagues in Regional Teams or the Integrated Care System to mandate redistribution of emergency conveyances in a more equitable manner) and lack of flow out of the department, resulting from a historic lack of capacity and the high number of COVID patients generated by the Alpha Variant.
- 46.14Medway was receiving 100 ambulances a day whilst other acute providers were receiving significantly less. From my perspective, I felt that there was no robust attempt either within the sector, the region or nationally to try and smooth out the demands on acute providers, or to provide an alternative such as use of the Nightingale at Excel as a step down facility for post-acute patients who did not need acute hospital beds. I spent one of my weekends off just before Christmas 2020 trawling the medical wards trying to find patients who could be discharged: I did find many (probably as many as 30 patients, mostly on the fraility wards) who did not need the facilities of an acute hospital (and who given the rates of nosocomial transmission would almost certainly be safer not being in one), but actually facilitating discharge was impossible due to the impact of Wave 2 on community service provision. I caught Covid myself during this weekend of work.

46.15In terms of lessons learned, if I have one request for regulators in the future, it is not to be influenced by their assessment of the previous issues facing a Trust (or a system) but to fully assess the data. This may have led to an earlier detection and understanding of the mutation of the Alpha Variant.

47. National Guidance relating to discharge from acute Hospitals:

47.1 I and my colleagues identified when implementing the National Guidance some conflict between operational demand and quality of care, further details of which is set out in paragraph 14.6 and 46.3.

48. Recommendations:

- 48.1 Please see my response at paragraph 46 above.
- 48.2 Further information has been provided in the statement of Alison Davis, current Chief Medical Officer at Medway Maritime Hospital.

Statement of Truth

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



DR DAVID SULCH

Dated	June	5^{th}	2024