Witness name: Dr Lucia Pareja-Cebrian
Statement number:1

Exhibit numbers: LPC/1

Date: 29/04/2024

UK COVID INQUIRY

WITNESS STATEMENT OF DR LUCIA PARJEA-CEBRIAN

I, Dr Lucia Parjea-Cebrian of Newcastle upon Tyne Hospitals NHS Foundation Trust ("the Trust") Trust Headquarters, Freeman Road, Newcastle upon Tyne, NE77DN will say as follows:

1. I make this statement to assist the UK COVID-19 Inquiry and further to a Rule 9 letter which was received by the Trust on 13th December 2023. I can confirm that I have held the post of Associate Medical Director since March 2018 and therefore was part of the Trust throughout its response to the COVID19 pandemic. I can also confirm that in order to prepare this statement, I have spoken to my colleagues within the Trust in order to ensure that information could be provided to deal with each request for information.

2. I am a Consultant Microbiologist and have qualifications LMS, UAM (Spain), FRCPath. I joined the Trust in 2015 having worked as a Consultant in Yorkshire for nine years before that. My areas of interest include infections in Paediatrics, Sepsis, Antibiotic Stewardship and Infection Prevention and Control. I held the role of Director of Infection, Prevention and Control from 2017 to 2022.

Newcastle upon Tyne Hospitals NHS Foundation Trust – Royal Victoria Infirmary

3. Although the Trust is responsible for a number of hospitals and services across the region and provides local, regional and national services, for the purpose of this statement, I have focussed on The Royal Victoria Infirmary (RVI) as set out in the Rule 9 letter. The RVI serves as a district general hospital for a Newcastle population of 300,200 people and provides regional services for the North East and North Cumbria ICB population of circa 3 million people. The Trust provides local, regional and national services. The RVI has 78 wards including maternity wards and 33 other (day case wards and outpatients etc). The total staff number was, at the time of the pandemic and taken from the annual report, Full Time Equivalent ("FTE") of 14,710.5.

4. Newcastle has an overall Health Index score of 88.6, which is up 1.5 points compared with the previous year and is ranked in the bottom 10 percent of local authority areas in England for health in 2021. Its score for "living conditions" fell from 104.9 in 2020 to 103.2 in 2021. This means Newcastle upon Tyne went from being in the bottom 40% of local authority areas to being in the bottom 30% across England for this subdomain. The change was largely because of an increase in air pollution (the index worsened by 12.7 points). This information has been taken from the public census and is publicly available on the Office for National Statistics Website.

5. The North East and North Cumbria includes a large and diverse geography, from cities and towns to rural and coastal communities. The population in this area is older and 21% of the population are over 65 compared to 18.6% in England. Our population experiences significant socio-economic deprivation and 1 in 3 people within the area live in the most 20% deprived communities in England. Our population experiences health inequalities. Life expectancy and healthy life expectancy at birth are significantly worse than the England average as evidenced in the 2021-2022 Office for National Statistics Public Census.

Staffing at The RVI

General Staffing comments in respect of the relevant period:

6. Whilst sickness absence increased due to Covid-19 related absence and a number of staff shielding across all staff groups, the mitigating factors outlined below ensured safe staffing levels across all groups of staff were maintained. Maternity was closely

monitored due to the unique nature of the workforce and specifically due to the specialist training which is required of the maternity workforce group. However, during this period, due to utilisation of existing escalation frameworks, appropriate staffing levels were maintained. It is noted that if the significant and sudden reduction in non-urgent elective activity was not operationalised, there would have been significant staffing challenges across all core workforce groups (i.e Nursing staff, Medical staff, Allied Health Professionals and support services etc). Changes to staffing/patient ratios in critical care were considered in line with NHSE critical care surge guidance, for example 2RN (1 critical care nurse, 1 theatre nurse who had received surge training: 2 patients). Exhibit LPC/01,INQ000477460 details the Nursing and Medical Staffing guidelines used during the pandemic. This document includes the escalation framework and trigger points. This guidance was used from February 2021 and staffing ratio's considered, however the guidance was not used beyond registered nursing staff. Prior to this guidance the Trust used a standard electronic rostering and attendance policy used by all staff.

7. It should be noted that due to workforce management, the Trust did not have any particular areas of staffing shortages within any specific areas.

8. The first known positive Covid -19 patients in England were admitted to the Trust on Friday 31st January 2020 and at that point the Trust enacted its Emergency Planning Resilience and Response plans. The management of in-patients with Covid-19 presented an almost immediate challenge. To ensure the Trust could support the necessary immediate response, a training needs analysis and comprehensive workforce plan was undertaken for critical care and in-patient areas. This was to ensure a clear a framework was in place to care for acute Covid-19 cases whilst still providing ongoing acute care to patients with non-Covid-19 presentations.

9. The main challenges were:
   a. The requirement for significant expansion of Critical Care capacity
   b. Expanding non-critical care in-patient capacity and resourcing the emergency care pathway
   c. Providing a Respiratory support unit for delivery of NIV/CPAP for those Covid-19 patients not in Critical Care
   d. Maintaining the required non-Covid-19 elective and emergency capacity.

10. Throughout March 2020, staffing models were reviewed to agree the workforce requirements for a number of critical care, Covid-19 and Non-Covid-19 scenarios. This included converting wards to alternative functions and operationalising a training and development framework to ensure staff were appropriately trained. The final framework was signed off in by the Executive Team during the second week in April. This framework outlined a phased escalation of staffing (nursing/medical/AHP) and bed capacity as required. The Trust guidelines relating to safe staffing were updated to reflect the changes.

11. The following key operational points which were adopted by the Trust are noted during the time period identified:

12. Pre-Surge (before an increase in demand for healthcare services)

a. The significant and sudden reduction in elective activity created additional bed capacity and released the required staff to be redeployed across the Trust and maintain appropriate staffing levels.

b. Additional staff were redeployed to expand and re-design the front of house clinical model and prepare for additional ITU capacity as required. The number of staff required was based on adjusted staffing templates to ensure staffing need was in line with existing governance and assurance processes. Nursing and AHP staff moves were led and overseen by the Executive Chief Nurses Team and medical staff by the Medical Director to ensure safety for patients and staff and consistency in application.

c. ITU modelling was undertaken to understand the required staff based on the Covid-19 staffing models outlined by NSHE which ranged from phase 1 (normal 1:1 ITU Staffing) to phase 4 (1:6 critical care nurse to patient ratio with additional registered nursing support).

d. Over 1000 existing Nursing staff attended preparatory training in April 2020 to be redeployed into ITU and other clinical areas as required.

e. Additional staff were recruited through the Staff Bank to support staffing as required. During that period an additional 48 Registered Nurses were trained and deployed with an additional 56 planned. 45 Healthcare Assistants were recruited and deployed with an additional 90 planned.

f. 157 final year nursing students were employed as Band 4 Aspirant Nurses to support wards and departments whilst continuing to complete their studies.

13. During Surge (during an increased demand for healthcare services)

a. Critical Care surge was led, planned and executed through close partnership working between the Medical Director, Executive Chief Nurse and Chief Operating Officer. The clinical and staff reconfiguration was significant; 104 members of clinical staff (nurses, operating department practitioners, AHPS) were re-deployed from a number of areas to assure safe staffing in critical care and provide a resilient workforce. An additional 400 circa were trained in case there was a need for further staff to support in critical care. The staffing levels were maintained between phase 1 and 2 with no requirement to further escalate.

b. Inpatient wards - A number of wards were converted to Covid-19 positive wards to ensure where possible, all wards were at 50%-60% capacity but remained fully staffed. This was to ensure staff had appropriate length of breaks out of PPE and to mitigate any increase in sickness if required. This was achieved and maintained through reducing 6 bedded bays to 4 beds where possible. A total of 400 ward-based staff were moved to assure safe staffing across adult and paediatric wards during this time.

14. On Monday 12th July 2021, the Trust reported the highest and most significant workforce gap since the onset of the Covid-19 pandemic. This had already been reported in the media as part of a BBC news article from 9th July 2021. The main drivers for the workforce gap which was reported was the requirement for staff to self-isolate following a contact. An extract from the Gold Command logs on this date reads as follows:

a. There is a total of 411 staff absent due to COVID related reasons, with 97 testing positive to COVID and 288 self-isolating.

b. 151 Registered Nurses/Midwives off with covid related absence and 251 with non-covid absence. 7.86% total registered workforce loss.

c. Unregistered workforce loss is also significant and impacting on the ability to provide 1:1 enhanced care.

d. Agency use significantly increased in the last 3-4 weeks.

e. AHP workforce at 7% sickness absence.

f. Medical staff absence is critical in key directorates – medicine, cardio, surgery.

g. 118 Beds closed due to nursing and midwifery staffing gaps or infection. Unlikely to be able to further mitigate due to emergency pressure.

h. Request for further 10 beds to be closed today (12th July 2021 – 17th July 2021) due to further gaps which cannot be resolved as of today.

i. We continue to report OPEL 3 due to significant numbers through ED (Emergency Department), Same Day Emergency Care (SDEC) - sustained since April 2021, Bed occupancy is at 84%.

j. Since the 5th of July 2021, 115 patients cancelled inclusive of today (12th July 2021) with a further 80 anticipated for this week.

15. In view of the developing picture specifically relating to the impact of the staff shortages, risk assessments were carried out to review the possibility of reviewing, assessing and overturning staff isolation orders. A SOP was developed whereby the Trust's Director of IPC could review every case where a staff member had been in contact with a confirmed Covid-19 case and could review mitigations to ensure patients were not put at risk by a member of staff returning to work even though they had been in contact with a confirmed case. For example, repeating a staff member's PCR test at day 0, 5 and 10 following a return to work.

16. From 6th July 2021 to 28th October 2021, 300 household contacts were risk assessed by the Director of IPC, of which 289 individual staff were authorised for return to work, and 11 of those reviewed were not suitable for return to work as it was deemed that they were infectious and not suitable for a return to clinical duties. This process continued from July 2021 to October 2021 whilst the requirement to isolate remained, with different variations in the frequency of PCR testing following return to work.

The effect on staff and staff capacity in respect of PCR and antibody testing:

17. The Trust implemented Staff PCR testing from 10th March 2020 and were one of the first Trusts in the country to do so. Staff PCR testing was managed on a demand basis initially by weighing up the availability of test kits overall and ensuring patients were prioritised according to clinical protocols for when testing was appropriately required. The Staff PCR testing was established at a time when routine community testing was not available and decision making relating to this was threefold: the need to maintain the health and welfare of our staff; to enable rapid identification and isolation of infected health-care workers to protect patients and the wider community, and to enable more rapid returns to work for our staff.

18. The PCR Staff testing was initially managed by the Trust's Occupational Health department. However, the Trust later established a standalone Test and Trace Service which was staffed by the secondment of nursing staff who were unable to work in clinically facing roles, this was due to a number of reasons primarily this staff group were deemed to be clinically vulnerable.

19. At the time of the Covid-19 Pandemic the Trust employed a large number of staff, who had friends and families and who were socialising with the wider communities. Staff testing enabled the Trust to track when the pandemic wave reached Newcastle areas in real time. This work was published in the Lancet Online on 22nd April, 2020. A copy of the published article can be found in exhibit LPC/02, INQ000477461.

20. The benefits of this approach were many including that staff felt confident to return to work knowing they had not put patients at risk and when positive, staff self-isolated from their own family members, some of whom were vulnerable. At times results were expedited to be available within as little as an hour from sampling and this ensured surgeries and clinical services continued. Subsequently at later stages of the pandemic, a Point of Care Test (LumiraDX) was also made available for staff and household testing, turning results around in 25 minutes.

21. Although the Trust did have a successful testing programme in place, it should be acknowledged that it was not without its challenges and the Trust struggled every day for 3 years throughout the pandemic to ensure that staff, space, testing platforms, kits and consumables were available. At times supplies were down to single numbers but the Newcastle area worked together as a network to ensure testing could continue. Despite the challenges the Trust did not stop testing throughout the

period in question and staff reflections on this has received mixed emotions but demonstrated a formidable approach to protecting patients and families.

Increasing staffing capacity and constraints on increasing staffing:

22. There were a number of reasons as to why increasing staffing capacity was difficult and I have highlighted below the key points.

23. Increasing staffing capacity was constrained by staff clinical experience and skill set. This was addressed through a comprehensive training programme delivered internally for critical care and non-critical care areas. A set of redeployment principles were also operationalised to support effective and safe redeployment. This was effective and ensured adequate staffing levels throughout the relevant period of the pandemic.

24. Staff wellbeing/sickness absence/shielding impacted on the ability to increase staffing capacity. This was in part mitigated by a workforce and redeployment hub group which met weekly, consisting of professional leads, HR, Occupational Health, Staff Side colleagues and other key stakeholders within the Trust to oversee actions and initiatives relating to these key issues. This was a key group in our workforce response and remained in place throughout the pandemic.

25. Due to the unknown nature of the impact of the pandemic, it was not clear pre-surge what the potential case mix of patients would be. This impacted on the ability to train and re-deploy staff in advance of the surge and with certainty. This was in part mitigated by having a phased escalation model of both critical and non-critical care capacity based on agreed triggers, although until the specific patient mix was received by the Trust there were limitations to this approach.

26. NHS England's agreement for the Trust to employ students as aspirant nurses and healthcare support workers supported an expansion in the unregistered workforce to mitigate workforce loss. Whilst in some aspects this was helpful, there was still a requirement to support effective student learning and development, and therefore the workforce was not fully utilised in an employed capacity.

27. NHS England's national guidance, which was released which outlined critical care staffing ratios, supported critical care expansion at scale and ensured adequate

workforce modelling was challenged. This supported effective workforce modelling and requirements within the Trust.

28. Furthermore, NHS England provided the following guidance documents

    a. Management and Assurance of Nurse Staffing During current wave of COVID 19 Pressures; and

    b. Acute Adult In-Patient and Acute Adult in-patient reference guide to support Staffing Assurance Framework Deployment and assurance of clinical nursing workforce during the COVID 19 emergency in February 2021.

29. These documents supported the Trust to assess, via gap analysis, the Trust's staffing levels as resources were released for example Modelling was undertaken for various degrees of workforce loss/release in critical and non-critical care areas and tested. Surge and super surge plans were operationalised and reviewed with adjustments made based on planning. Training and competency processes were put in place e.g. critical care training not non critical care nurses. Impact was monitored via Nurse Staffing and Clinical Outcomes group. A nationally validated system was in place to support daily nurse staff deployment which was co-ordinated through the corporate staffing team this supported effective governance and assurance across the Trust.

30. It was clear that throughout the pandemic, redeployment of staff within the Trust, outside of their specialism impacted on the staff morale and wellbeing. This was noticed to a lesser degree in the time period of March 2020 - June 2020 during the first wave but was more prevalent in future waves. Although staff within the Trust were redeployed to other areas within the same Trust, it is important to note that no staff were redeployed to other hospitals.

31. The impact on staff morale and wellbeing was evidenced by an increase in sickness absence and staff highlighting concerns around being redeployed. The mitigating actions to address this has been previously noted (training/operating procedures/redeployment principles).

32. Whilst all staff had access to the necessary training if they were redeployed, it is recognised that redeployed staff were not fully experienced in those clinical areas and some staff did not feel sufficiently skilled to undertake new roles. Where concerns were highlighted, these were addressed and managed through additional

training, occupational health support and close working with line managers but it was felt that this impacted on staff wellbeing and morale.

33. Clinical incidents and concerns were closely monitored to identify any impact that redeployment may have had on patient safety. Due to the significant reduction in elective capacity within the Trust safety risks were managed and mitigated by:

    a. a significant number of staff were able to be redeployed to other areas,

    b. wards were managed at reduced capacity to increase staff breaks and

    c. rest for staff ensured.

34. The Trust was asked to lead the establishment of the regional Nightingale Hospital. Whilst this was never operationalised, the number of staff required to support the planning, build and preparation to open the unit did impact on the senior resource which was available within the Trust to balance multiple priorities.

35. Internally a training team of 12 staff (re-deployment team) was established to manage redeployment training across the Trust. This allowed for resilience to be built into the team should Covid-19 effect the re-deployment team. The admin support was provided by members of Trust staff working from home and they were the point of contact to book onto the training sessions, to provide a register for the training days and also chase up any non-attenders. Whilst this was effective and efficient, it was an additional overhead of staff cost to support this process.

36. To manage the impact of redeployment and proactively address burnout, the Trust implemented a number of measures to mitigate any risk. This included additional funded psychology support posts and wellbeing and support hubs. This was a key support mechanism, particularly in further waves where the cumulative impact on the pandemic become more apparent.

The impact of long Covid on staffing within the Trust, the support for staff suffering from long Covid and staff deaths

37. During the early part of the pandemic in 2020, queries began to arise related to workplace implications of COVID-19 contact for healthcare staff returning to work. A key theme was noted during spring/summer 2020 which was the growing proportion

of staff continuing to experience distress, ongoing symptoms, and functional impairment for prolonged periods following suspected or confirmed COVID-19 infection.

38. Local Occupational Health Service (OHS) coding of referrals to the OHS relating to staff with ongoing symptoms following COVID infection (later known as "long COVID") was commenced by Newcastle OHS in April 2020. This was as a result of an emerging pattern of symptoms persisting beyond the initial period of persistent cough, fever and fatigue.

39. OHS developed a bespoke pathway for those staff with long COVID symptoms supported by Newcastle Hospitals Charity funding (originating from NHS Charities Together). The objectives of the pathway included the following:
    a. To provide timely advice and guidance to staff experiencing ongoing symptoms consistent with long COVID, with access to a multi-professional team.
    b. To reduce the impact of these symptoms on work function and sickness absence rates.
    c. To build capacity and capability within the OHS multi-professional team in the management of and response to a then-novel condition.
    d. To develop resources and information for these staff groups, especially in the absence of other service provisions in the initial stages.

40. Staff accessed the service with the following symptoms.
    a. Cardiopulmonary e.g. breathlessness, limited exercise tolerance
    b. Musculoskeletal/physical e.g. joint pains/fatigue
    c. Psychological e.g. low mood, anxiety, loss of confidence
    d. Neurological e.g. poor concentration
    e. Other symptoms

41. Staff members who were referred to the Occupational Health Service with symptoms following COVID infection had recorded outcomes as follows:
    a. Returned to work
    b. Returned to work with adjustments
    c. Redeployed
    d. Re-referred to OHS and then returned to work
    e. Off work and no review by OHS
    f. Mutual termination of contract on grounds of heath

g. Ill health retirement (application via AW33E part C)

42. The total number of staff members referred to the Occupational Health Service with symptoms of long covid was 559.

43. The outcomes were also reported to Gold Command and any matters were managed through the individual teams and through the normal processes for sickness absence.

44. It is also important to note that although the Trust did implement a pathway for long Covid, and members of staff did suffer from Covid and long Covid, the Trust can confirm that there were no staff deaths arising from Covid. There was a news report on the death of a nurse which caused confusion and distress as some people mistakenly thought she was working for the Trust at the time.

Covid-19 vaccination as a condition of deployment ("VCOD"):

45. The Trust were prepared to mandate VCOD however a national decision was made that did not mandate VCOD and the Trust successfully double vaccinated 96% of staff.

46. Work was undertaken with the directorates across the Trust to understand the reasoning as to why the remaining individuals did not want to be vaccinated. Directorate Managers were required to provide a weekly update as to numbers of staff who was agreeable to VCOD and who was not. Managers were having active conversations and individually recorded meetings on a Trust agreed proforma with all staff. It is important to note that no one was stopped from undertaking their role as VCOD implementation was halted before those decisions needed to be taken. Letters dated 25th January 2022 went to all staff considered in scope, with a proforma to return to advise of COVID-19 vaccination status. The Trust did not proceed to arranging any dismissal hearings, in agreement with Staff Side, as the Trust felt this was not appropriate at that time. The Trust undertook to redeploy staff as appropriate and required.

47. Furthermore, there were weekly meetings with HR, Staff Side and Trust management to understand the following:

a. Progress and management should the VCOD legislation be enacted.

b. Each Directorate's response as to whom would agree and who would not agree to VCOD.

c. The impact of any non- compliance on their services within specific Directorates.

48. It should be noted that were some more robust discussions between staff prepared to be vaccinated and staff not prepared to be vaccinated, although no serious concerns were raised about the content of those discussions. Management were also careful not to impose their personal views on staff but were clear with staff in relation to the potential policy decisions. Information relating to staff vaccinations was also available on the Trust's intranet under VCOD.

49. Q&A sessions were organised with staff who were pregnant and with the Equality and diversity and Inclusion network to understand and clarify queries and concerns regarding vaccinations. These Q&A sessions were led by Trust Infectious diseases specialists.

Increasing bed capacity during the relevant period

NHS England / Improvement discharge policy:

50. On 17th March 2020, the number of occupied beds on general wards was 1064 (70.98% capacity) and in ITU the figure was 55 (63.95% capacity). Within 10 days of the implementation of the NHS England's discharge policy communicated on 17th March 2020, occupancy fell to 615 (42.71% capacity) on general wards and 45 (52.33% capacity) on ITU. This is a publicly available "Dear Colleague" document which was titled "IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19".

51. Prior to the 17th March 2020, initiatives were already being implemented to manage bed capacity. This included surging resources in the Discharge Team to expedite patient discharge and undertaking a review of elective priority on a patient-by-patient basis. A decision was then taken at Gold Command on 17th March 2020 to reduce non urgent elective operating. This was implemented from 18th March 2020. This decision allowed the Trust to reduce bed occupancy and afforded the Trust the time and resources to effectively train large numbers of staff, eg, theatre nurses to become ICU nurses, to support the anticipated surge in patients presenting with COVID-19 requiring high-level care. The Trust discharged 239 people in the 10 days

after receiving the letter, 13 of which were new care home residents and 226 were returning to their usual place of residence in the 10 days after receiving the letter.

52. Supplementary evidence in respect of bed occupancy in the period before and after the letter was received on 17th March 2020 can be made available to the Inquiry and if further detail is required on this issue.

ITU Capacity and the Critical Care Network:

53. In relation to ICU capacity, the Trust formulated a stepped plan to increase Level 2 and Level 3 capacity from the end of March 2020. This involved the conversion of general acute medical wards to care for Level 2 and 3 patients and the use of theatre recovery beds to care for Level 3 patients. The core bed base pre-pandemic was 89 Level 2 and 3 beds. The ITU expansion plan sought to increase this to 169 Level 2 and 3 beds (90% increase). These admissions related to covid admissions only. One of the most significant challenges was training nursing staff from general acute wards to work on ITUs. In the summer of 2020, based on the Trust's experiences during wave 1 in the Spring of 2020, a major refurbishment of a ward brought this area up to intensive care standard, converting a 29 bedded ward into a 17 bedded critical care unit with full isolation facilities. This ward was fully utilised in the winter of 2020/21 and was key to maintaining adequate COVID critical capacity in Newcastle, allowing support to be provided to other hospitals both regionally and nationally.

54. Decision making relating to the expansions were made at Trust level as part of internal Command & Control meetings. The decisions were taken at the Strategic (Gold) level, with the plans developed and implemented at the Tactical (Silver) level, directed by the Clinical Leads for both ITUs on the RVI site.

55. During wave 1, there were 83 admissions to ITU. There were 107 admissions during wave 2; and 228 admissions during wave 3. All of these figures relate to Adult ICU RVI. The number of admissions in wave 3 did not exceed bed capacity in ITU. This number is the total number of admissions during wave 3 and patients were not in the hospital all at the same time. ICU capacity was variable depending on the situation in the Trust and was able to be flexed up and down as required. The Trust critical care capacity was not a limiting factor at any stage.

56. Some patients were moved between RVI and the Freeman Hospital critical care units (both are part of the Trust) to free up capacity at the RVI for new admissions. The

Freeman Hospital in Newcastle upon Tyne is a specialist referral centre for patients living in the North East and beyond. Teams of clinical experts have an international reputation for pioneering and high-quality services, ranging from joint replacement and digital hearing aids, to heart surgery and multi-organ transplantation. Specialists offer innovative treatments for cancer care, complex liver, pancreatic, kidney, lung and heart-related diseases.

57. There were no COVID critical care transfers out of the Trust due to capacity reasons and the Trust did not transfer patients out to other ICUs in other hospitals across the country, although the Trust as a whole were concerned at the magnitude of events and the strain under which services were operating.

58. The Trust did receive a number of transfers in from hospitals across the country. Throughout January and February 2021, the Trust accepted 113 patients as ICU transfers from hospitals across the country. The Trust critical care capacity was not a limiting factor at any stage.

59. The Trust also remained an active member of the Critical Care Network and participated in daily network calls during peaks in demand. In respect of the patients, transferred into the Trust from other hospitals, 64 of those patients were within the Critical Care Network and 49 were from outside of the Critical Care Network (49). The highest proportion came from Birmingham (29 patients) but patients were also transferred from Sheffield, London, Surrey and Slough.

60. Furthermore, the NECTAR Service is a paediatric critical care transport service for the North East and North Cumbria which started in 2015 and which is provided by the Trust. It was originally known as the 'North East Children's Transport and Retrieval' Team. Its primary role is the stabilisation and transfer of critically ill children, although at the start of the pandemic, there were fewer critically ill children (as there were fewer respiratory viruses due to lockdowns) and this meant that NECTAR was less busy than usual. This occurred at a time when adult ICUs were under great strain. When an ICU is full and an additional patient requires admission, Trusts sometimes transfer one of the patients to a different ICU that does have capacity (decompression transfers). Due to the volume of adult ICU admissions, many units required decompression transfers.

61. The NECTAR Service were able to work with adult ICU colleagues to develop their skills in caring for critically ill adults, before doing many of these decompression transfers. This took the pressure of the ICUs, enabling staff to care for the patients within the unit without having to reduce their staffing levels to staff and support a transfer to another ICU. Subsequently, NECTAR received funding for a formal transport service for adults becoming known as the North East & Cumbria Transport and Retrieval team following its expansion in 2021 to undertake adult transfers. The Trust were able to draw on experiences from the more informal set-up which had been in operation to rapidly provide a full service.

62. Due to higher proportion of available critical care capacity in the Northeast (compared to elsewhere in the country) and NECTAR's skillset in the transfer of critically ill patients by air, the Trust were able to support areas of the country under the greatest pressure by taking some patients from those areas to the Northeast of England. As this work was established at short notice, with little planning, a great deal was learned along the way and the most efficient way to deliver the service was continuously re-evaluated.

63. NECTAR received a great deal of positive feedback from referring units, national colleagues and from some of the patients that were transferred. NECTAR were very proud of the contributions during the pandemic.

Availability of equipment and medicines:

Ventilators;

64. The Trust had for a number of years retained a 'pandemic' stock of ventilators in storage, these were made up of mainly Draeger, Evita 2 Dura and Evita 4 ventilators that had previously been replaced as part of the equipment capital replacement plan. Although these ventilators were aged there was experience in the team and commonality of service parts with newer models to allow the Trust to bring these ventilators up to a compliant clinical standard early in the pandemic. This ensured the Trust had equipment to ventilate more than 200 patients.

CPAP machines

65. There were also no initial issues encountered with the supply of CPAP machines, although the Trust did encounter an issue in respect of the supply of masks and associated circuits. On the 8th April 2020, it became apparent that the Trust had no

CPAP masks. This was discussed at Gold command and a critical incident was considered which would have stopped the Trust from accepting any more patients. However, the Trust developed a decontamination protocol using the Niagara wash and Sterad system decontamination (70C plus hydrogen peroxide). Decontaminated masks were subsequently used at times during the pandemic. The Trust also explored, and risk assessed the use of endoscope washers for cleaning and decontaminating the circuits, although it was never required to be used.

Oxygen, including the supply of piped oxygen to beds;

66. In order to provide assurance regarding the Trust's oxygen capacity and as part of preparations for a COVID-19 patient surge, a survey of the existing piped oxygen distribution infrastructure was carried out by the Trust and the Authorising Engineer (Medical gas pipeline system (MGPS)).

67. The survey reviewed the following areas:
    a. Capacity of existing bulk Liquid Oxygen storage vessels (VIE).
    b. Design of the 4 bar Medical Oxygen distribution pipework infrastructure.
    c. Maximum potential oxygen demand based on existing bed numbers.
    d. Stress testing of oxygen distribution system at critical locations.

68. The survey identified three main concerns with the security of the piped oxygen supply, and these were as follows, along with the mitigations which were put in place:

    a. Risk of oxygen starvation to COVID-19 wards due to peak oxygen demand exceeding the design capacity of the local MGPS distribution pipework. To mitigate the risk of oxygen starvation due to demand exceeding the design capacity of the local MGPS distribution pipework, the main and branch supply pipework to these areas was replaced with up-sized oxygen (and medical air) pipework. This was managed at Trust level with support from the Trust's MGPS contractors.

    b. Inability to maintain site wide oxygen supplies in the event that one of the two bulk liquid oxygen storage vessels (VIE) failed. To mitigate the risk of a site wide loss of oxygen supply if one of the two bulk liquid oxygen storage vessels failed the Trust engaged with BOC UK Ltd. to provide a more resilient solution. The initial response from BOC was that there were limited options available to improve the Trust's resilience due to a shortage of available bulk storage

vessels, vaporisers and control panels. The options put forward by BOC were rejected by the Trust as they did not mitigate all risks, and this was escalated to NHSE via the National Oxygen Wave One Programme. Following negotiations between the Trust, NHSE and BOC a satisfactory solution was reached with BOC installing an additional 5000LPM bulk storage vessels (VIE). This provided increased capacity and an additional layer of resilience within the MGPS distribution system.

c. Reduced resilience as the oxygen distribution system was not configured as a ring main system. To improve the resilience of the oxygen distribution system the pipework was re-configured as a ring main system. This was managed at Trust level with support from the Trusts MGPS contractors.

O2 cylinders

69. In respect of Oxygen cylinders, during the pandemic the Trust operated in accordance with the NHSE instructions to BOC, and therefore we did not adjust our cylinder stockholding and cylinders were only issued on delivery in exchange for an empty cylinder. We experienced a small number of cancelled deliveries of Oxygen cylinders by BOC and this was managed directly with BOC. On a couple of occasions, cylinder stockholding did get unusually low at both sites, but we maintained visibility of run rates and expected deliveries. At no point did cylinder stockholding interrupt treatment or dictate clinical decision making, it did however focus the portering and pharmacy teams on ensuring all cylinders were available for exchange on delivery days.

70. Although oxygen cylinders did not interrupt treatment, oxygen supply at the RVI was a potential concern at the start of the pandemic. Processes for close monitoring of utilization/supply were put in place. Work to upgrade the storage capacity and oxygen distribution network at the RVI was carried out between waves 1 and 2, including installation of an additional oxygen VIE.

Renal services and medicines

71. During the pandemic, the procurement of medicines was managed directly by the Assistant Director of Pharmacy, the Procurement Pharmacist, and the pharmacy procurement team. Monitoring of stock holding of critical medicines used in intensive care unit and Covid wards was given the highest priority. At no point, given the

careful management of the supply chain and the clinical strategies employed, was clinical care compromised.

72. A process of daily reporting from the pharmacy IT system carried out by the Trust Medicines Management Unit allowed us to effectively communicate with the Trust pharmacy staff ensuring that we were aware of daily usage and delivery of critical stock. This list was informed by lists produced by other organisations and amended to take into consideration local usage patterns and clinical and pharmacy staff recommendations.

73. The reports required daily review in order to incorporate intelligence on large increases in usage. Orders with external suppliers were closely monitored and when necessary, any outstanding orders chased.

74. Whilst the Trust experienced no problems with renal equipment, there were shortages of renal replacement fluids, as well as anaesthetic agents, pressors and opiates. Some of these were managed by allocation from NHSE. However, as the Trust was continuing to treat non-Covid patients, some of these allocations were not accurate as they were based on our number of reported Covid patients. This resulted in negotiations between the Assistant Director of Pharmacy, clinicians, and the regional and national organisations involved in authorising allocations.

75. Daily counts of products on wards, theatres and specialist areas were introduced when any supply of product was severely affected. This information was entered into spreadsheets held in shared drives and monitored closely by pharmacy procurement staff.

76. A weekly briefing from the North East and North Cumbria Pharmacy Procurement Service was amended by the pharmacy department to include Trust details sent to the Trust Executive Steering group (Strategic Command attended by the Director of Pharmacy) managing the Covid crisis in the Trust. The weekly briefing document is provided in Exhibit LPC/03, INQ000477462.

77. A number of strategies were employed to maximise the use of available supplies in line with recommendations from national bodies including, NHS Specialist Pharmacy Services and the Royal College of Anaesthetists (This included “vial sharing”, a

practice that is not normally recommended given the single use licence of such medicines and a local SOP was put in place).

The use of the private healthcare sector

78. Although the use of the private sector was explored, due to the shielding guidance the Trust found it very difficult to transfer services to the private sector. The local private hospitals would not accept patients who had not shielded for 14 days, and this process made it very difficult to direct patients to the private sector for care.

Elective care:

79. The Trust did not pause elective services but rather reduced these, continuing to treat urgent elective patients throughout the pandemic period. The reduction in elective services was done for the following reasons:
    a. Initially in the first wave of covid to reduce the risk of elective patients being exposed to Covid, and
    b. to release staffed capacity to care for Covid patients both in critical care and in ward environments.

80. The overall volume of beds opened was impacted by staff availability, which was itself mostly driven by how many staff had Covid and/or were shielding and unable to be at work in the hospital environment. By way of context, prior to the Covid pandemic around 80% of beds were occupied by emergency patients and 20% of beds were occupied with elective patients. This 80:20% mix shifted to closer to 95%:5% at peak covid periods.

81. We do not believe that a higher volume of elective patients could have been maintained for longer as this was assessed and adjusted on a continual basis throughout the pandemic period. For example, in June 2020 the Trust was performing elective levels of activity that were around 50% what they would otherwise have been, with some service lines as high as 85%.

82. The decision to reduce elective procedures was taken by the Trust's 'Gold' Operational Executive Control Group (OECG), chaired by the Medical Director. This Group was attended by members of the Executive Team – including the Chief Operating Officer, Executive Chief Nurse, Finance Director, Director of HR, Chief Information Officer, Director of Quality and Effectiveness, and Assistant Chief

Executive – as well as key members of the operational and clinical leadership team – including the Director of Infection Prevention and Control – and met daily.

83. On review of the Trust's approach taken at the time, and whether any lessons could be learnt for the future, it is the Trust's view that overall, it would take the same approach. However, the Trust does consider that it would be better at re-introduction of non-urgent elective procedures by being more responsive, for example being braver about allowing covid positive patients who were well and asymptomatic to have their surgery undertaken and to maximise use of capacity by cohorting such patients together.

84. The decision to cancel non-urgent electives was taken at Trust Strategic Gold Command on 17th March 2020 and was effective from 18th March 2020. A reset, and recovery cell was commissioned by the Trust Strategic Gold Command on 11th May 2020 to begin looking at restarting the elective recovery program in a 'Covid-19 safe' way. The group began presenting restart proposals to Trust Strategic Gold Command on 21st May 2020. Clinical specialities were gradually stepped back up over the following weeks to June 2020 and I provide more detail in the paragraphs that follow.

Infection prevention and control

Classification as a High Consequence Infectious Disease (HCID) centre:

85. The Trust is a commissioned airborne HCID centre, with previous experience of treating airborne HCIDs. This meant that there was good familiarity with the PPE approach amongst our staff and the ability to rapidly refresh and scale up training when the first patients were treated at the Trust.

86. The unit has protocols and SOPs developed to deal with all aspects of treating a patient with a HCID including PPE, sample collection and processing, waste management etc. At all times there is an ability to activate the unit at short notice to manage patients with confirmed and potential HCID. The medical and nursing teams on the unit, as well as supporting teams from elsewhere, were trained to manage these patients.

87. Prior to the first COVID-19 patients being admitted to the Trust's services the medical and nursing team on the HCID were involved in the national meetings that were set

up to ready the HCID units across the country to receive the first patients with COVID-19. NHSE / NSID network would hold the minutes and the distribution list if it was considered that the Inquiry would like to obtain further information from them.

88. In January 2020, when the first patients were identified, the national HCIDU network met to determine where these patients would be treated. This was around 48h before we received the patients. The patient was then in Hull, having been transferred there from York (where he was a student) and had been travelling around the UK with their parents. The three of them were admitted to our HCIDU, one as a positive case and two as contacts. One of the parents was subsequently found to be positive.

89. Training was refreshed for all available staff that were initially going to care for these patients which ensured they were safe, competent and cascade training was rolled out as per our policy.

90. Due to the significant demand on staff and uncertainty about the likely clinical progression of the patients, the Trust reconfigured the infectious disease unit to allow staffing ratios to match the demand. A meeting took place the day prior to the patients arriving to discuss how preparations were going, ranging from stock levels of PPE to laboratory preparations, and a decision was made to follow the Trust's Pandemic Flu plan and policy.

91. Accepting the first patients allowed the Trust to gain clinical understanding of the disease process. These patients and the consequent patients managed in the early first wave were all clinically well.

92. The Trust's initial approach to providing care was driven by daily command meetings which generally worked well. The expertise from infection specialists, including those working in our HCID centre was appreciated and listened to. However, the work that was required of the centre leads in coordinating the national response through the airborne HCID network was significant.

93. It is also important to recognise that the airborne HCID network had not be designed with managing the early weeks of a global pandemic of a new infection in mind. The network design was based on an assumption of occasional sporadic cases (as had been the experience historically for contact HCID, i.e. Viral Haemorrhagic Fever).

Thus, it was very challenging for the network as a whole to plan, in real time, how to transition rapidly from looking after small numbers of cases in airborne HCID treatment centres, to an NHS-wide response to rapidly increasing numbers of cases. It did not feel that the government had planned in advance for this scenario.

94. It is also important to note that the frequency of meetings to determine placement of the first patients with COVID was demanding on clinical staff with additional daily national meetings and complex decision making. The unit was activated and took patients around one month before the first deaths from COVID-19 occurred in the UK. There were a number of significant issues with the management of these relatively well patients, not limited to:

a. Discharge protocols for covid patients had not been fully formulated and therefore there were significant delays in discharging the first patients. Testing was done twice daily to ensure the patients were negative before discharge. Testing was initially performed nationally at a testing laboratory, and this meant that it took days to get results back this increased delays to discharge

b. The first patients had no local accommodation and discharging was extremely complicated and required liaison with multiple agencies.

c. There was limited capacity within each HCID unit, including the Trust, to treat patients. At this stage the management of well patients was extremely demanding and required the constant presence of medical and nursing staff trained in PPE. Staff needed to be trained and brought in from other areas of the Trust to support this which put additional pressure on beds elsewhere in the Trust.

95. In late January 2020 to February 2020 the Trust's unit was covering a vast geographical area including the North East and Cumbria, Northern Ireland and South West England, with 2 patients transferred by aeroplane from the South West. Around the time of the first UK reported deaths the HCID networks were stepped down as Covid-19 was de-classified as a HCID.

96. Once Covid-19 was declassified as a HCID, the following measures were put in place:

a. Hospital management worked hard to quickly develop redeployment plans for clinical teams to increase capacity for medical management of in-patients with severe C19.

b. This was supported by a prompt move to write clear protocols and guidance to support non-specialist medical and nursing teams in all aspects of clinical management, which was initially in the absence of any evidence base for effective treatments. This started as a one-page guide for 'front door' assessments, expanding over several iterations to cover medical management, diagnostics, safe movement around the hospitals, palliation, etc. This was a risk assessment form that was built into the Trust Electronic Patient Record (EPR) which gathered vital information to ensure the safety of patients and staff on attendance at the hospital. A copy of this can be found in exhibit LPC/04, INQ000477463. This was also supported by an info leaflet for patients being discharged after an episode of Covid 19 that was fast-tracked for Trust approval and distribution. Care was taken with all of this to ensure that usual and adequate governance frameworks were in place, calling on existing committees for review and approval of all internally endorsed guidance along with convening relevant working groups drawn from appropriate clinical and diagnostic specialties.

c. Research was given a central role throughout, with the Trust making a major contribution to clinical studies and trials (ISARIC, RECOVERY and others) along with vaccine trials in due course, which continue to the present at the Trust. This activity fed back into clinical guidelines and protocols in that patients admitted at the Trust were protected from being exposed to unvalidated or untested treatments in an ad hoc way which have subsequently been shown to be futile or even harmful (hydroxychloroquine, ivermectin etc. etc.). In this way, when trial treatments were available a good number of the Trust's patients were able to benefit from these in advance of them being adopted as standard of care (e.g. dex, IL-6 inhibition, JAK inhibition, nMABs).

97. Finally, there was a specific episode early on where we were informed that an instruction had come from the Minister for Health that patients admitted to the RVI who had been on the Diamond Princess were to be kept in hospital and returned to Arrow Park in Liverpool. At that point they were negative and beyond currently agreed isolation periods and, according to agreed clinical definitions we were working

to at the time, they were safe to discharge to the community. The patients involved did not question this instruction, but had they done so, we would have had to return to the question of which legal framework we would be able to use to detain any given patient in hospital. This was an extremely stressful time for our clinical teams.

The use of national IPC guidance:

98. In January 2020 the HCIDU team developed an area to assess community patients that could potentially present to ED. This was in a portacabin building in the medical education centre, outside of the main hospital, which was usually set up as a simulation ward for medical students. This was very different from the national advice of what a "pod" should be because the Trust wanted an area where patients would be clinically assessed. The national guidance in this respect was that there should be an area with a phone where people with suspected covid could phone 111 from. Our departure from the guidance allowed the Trust to gain invaluable experiences on the use of PPE in ward-like settings, performing testing, packing up swabs etc. It was also very demanding on the team as the rota was staffed by the same people that were also covering the ward.

99. Whilst the Trust mostly followed national guidance, there was also interpretation which took place at the Trust, and therefore there were some departures from national guidance. Where the Trust did depart from national guidance, this is set out in detail within the paragraphs below, together with its reasoning for departing from guidance. Any departure from guidance was risk assessed and ratified by Gold Command.

100. Within the Trust there was visibility of senior staff and IPC teams and accessibility to advice 24/7. The Director for Infection Prevention and Control (DIPC) and senior Infection Prevention and Control Nurse (IPCN) leads personally briefed senior staff daily on changes to guidelines, concerns and also provided advice and reassurance to teams. Individuals could contact the IPC team or Trust's Test and Trace teams 7/7 and communication channels remained open and accessible to all.

101. Where possible, the Trust approaches were also shared at a regional and national level. This was through the regional NHSE IPC lead, the Shelford IPC lead group, Medical Directors Group and Directors of Nursing groups.

102. In the Trust's view, national policy did not always take into account the practicalities around implementation, nor did it consider real life scenarios. For example, when national policy was that patients had to be isolated for 14 days this did not consider that most patients are not admitted with COVID on day 1 of infection. We did our own risk assessments from that perspective, and subsequently this risk assessment approach became part of later versions of the national guidance.

103. Furthermore, it is the Trust's opinion that NHSE and NHSI failed to share good practice (and bad) across different regions in an effective way. Occasionally there was a hint of potential changes that could come up in the next iteration of national policy, but this was not always so. There were times when the Trust IPC Team were asked by regional NHSE IPC representatives whether a potential measure would be feasible on the ground, however feedback was seldom taken into consideration by NHSE. When we saw some of our own innovation reflected in national policy there was no acknowledgement.

104. Interpreting the guidance by staff members was not without challenges as teams wondered what the rationale for these changes were when there was a different approach from national guidance and there were examples of individuals challenging the Trust's decision making around a departure from national guidance, although any departure from guidance could be explained. For example, when porters asked why the requirement for gloves was removed the IPC Nurses were able to explain that as Covid 19 was a respiratory virus there was an importance of hand hygiene as well as providing education about respiratory spread.

105. Furthermore, specifically from a PPE perspective, our lead PPE practice nurse, who had just returned from completing a review of HCID units internationally, advised in January 2020 some changes to the national posters on the donning and doffing process. As the advice from UKHSA changed progressively the Trust assessed the need and appropriateness of donning and doffing processing for example the Trust also removed the requirement to use gloves for porters for the transfer of patients early on as this was seen as a potential mode for environmental cross infection. The Trust also maintained the use of visors longer in red and amber areas due to the higher risk of infection via conjunctival routes. Exhibit LPC/05,INQ000477464 provides an example of PPE posters and guidance.

106. There was also a Trust response to the combined Royal Colleges' position statement on aerosol generating procedures in theatres. The Trust had an approach to patient testing prior to elective surgery, a PPE process for patients undergoing dialysis, isolation of positive patients and staff isolation. Exhibit LPC/06, INQ000477465 summarises the Trust's response to the position statement on AGPs in theatres.

Furthermore, the independent advice that some professional bodies were providing, which was different and often in sharp contrast from national policy, was a real challenge which required a lot of time and effort to navigate. The Trust listened to concerns and adapted to what was pragmatic, possible and ultimately safe. Exhibit LPC/07, INQ000477466 provides an example of guidance issued by The British Association for Parenteral and Enteral Nutrition (BAPEN) as a position statement that Nasogastric and Nasjejunal Tube insertion (NGT and NJT respectively) are aerosol generating procedures, which was in contrast with what had been included on the national guidance and on UKHSA (then PHE) guidance on what constituted AGP. This is an example of how differences in opinion led to conflict in advice, in turn promoting worry, concerns and encouraging distrust on the "real world advice" that Infection Prevention and Control professionals were providing.

There were other similar examples where guidance coming from different professional bodies created confusion and even alarm. Each one of these posed a challenge which IPC teams approached with pragmatism and inevitably variation across the country.

107. For example, please see the Exhibit LPC/08, INQ000477467 national guidance for children with tracheostomies which conflicted with guidance from the British Thoracic Society (exhibit LPC/09, INQ000477476).

108. The Trust has reflected on its practices during the pandemic and whether it would change its practice should another pandemic present itself. In the Trust's view, the main learning points a future pandemic came from the challenges and we would, in the future, apply the following changes:

a. ensure that enough staff are trained to support the HCID after initial activation.

b. the process of de-centralising virology testing should be expedited as much as possible (allowing for limitations due to the need to validate tests locally in the absence of positive samples)

c. provide greater clarity about what hazard category laboratory samples are; and

d. PPE supplies need to be available both centrally and locally, ensuring the units have access to sufficient reusable hoods and respirators.

Use and staff understanding of IPC guidance:

109. Information regarding IPC guidance was disseminated generally via Trust wide communication emails, intranet page, posters (primarily in respect of PPE and isolation guidance), operational meetings (attended by all directorate managers and operational leads), matrons forums, directorate meetings and departmental meetings. On the 4th March 2020, the Trust established an easy access intranet site which housed all regular guidance updates in respect of Covid 19.

110. In addition, IPCN team met with bed management teams on a daily basis and when required more frequently to share guidance changes and to discuss the operational impact.

111. The IPCN teams also visited wards and departments to disseminate information across the Trust prioritising front line departments. The team were very aware that staff working directly with patients did not have the capacity to keep abreast of guidance via electronic means so communication face to face was a vital component of maintaining staff confidence in the changes being implemented.

112. The IPCN team increased staffing levels at weekends as there was reduced staffing out of hours to support senior management on call teams, to ensure front line staff had the support required in relation to new patient management decisions and that the test and trace service were supported by senior members of the IPC team enabling swift decision making. In addition, senior members of the IPCN team made themselves available at weekends to support the whole IPCN team.

113. Posters were developed giving visual aids to staff in relation to PPE and isolation requirements. These were distributed by IPCNs and displayed outside clinical areas

so that staff were reminded of what protection to wear when entering an area, as well as within clinical and non-clinical areas.

114. Assurance of compliance to standards were monitored via a Covid19 audit undertaken by IPCNs and in March 2021, the IPC Team rolled out the national initiative of Hands, Face and Space. This was a locally adapted programme that supported all areas of the Trust including non-clinical areas. It involved a checking system to keep all staff safe in relation to hand hygiene, mask use and availability and social distancing. This programme was monitored and was used to provide assurance of practice by members of staff, and thus also provided assurance in respect of the dissemination of information.

115. Early on during the pandemic there were national webinars led by NHSE and DHSC and this allowed teams to be alerted to what changes to expect in forthcoming updates made to the national policy, which would often come out on a Friday. The practice of these webinars and an element of pre-warning would allow the Trust a bit of preparation time ahead of the changes and to ensure that the Trust was able to react to changes. However, there was a notable change around May 2020 time when guidance was released without warning and at the same time or after a televised public update. Due to this approach, IPC staff would stay at work until the statement of change had been given which allowed them to review the guidance and make any necessary changes to existing or to agree to develop new Trust guidance during the weekend. During this time, the Trust's aim was to have new policies written by Sunday and then for these new policies to be ratified at Gold command meetings on Mondays ready for circulation Trust wide.

116. Changes and updates were accepted by clinical teams which was felt to be a result of the visibility of senior decision makers, ease of access to advice and communication, as well as on-the-ground presence of IPCNs

Difficulties implementing the guidance:

117. As a result of the additional work which was created, the Trust made pragmatic decisions on whether national policy changes were practical, necessary or significant, always prioritising patients and staff safety.

118. The introduction of universal mask wearing (15th June 2020) was challenging as there had been no time to prepare and there was very little notice to ensure the Trust

had enough masks. In addition, disseminating this information, particularly to visitors (patients and relatives), was difficult. This meant that staff would experience abuse and stressful conversations with relatives and visitors and there was much confusion for the public within a hospital setting.

119. Aerosol generating procedures required different levels of PPE. However, the evidence base on the definition of an aerosol-generating procedure was inadequate and guidance changed over time and so the Trust was required to review and adopt practices in line with the changing guidance.

120. The requirement to isolate patients, rather than adopting a risk assessment approach, changed several times during the pandemic and this was a challenge to maintain due to our limited cubicle availability. Ultimately although the national guidance set out the necessary requirement to isolate, the Trust implemented decision making on isolation based on risk assessment.

121. The national supply of PPE as a whole was felt to be unreliable. Supplies arrived on a Friday however it remained uncertain until the time of receipt of the pallet if all items requested would be received. Spreadsheets based on PPE use forecast were developed that enabled the Trust to track use rate of PPE in each area, to predict shortages in each area. At one point the Trust felt there may be a shortage of gowns. The Trust's sewing room were already supporting the Trust in developing a prototype gown using water-resistant material in theatre which was primarily used for wrapping sterile surgical trays. The seamstresses then committed to making gowns, but it was clear that these would never be enough for what we needed and therefore the procurement team actively sought to buy as much material as we could. Barbour subsequently offered to make gowns based on the seamstresses' prototype and with the same material, these were distributed across Trusts in the region.

122. The Trust's medical physics team made visors for our staff and then subsequently the Trust received offers from many members of the public and organisations to make these masks.

123. Community prevalence was used as an indicator for hospitals to escalate measures, yet UKHSA leaders in Newcastle did not make this information available to the Trust DIPC initially until August 2020 and it was not shared regularly until September 2020.

124. In addition, data was not readily available or shared in a timely fashion. For example, it was not possible for the DIPC to access data on other regions other than North East England on the TABLEU system or OUTBREAK system.

Limitations of the Trust's estate

125. The location / layout of wards meant that it was not possible to implement a one-way system meaning entrances and exits had to be the same route. It was very challenging and sometimes impossible to maintain red / amber and green pathways in some specialties given the layout of the hospital and this limited the availability of side rooms. Instead, priority was given to minimising the number of patient moves and cohorting areas. In Surgery the priority was to keep elective and emergency patients separate.

126. The Trust has a Ventilation Safety Group which was established long before the pandemic. This group receives data regarding ventilation in all areas in the Trust and provides assurance on all aspects of ventilation safety to the Trust board via the DIPC. This meant that the Trust had a good understanding of ventilation in all areas of the hospitals prior to the start of the pandemic. This supported some areas of the Trust to perform rebalancing of bays when a decision to change to Covid wards was agreed. There were known deficiencies in the ventilation of some areas and staff working in those areas were advised to wear certain PPE. This sometimes meant deviating from standard clinical guidance to protect staff members using a risk-based approach.

127. The infectious disease unit, for example, did not have cubicles that were compliant with the HTM standards for isolation cubicles and as covid-19 was a respiratory virus this was a concern. In paediatrics, this was also the case, and the necessary cubicles were notably absent in the paediatric intensive care unit. Other areas in the hospital were similarly challenged, however, being aware of the deficiencies enabled effective decision making regarding the placement of patients.

Testing as an IPC measure:

128. The Trust centre had a large numbers of asymptomatic staff signed up to the vaccine trials and SIREN studies. For the COV002 (the first Astra Zeneca study) 695 participants were recruited and SIREN 383.

129. PCR testing for staff was implemented by the Trust in November 2020 and LFT testing was widely implemented from 30th November 2020. The Trust developed an inhouse app to report the tests which enabled individual areas to monitor compliance with testing. Asymptomatic testing allowed the Trust to identify cases early, while continuing to rely on the symptomatic staff testing. Timing of when testing was completed was dictated by the national requirements set out by the Department of Health and Social Care and the availability of testing kits.

130. Asymptomatic testing policy using LFT was similar to national policy.

131. A decision tree algorithm for testing all patients with a significant travel history was available from 2nd February 2020. This enabled the Trust to identify patients who should be tested. The Trust was performing tests as a regional laboratory from 17th February 2020. An algorithm to test all patients presenting with a respiratory infection was available from 9th March 2020.

132. At the very early stages testing was centralised and thus there was a protracted turnaround time from testing to results, although it is the Trust's view that there was no significant delays in testing however this did cause a delay in results. In the initial stages tests were prioritised depending on clinical presentation and this prioritisation was developed as the criteria for testing broadened. The Trust established a testing "pod" which included staff who could clinically assess patients, which meant that patients could be clinically triaged for testing in the early stages. Later the Trust adopted a point of care test called LumiraDX which took 25 minutes and had good sensitivity. All patients that were admitted to hospital had a Lumira +/- which is a point of care testing device and then a subsequent PCR for confirmation depending on the result. Whilst the Trust implemented PCR testing in November 2020, the Trust did not establish blanket PCR testing of staff in some areas like other units did, a staff testing facility enabled contact testing for contacts of cases and symptomatic testing for symptomatic staff. This was due to concerns relation to the impact on workforce availability as a result of asymptomatic testing using LFTs.

133. The centralised approach to testing, caused logistical challenges early on the pandemic and later on hampered the wider understanding of local prevalence and incidence. Any global pandemic or national epidemic is made up of lots of local outbreaks even when we had a locally validated diagnostic test, which was fairly early on, we were required to continue using the national reference laboratory

service, which was quickly overwhelmed by numbers. At the very least, during the early part of the pandemic, this led to delays in moving patients through the system as we were unable to discharge patients who we knew to be negative on local tests, instead having to wait for the central test result which took longer and longer as the system became more stretched. A large commercial opportunity to develop centralised testing was pursued in favour of devolution to local task forces to mobilise PCR capacity in different sectors (uni labs, veterinary, research etc.) that could have given a richer epidemiological map much earlier as well as supporting local clinical services to move patients more quickly. This approach had been discussed originally as part of the testing resilience plan and was part of the response in Germany and other European countries.

134. Another aspect relating to testing and the implementation of testing was the very dogmatic UKHSA guidance which set out who could be tested. The Trust knew fairly early on from anecdotal experience and professional networks that the ski season in Europe and travel between UK and Italy/Spain/France/Austria were more important than Wuhan or SE Asian countries to the early UK epidemic, but we were stuck for too long not being able to access tests for the most relevant groups of travellers.

135. COVID-19 testing became available as an onsite test from 17th February 2020, these were local PCR tests at the Trust.

136. Some areas did weekly PCR for staff, but this was limited for the reasons explained in the sections above. The Trust also tested parents of children who required overnight stay in high-risk areas such as ITU or cancer wards.

137. Challenges and struggles remained for 3 years relating to staff, space, IT, testing platforms, kits and consumables. The Trust did not stop testing.

Responding to outbreaks of Covid-19

138. Identification of a potential outbreak was made by the Infection Prevention and Control Team (IPCT) and monitoring of electronic results. Every potential outbreak was investigated by an IPCN by visiting the area in the first instance. All potential outbreaks including staff outbreaks were discussed at a daily meeting with the then

Lead for IPC or Matron in her absence prior to declaration using a document titled Version 1 IPCN in patient Covid19 outbreak declaration.

139. On declaration of the outbreak the ward would be closed to admission and discharges (with the exception of discharge to patients' homes if the patient was well enough). The ward would also be closed to visiting with some exceptions. Covid 19 patients were isolated. All patients on the ward were screened for Covid19 and an outbreak meeting was called when a suspected outbreak was confirmed.

140. The IPCNs maintained daily contact with the area and visited all outbreak areas where feasible on a daily basis. IPCNs undertook an audit of practice in relation to the clinical environment on declaration of the outbreak. Non patient areas were visited. Updates on the ward outbreak situation were reported at daily patient flow meetings (meeting between IPCN, test and trace team and patient bed management).

141. The ward / staff outbreak would be monitored until closure and terminal cleaning had been completed. All outbreaks were reported nationally via Sitrep and on the newly launched Outbreak national database, 7 days per week as advised by NHSE. The total number of staff and patient outbreaks was 110. The length of time that a ward would be closed would be dependent on the monitoring in place, the cleaning of the ward and the ability to reopen the ward.

142. Outbreaks and themes emerging were presented at the weekly meeting with regional IPC leads, sometimes attended by regional NHSE representatives. This purpose being to share support and advice and shared learning themes from other regions.

143. The Trust followed national guidance in relation to the criteria for outbreak declaration until 30th March 2022. At that time the Northeast ICS COVID meeting agreed to reduce the outbreak duration to 10 days in line with the changed national reporting timeframe for care homes. It was also agreed all IPCTs could define an outbreak at a local level rather than adhering to the national definition of 2 connected HO.pHA/HO.dHA.

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

144. It became apparent during the period 20th March 2020 to 31st March 2020 that the NHS Supply Chain could not meet the increasing demand for PPE and so the Trust started to purchase some stock locally from known suppliers. All PPE with the exception of examination gloves were then moved to the 'Push' allocation strategy around this time.

145. In the run up to Easter 2020 push deliveries and the allocation of PPE to each Trust, across the Region appeared to have no real logic. We were very fortunate in that a combination of locally sourced, push stock (including National Supply Disruption Response (NSDR) requests for gowns), in-house production and donations from industry supported the Trust through what was a particularly challenging time over the Easter weekend. As an example of the illogical allocation, the Director of Finance from a neighbouring Trust collected 400 gowns to get that particular Trust through the weekend prior to Easter which then resulted in Newcastle having to raise an NSDR the following week to ensure supplies were available throughout the Easter weekend.

146. The Trust's understanding was that an allocation of PPE was made using the stock position provided by each Trust to NHS Supply Chain but that this could then end up being either reduced or cancelled at a daily review meeting which was conducted by the National NHS Supply Chain. To this date we do not know what intelligence/information was being used to make those decisions as to the allocation system. The positive was that emergency requests through the Emergency Request System were usually fulfilled and therefore the system was effective. Emergency requests usually came about due to either, a surge in demand (sometimes due to new national guidance of when to wear PPE) or the allocation being too low to meet demand.

147. The Trust also helped several local GP surgeries on at least two occasions during this period with PPE and had to turn others down. Every request for mutual aid went through our Silver Command for agreement with a stock status report provided to aid their decision-making process.

148. The IPCT would review the integrity and appearance of masks when a new batch arrived and would advise that it was acceptable or rejected for use in clinical areas. Any occasions where the Trust received unsuitable PPE was reported to the NHS Supply Chain in accordance with policy. For example, it was never agreed to use the

valved FFP3 masks as it was evidently clear that the valve masks protected the wearer but not the patient. There were also many occasions when Type 2 masks would not be used because there were concerns about integrity.

149. There were also times where a batch of Type II mask was delivered instead of IIR mask and there were several recalls of IIR mask which were found to be more Type II than IIR. This is important because the difference between Type II and IIR masks is their fluid resistance and degree of impermeability, which is a protective property for the wearer. There was also one incident reported on the Datix risk management system relating to black sticky residue found on gloves when the box was opened. The Trust also received Aprons that tore easily due to the perforations not being there when tearing them off the roll.

150. There was also a requirement to fit test for FFP3 masks. There were known issues with the reliability of supply of certain brands of FFP3 masks and due to the unreliable supply of certain brands of FFP3 masks, individuals would have to be re-fit tested to whichever brand was available.

151. Overall, the Trust maintained good stocks of PPE throughout the pandemic, but this was due to the Trust Procurement Team purchasing stock rather than reliance on the supply chain. Even then, there were a couple of times when the Trust were very close to running out such as during the Easter Bank Holiday 2020 where there was only one box of FFP3 masks for the entire Trust.

152. A dashboard was created with the "PPE burn rate" of each area, and a forecast of when those areas would run out. This was a really useful tool developed by the Procurement Team at the Trust and influenced the Trust's decision making.

153. Until April 2020 pandemic the Trust did not have enough masks to be able to provide these to patients. This was a particular concern for renal patients who were identified as high risk of mortality. When a stock of masks became available these were then made available to patients and visitors.

Visiting Restrictions

154. The Trust's internal visiting policy was updated on 12th March 2020 to indicate that vulnerable people should not visit COVID positive patients. In April 2020 the first iteration of the Trust's visiting principles was issued. This was reviewed several

times throughout the pandemic. Exhibit LPC/10 **INQ000477477**, LPC/11 INQ000477478, LPC/12 INQ000477479, LPC/13 INQ000477482, LPC/14 INQ000477483,LPC 15 INQ000477484 provide examples of the changes to Trust visiting principles.

155. In respect of children, it was determined that they could have one parent staying with them or two if they were end of life, with siblings also being able to visit in special circumstances for example where end of life care was being provided. Women in labour could have a partner with them although partners did not stay overnight.

156. Other exceptions were discussed with the DIPC at the time, and overall, there was a pragmatic approach whilst trying to protect the visitors. The Trust did allow parents of covid positive children to stay with their child and also allowed covid positive parents to stay with their covid positive children on the ward, whilst the ward staff would enable isolation.

157. The neonatal unit stopped cuddles with babies, which was restored once it was realised there was no logical basis to this. Positive covid mums were allowed to see their babies in SCBU from May 2020.

158. In critical care, staff always tried to maintain a balance between minimising the risk of infection and allowing reasonable visiting, particularly at the end of life. Visiting restrictions certainly added to emotional distress for patients and their relatives. Practice around visiting and precautions taken for visitors to intensive care evolved as guidance changed and understanding of the disease and the risks of transmission improved.

159. To help ensure we took all views into consideration in respect of visiting restrictions, a task and finish group was developed, which comprised of a multi-disciplinary team to help ensure any changes implemented had the minimum impact. The Trust also implemented virtual visiting and provided wards with I-Pads so that family members were able to book a virtual visit at their convenience. We also, encouraged patients to bring in their own handheld devices and provided information on how to connect to the free Wi-Fi within the Trust.

160. The Trust also implemented keeping in touch email addresses where family members could send photos, poems and letters to their loved ones in hospital. We also provided free outgoing telephone calls made from the bedside units.

161. All efforts were attempted to implement adjustments for example: wheeling patients out of the hospital in their ICU beds, and specifically, staff supported a young adult who was in PICU with covid to be visited by the family pet dog and her school friends and a patient with dementia and his relatives were supported to stay (1 at a time) 24/7.

162. The Patient Experience Team contacted wards on a regular basis to discuss how the visiting arrangements were being received and whether any further action was necessary. Patients and visitors understandably were distressed that they were unable to visit as they would have normally been supported to but did understand the reasons for the restrictions. Information was shared on social media, the Trust website and with voluntary organisations for wider dissemination. Having reflected on the processes we adopted at the time, the Trust is confident the measures implemented were the least restrictive possible in the context of trying to keep patients and staff safe whilst maintaining confidence in the patients and population we were providing services to.

Maternity services:

163. In response to the COVID-19 pandemic, the Maternity Service developed a revised Business Continuity Plan (BCP) to include an Operational Response Framework and comprehensive COVID Bundle. These documents provided the necessary guidance to ensure that both staff and patients were protected, risk identified, and mitigations put in place where necessary. Exhibit LPC/16 INQ000477485, LPC/17 INQ000477486, LPC/18 INQ000477487, LPC/19 INQ000477488, LPC/20 INQ000477489,LPC/21 INQ000477490, LPC/22 INQ000477491, **LPC/22a** INQ000477492,LPC/23 INQ000477493, LPC/24 INQ000477494 provides examples of these documents.

164. In relation to workforce planning the following actions were taken to maintain maternity services to a safe level:

a. Revision to clinical workforce plans aligned to BCP and Operational Response Framework, including internal escalation, environmental closure, and redeployment of staff. Exhibit LPC/25 INQ000477495, LPC/26 INQ000477496, LPC/27 INQ000477497, LPC/28 INQ000477498, LPC/29 INQ000477503 provides examples of this in practice.

b. Creation of a Senior Midwifery role to continuously monitor beds/patient flow within the Department.

c. Process implemented by the Trust for escalation to Trust Gold Command/Executive Directors, with daily meetings to discuss operational pressures.

d. Statutory reporting to regional and national teams continued throughout to provide regional and national oversight.

e. Changes to learners accessing clinical placement time within the Department in conjunction with HEI's. Removal of learners was a protective measure for the learners due to the unknown ways in which the Trust was working in response to the pandemic. The Trust did not feel that this impacted on workforce capacity. Exhibit LPC/30 INQ000477504 provides further information relating to what this meant in practice. The Covid-19 placement guidance ensured that guidance was provided to students in relation to the covid-19 emergency pathway that impacted the Trust wide isolation capacity. The guidance gives a clear process on the management of inpatient admissions with a rag rating system, blue: confirmed or highly suspected case of covid-19, amber: status unknown- now that everyone requires a swab and green: patients who are shielding. The guidance then goes to provide guidance on admitting patient to wards based on the rag rating criteria.

165. Revised SOPs were developed for a number of key areas including:

a. Outpatient Triage

b. Inpatient Triage

c. Change to method of managing outpatient appointments, including the offer of virtual and telephone appointments where possible (both acute and community)

d. Revision to discharge from hospital checklist to direct post-discharge care with options for non-face to face follow up for some appointments

e. Revision to inpatient pyrexia and the deteriorating patient SOP and flow-chart

f. Revised guidelines for anaesthetic management of confirmed or suspected COVID-19

g. Obstetric Sonography – SOP and framework implemented with reduced scanning through a process of triage whereby workforce issues impacted the usual nationally recommended timeframes – time defined scans prioritised

h. Creation of SOP for COVID testing in line with national recommendations. The testing of patients evolved from lab based LFT to point of care for those assessed as high risk requiring an urgent result, for example, women accessing intrapartum care or those symptomatic.

166. In relation to PPE, the following measures were taken:

a. PPE closely monitored at corporate level to ensure that staff and patients accessing the Maternity Service both within the acute and community areas were adequately protected.

b. Face mask fit testing for all staff undertaken.

c. Appropriate PPE provided for aerosol generating procedures.

167. In respect of Statutory Reporting the following measures were taken:

a. Compliance with national and regional statutory monitoring and reporting requirements.

168. In respect of visiting which took place within maternity services, the following measures were taken:

a. Changes to visiting arrangements aligned to national recommendations for Maternity Services and my statement describes the local practices in more

detail in the preceding sections to include adopting plans to ensure that partners were able to remain with women in labour at all times throughout this period.

b. Restrictions on visitors in place aligned to the constraints of the estate within the Department

169. Communication with service users through Maternity and neonatal voices partnerships (MNVP).

Ambulance handover:

170. We do not hold comparative information on ambulance handovers during the relevant period of the pandemic. A new NHS England report on this data was introduced in October 2023.

171. By way of overview however, in terms of increased waiting times in A&E for patients to be admitted, there was generally an increase in ambulance handover times due to busyness of staff in the A&E department and physical space constraints with the department being relatively small compared to other A&E departments with similar volumes of patients. Relative to other trusts, the Trust has been consistent with lower waits for ambulance handover due to the ways staff in the department worked and prioritised ambulance handovers. We were however the subject of some media coverage such as the BBC on line news report of 21st October 2021. Exhibit LPC/31 INQ000477505 provides a copy of the news report.

172. Action was taken nationally, regionally, and locally to reduce ambulance handover delays in line with the national action addressing ambulance handover delays from NHSE and NHS Improvement dated October 2021 and regional North East and North Cumbria ICS Ambulance improvement plan 2021/2022. Key steps taken within the Trust were consistent with the national Urgent and Emergency Care (UEC) 10-point plan published by NHS England on 22nd September 2021 to reduce handover times. These measures included investment and recruitment of additional staff, strengthening of same day emergency care services and flexing elective ward capacity to care for more emergency patients.

Escalation of clinical care and the use of ventilation

173. Concerns were raised by the Trust Lead Emergency Planning Lead to national leaders in Intensive Care Medicine (ICM) on 10th March 2020 regarding the likelihood of requiring triage for ICU admission and requesting clear clinical leadership in the absence of a national decision-making tool for rationing care.

174. Subsequently, work completed at national level (including by Chief Medical Officers) was felt to be too vague to help and reassure front-line workers and decision makers. This was of sufficient concern that the North of England Critical Care Network approved a regional document for clinicians involved in the decision making. A version of this document was first drawn up several years previously for use during the Ebola outbreak in West Africa. The document was broadly similar to subsequent national guidance from Intensive Care Society (ICS) Faculty of Intensive Care Medicine.

175. The Trust Lead for Major Incident Planning, along with one of the Trust Associate Medical Directors and Professor Andy Fisher, (Professor of Respiratory Transplant Medicine and Honorary Consultant Chest Physician) worked on developing a triage tool that could be used in real time to aid clinical staff. This was based on an organ matching computer programme that Professor Fisher was using for optimising matches of lung transplants-recipients. This was in addition to national work on the subject. Exhibit LPC/32 INQ000477506,LPC/33 INQ000477507,LPC/34 INQ000477508, LPC/35 INQ000477509, **LPC/36 INQ000477510 provides copies of the** regional document, the critical care document, the ICU triage tool and the aid memoire. The regional document and triage tool were never used in practice by the Trust as CRITCON 4 was never reached throughout the pandemic.

176. The Trust's Clinical Ethics Advisory Group was initially sighted on the wider debate relating to the triage tool, but subsequently (early 2021) as a discrete project dealing with this topic. Initially there was an Ethics team 24/7 rota to facilitate discussions and help decision making when needed.

177. There were a number of drafts of ICS/FICM guidance, especially after the issue of frailty /disability was raised.

178. A high number of Treatment Escalation Plan (TEP) decisions that would usually be devolved to Critical Care review were made by front of house staff and many patients

who would have been referred (and possibly admitted to ICU for a trial of treatment) received ward-based care instead.

179. The Trust did not use any decision-making tools based around equitable access to limited resource as there was never a need to restrict access to critical care for patients who staff felt would benefit from this. Many patients were declined admission to critical care on the basis of clinical futility. By clinical futility we mean that some patients were not admitted to critical care as at the time of review they were deemed to be unlikely to benefit from organ support. Within the Trust, these assessments were not different from our assessments outwith covid, as we were never in a position where we were resource limited. Such assessments are multifactorial, it would encompass the patients presenting condition, its reversibility and its prognosis, any other existing medical issues and their progress, the level of functional capacity/limitations that may be pre-existing and the patients values, beliefs and wishes related to medical treatments and their outcomes. The criteria used in coming to these decisions did change over time as clinical experience developed and new evidence and treatments emerged. Criteria for admission to critical care remained the same as they were prior to the pandemic, namely clinical utility.

180. The Trust has a 24hr Critical Care outreach service, which also operated during the pandemic, following a set of clinical criteria that should be referred for critical care support.

181. Ventilation is a non-physiological estate which means that although it replicates the function of breathing, it does so by means which are not the same as what happens naturally, and this can cause problems too. For example, it requires a plastic tube to be placed down the throat of a patient which can serve as a conduit for infections as it is a foreign object.

182. The use of a ventilator can be harmful (eg ventilator associated lung injury and ventilator associated pneumonia are well described examples of additional risk). In the Trust there was early admission of patients with severe covid to ICU not necessarily to be ventilated but to provide CPAP and NIV support. This was particularly so during the first wave. Patients in the third wave that had not been vaccinated or had immunological poorer responses to the vaccine did worse.

183. The Intensive Care National Audit and Research Centre (ICNARC) data shows that the mortality rates at RVI in wave 1 national mortality ICU = 39.4%, this is the same time frame as the Trust wave 1 (19.3% for RVI), wave 2 national mortality ICU = 37.5%, this time frame covers the Trust wave 2 and wave 3 (20.1% and 26%). The Trust local combined data waves 2 and 3 reported the composite Mortality (RVI ICU) was 87 deaths / 362 patients = 24%.

184. In relation to the use of CPAP/NIV in critical care, it is true to say that practice evolved very rapidly particularly during wave 1 of the pandemic as a consequence of rapid dissemination and sharing of experience. The Trust had time to prepare for two reasons (1) reducing non urgent elective work early and (2) because the North East of England were approximately 2 weeks behind the initial wave of Covid.

185. As a large research centre, there is huge advantage to the Trust in having HCIDU expertise as well as on site ID, microbiology and virology expertise to advise 24/7. As a large research centre, the Trust also saw benefit from early communication regarding the latest outcomes from national or international research studies which were integrated in our guidelines very early on.

RESPECT forms and DNACPR

186. Practice within critical care around DNACPR and escalation of care decisions during the pandemic aligned with practice before the pandemic. Practice did not change and remained aligned to pre-pandemic practice.

187. ReSPECT forms were not in widespread use during the pandemic, but Emergency Health Care Plans (EHCP) were used.

188. At the onset of the first wave of the pandemic, a number of geriatricians and community staff worked to identify patients in care homes at high risk of admission to establish their wishes and, where appropriate, to ensure these were documented in an EHCP. This was an extension of existing work that had been ongoing pre-pandemic. There was also regional clinical guideline that was drafted by a number of senior clinicians and evolved over time due to learning, which was taking place during the pandemic, which covered modes of respiratory support as more evidence became available and escalation decisions.

189. The section of escalation decisions is as follows in version 1.0:

"*All resuscitation decisions being made for patients admitted to hospital with COVID-19 must be reviewed by the consultant responsible for each individual patient. Escalation decisions will take into account pre-morbid performance status and frailty. Due to the anticipated volume of patients, we ask that front line clinical teams habituate themselves to taking a uniform approach to these assessments. This means familiarising yourself with, and using, the validated NHS Clinical Frailty Scale, and incorporating this into any initial patient assessment and clerking. Please see the appendix of this document for full details*".

190. Any advanced wishes expressed by a patient would be taken into account and whether to offer any intervention was and is based on the likelihood of restoring an individual patient to a quality of life they would find acceptable. A DNACPR notice in itself does not preclude other modes of organ support, but organ support is used in the context of extending and preserving quality of life.

191. At the Trust DNACPR notices form part of the patient electronic hospital record. No concerns were raised within the clinical teams to my knowledge that any DNACPRs notices were issued to anyone with protected characteristics, nor were any concerns raised that patients were arriving at the hospital with DNACPR notices that did not appear to be clinically appropriate. Furthermore, we did not observe increased numbers of patients arriving with DNACPR notices in their notes.

Guidance on the use and communication of DNACPR decisions:

192. Guidance was issued on the use of DNACPRS as outlined above but staff were also supported by a palliative care 'cell' who supported staff with challenging communication and end of life care.

Unequal impact on patients

193. The Trust does consider that there were a number of issues which the Trust faced which meant that there was an unequal impact on patients across the Trust and through the services which it provided. These are set out in more detail below:

a. There was a lack of available face to face interpreters and the nature of the restrictions which were in place that could not allow for face-to-face interpretation. Services had to utilise telephone interpretation significantly more compared to pre-COVID. This had a higher impact for Deaf patients where face to face interpretation is the best form and the Trust did not have suitable access to on-demand video interpreting for staff to use. This has been addressed by the Trust and devices are now available, but they were not implemented until January 2023.

b. Significant numbers of appointments were rescheduled as telephone appointments rather than face to face appointments. Many deaf patients were provided telephone appointments due to them not having flags that they are deaf and unable to take telephone calls. These patients had to have appointments further rescheduled as face to face appointments which did cause a delay in them accessing services.

c. The Trust were unable to access a sufficient number of transparent masks, meaning deaf and hard of hearing people who relied on lip reading struggled with communication.

d. Wards had limited access for unpaid carers, which impacted patients more who needed their family member/friend to support with personal care needs. This potentially impacted the disabled and elderly more.

e. Birthing partners had limited visiting access for their partners who were pregnant. Birthing partners would have to wait elsewhere and would be called by staff to come into the department when necessary.

f. Information was changing constantly and quickly, which was not always available in accessible formats. This impacted patients who have communication needs due to a disability including deaf, blind and people with learning disabilities.

g. Patients who required certain cultural or religious observations with family or a member of a particular faith, particularly at end of life, may have gone unseen due to visiting restrictions.

h. There were issues with understanding COVID testing requirements before coming into hospital, which was more apparent with people who did not have English as a first language or those with low literacy.

194. In addition, transparent masks were considered to promote communication and visibility however these were not endorsed by NHSE and therefore were not rolled out in our organisation. Risk assessments were undertaken to review when staff should remove masks (when safe to do so) in order to facilitate communication with patients, whilst, for example, maintaining a distance in a well-ventilated room.

195. Whenever possible hoods were utilised, although this was not always practicable because the Trust did not always have enough hoods for the entire team. Hoods are transparent and therefore do not obscure the face. For these to be practicable in this setting (i.e. to be useful to someone who lip reads) they would be required to be worn by the entire team. This was not possible as there was a limited supply of hoods that needed to be worn by other people (eg people that fail fit testing) and therefore the use of such items had limited impact on patients.

Cancer surgery and treatment:

196. The Trust was able to maintain cancer surgery and treatment during the relevant period and set out below are the ways in which the Trust achieved this. The response has been separated into Radiotherapy and Chemotherapy along with specific reference to the Prostate and Breast Cancer clinics, as the actions were independent of each other, although there were some overlaps.

Radiotherapy:

197. The following measures were put in place and demonstrates how the Trust was able to maintain its Radiotherapy services to patients:

a. Triage call to patients 24 hrs before treatment due- testing if symptomatic in department.

b. Remote consultation process introduced with electronic consent where possible.

c. Face to face clinics and reviews by exception only.

d. Immobilisation device changed to reduce number of patient visits; Immobilisation devices are tools used to help patients stay in the same position when receiving radiotherapy treatments.

e. Patient who attended via their own transport would call from the call park to make sure on time - arrive only 5 mins before time.

f. Covid positive patients treated where possible in guidance with national policy- aimed to treat at end of the day to enable appropriate cleaning of the machines.

g. Reduction in fractionation for some patients to enable fewer patient visits and maintain capacity. Biggest impact on service was reduction in breast and prostate fractionation see below.

h. All sites were reviewed, and many fractionation changes made. All benign work was suspended.

Prostate Cancer services:

198. In respect of Prostate services, the Trust implemented the following measures:

a. March 2020
- Prostate on treatment re-planned for longer treatment gaps where clinically appropriate
- All new referrals for prostate only cancelled.
- All new referrals for prostate + Lymph node cancelled.
- All prostate brachytherapy treatments stopped

b. April 2020
- Restarted new patients less than 70 years of age

c. May 2020
- Regional Network meeting to agree new urology protocols
- Some low risk and low- intermediate prostate patients to receive prostate SABR (former trial arm of PACE) - reduction in fractionation from 20# to 5#

Chemotherapy:

199. In respect of Chemotherapy services, the Trust implemented the following measures which enabled services to continue:

a. Re-allocation of subcutaneous /oral patients to outpatient clinics – this was originally a Covid measure, but this has now become standard practice which has proven beneficial to both capacity and the patient's receiving treatment. This includes NCCC outpatient department and community clinics.

b. Restructuring of pre-assessment clinics which were initially 2 part to a single visit to include bloods, pre-assessment checks and a video explaining the treatment and processes plus follow up.

c. Screens were put in place between chairs to provide distance without having to reduce physical space, this resulted in a reduction of 2 chairs due to physical space constraints but was an effective deterrent against Covid infections.

d. Option for patients to be accompanied by a family member/friend/carer whilst in the chemotherapy unit was removed.

e. Waiting area made Covid secure with appropriately distanced sitting and companions requested not to wait whilst patient was on treatment in this area.

f. Some regimes were reviewed and paused during Covid where the % of remission was less than the % of death if they contracted COVID whilst immunocompromised.

g. Chemotherapy regimes were reviewed such that some previous inpatient regimes became long day case regimes – this has been adopted as best practice in the period after the Covid pandemic.

h. Inpatient Wards at NCCC took day cases where they had spare space to be treated in a cubicle if patient was suspected or confirmed as being Covid +. Lumira testing machines were introduced to confirm patient status in the chemotherapy day unit as well as 2 of our inpatient wards.

200. In addition to the above changes to the radiotherapy services and chemotherapy services, two lower floors of the multi storey car park opposite the cancer centre were

changed to be for cancer centre patients only. Patients were allowed to park free of charge and phone the radiotherapy/chemotherapy unit to advise of their arrival. They were asked to remain in the car until phoned and told to come into the cancer centre where they were met by a member of staff at the main entrance and escorted to their treatment venue. Therefore, reducing time in the hospital and reducing and mitigating the risk of Covid infection whilst at their appointment as well removing potential barriers to treatment by making parking free.

The establishment of the long covid clinic:

201. Initial discussions in the Trust regarding a covid follow-up clinic were held in Summer 2020. This pre-dated the emergence of the 'long COVID' concept and there was initially anticipated to be a significant need for follow-up of patients with significant post-inflammatory lung injuries along with post-traumatic support for patients who had been escalated to level 2 or 3 care, including those who had been sedated and ventilated.

202. Initial planning was between an MDT drawn from Respiratory Medicine, Critical Care, Infectious Diseases, Physiotherapy and Health Psychology, with representatives from all of the listed Trust specialties contributing to the clinics. The clinics initially ran on a 'carousel' model, whereby attending patients would be able to see a physician, a physio and a health psychologist all on the same visit, as well as completing investigations including pulmonary function tests.

203. Initially the clinic was held on an ad-hoc basis and was commenced on 16th June 2020 to review patients discharged from hospital and more specifically from ITU. In around about September/October 2020 a weekly clinic was established due to the numbers of patients affected.

204. The clinics have to date been funded out of a central 'COVID' money pot from NHSE. However, it is important to note that the budget provided to the Trust for the covid clinics does not meet the costs of running the service and additional funds were required from the Trust.

205. At present the Trust's covid clinic is funded until 31st March 2024. During April 2024/5 funding will come from ICB rather than NHSE. The Trust is currently awaiting details from the ICB about how much this funding will be and how this will affect the service that the Trust currently provides.

206. The clinic is staffed by the following individuals

a. 1x Post Covid Nurse Specialist
b. 2 x advanced physiotherapist
c. 1 x occupational therapist
d. 1 x physiotherapist assistant
e. 1 x clinical psychologist
f. 1 x admin

207. From the commencement of the service, the following data has been collected in respect of the number of individuals that it has supported:

a. received 2524 referrals (all accepted, this doesn't include redirected or inappropriate referrals)
b. reviewed 1274 patients face to face which equates to 50.4% of referrals.
c. discharged 1250 patients
d. 285 patients who have been referred into the rehab team, 28 declined and 257 patients seen.
e. psychology have seen 329 patients referred for 1:1 psychology therapy in Psychology
f. 244 referred into sleep CBTi group (total 573)

208. The service was open to referrals from GPs and other specialists as well as patients being discharged from the Trust after an episode of COVID, with this being part of the default discharge arrangements. The patient must be a Newcastle resident – any out of area (OOA) referrals are re-directed.

The effect of the pandemic on staff morale and their physical and mental wellbeing:

209. In the earlier sections of this statement, I have described some of the effects of redeployment on staff morale and I do not repeat all those comment here. In order to try to minimise the impact of the pandemic on staff members and to promote their physical health and mental wellbeing the Trust undertook and encouraged a number of initiatives.

210. These initiatives were as follows:

a. Agile/flexible/home working.

b. Covid risk assessment including guidance on starting a conversation about ethnicity.

c. Strategies to assist with the physical health of staff including, virtual pilates / workout classes, the establishment of a Strava group, the opening of a staff gym, the drafting and implementation of a health and wellbeing policy and the implementation of a Trust health and wellbeing strategy.

d. 'Covid Secure' workplace/environmental assessments.

e. The implementation of social spaces for members of staff including a staff social club and virtual common rooms.

f. Support from other specialties within the Trust including clinical psychology support counselling support, chaplaincy support, mental health first aiders, wellbeing champions and Occupational Health.

g. The commencement of staff networks and schwartz rounds which provided a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.

h. The implementation of a number of support services including - bereavement in the workplace guidance and support, guidance to support 'shielded' staff and return to work planning, safeguarding children support, safeguarding adults support and domestic abuse support.

i. cultural ambassadors.

j. F2SUG (Freedom to Speak Up Guardian) Services.

k. Guardian of Safe Working Hours.

l. speak in confidence system.

m. support for staff in respect of finances including a credit union, money mentors, enhanced overtime payments, arrangements for early access to a proportion of monthly pay, free car parking, thank you included £100 and an extra day annual

leave, on-site nursery stayed open, free/discounted hotel accommodation, discounted travel pass for public transport, free food/meals, salary sacrifice schemes and the implementation of a retire and return option for members of staff.

n. Citizen Advice Bureau ('Helping Hands').

o. pulse survey.

p. Our NHS people wellbeing mental health hotline.

q. 'your covid recovery' rehabilitation.

r. The implementation of strategies around annual leave and sickness absence including - selling annual leave process/policy, relaxed restrictions on annual leave carryover, Covid-related sickness absence not treated as sickness for occupational sick pay purposes or managing attendance special leave policy, and daily monitoring of sickness absence and Covid data.

s. Information sharing within the Trust including clinical briefings, formal debriefings, staff huddles, 'wobble' rooms, weekly workforce cell meeting on Covid issues, virtual 'town hall' sessions with experts to build confidence regarding safety and efficacy and weekly e-briefings for all staff.

t. Headspace.

u. The implantation of schemes associated with covid and the covid vaccination vaccination programme including a staff vaccination programme E-induction for all new staff ensuring informed about covid, risk assessments, Covid testing, vaccine, etc.

v. Togetherall mental health and wellbeing service.

w. ICS wellbeing hub, redeployment arrangements in place.

211. As set out above, there was a great deal of work undertaken by HR, Staff Side and managers to reassure staff about the support which was available to them and the

initiatives which were in place. Teams Forum were open to staff with HR, Staff side and Clinicians to answer questions.

212. Covid 19 risk assessments for staff were implemented for BAME staff in May 2020 and for all other staff in July 2020. These risk assessments (as set out in the section above) were co-produced and implemented in partnership with the Covid Workforce Cell. No specific concerns were brought to the attention of the Trust about the use of, or implementation of these risk assessments.

213. Team meetings were organised with departments to clarify specific queries. The DIPC and Medical Director attended weekly BAME network meetings to help clarify queries and concerns regarding specific risks associated with protected characteristics of staff members.

214. Throughout the relevant period, Equality Impact Assessments (EIAs) continued to be carried out, although the Trust did not carry out specific EIAs in respect of covid or IPC guidance. As such it does not hold specific data on these points to be able to share it with the Inquiry. It should also be noted that no issues were identified or raised with the Trust in relation to unequal impact of measures.

215. Furthermore, Trust policies routinely include an Equality Impact assessment, and these continued during the pandemic and beyond.

216. On discussion with Staff, staff felt that hospital management were extremely responsive to requests for resource, listened to the needs of the clinical services and were willing to devolve decision making to those with front-line expertise. In particular, the re-development of a ward as a new critical care isolation facility was a major project which was agreed, planned and delivered in a very short timescale, in a way I had never experienced pre-pandemic.

217. However, there was a requirement to update all outbreaks on the national database daily (7 days a week) and for a daily reporting with DIPC sign-off of all new hospital covid cases (7 days a week). The additional work that this created meant that the personal toll on individuals was significant.

Recommendations:

218. The Trust has considered the Inquiry's wish for proposed recommendations or points of learning in respect of how hospitals should respond to a future pandemic. The Trust would like to comment as follows:

a. There should be a clear requirement for training and time must be given to allow key members of staff to train. Management of HCID is complex and training is key to managing these patients well without transmissions.

b. There needs to be early recognition of the limitations of HCID units in the context of a pandemic as they will quickly become overwhelmed.

c. There is a lot of pressure on a Trust with HCID specialism early on in a pandemic, while trying to maintain services. This is because there is requirement to set up testing facilities, develop laboratory systems for testing, treat and manage patients and prepare for the pandemic. The people doing this are those who will also be involved in the management of patients at a Trust and will be involved with early preparation for the pandemic. This should be recognized early, and mitigations put in place to allow time to be given to these preparations.

d. Consideration of pathways of admission into hospital is the key to getting it right.

e. Early testing of staff and patients is critical and requires rapid adoption of testing in hospitals with rapid de-centralisation for testing as soon as is practicable.

f. Rapid development of guidelines is important to cover the following key area- admission, any treatments that become available, use of oxygen, PPE, escalation etc. These may need to be developed within the Trust and applied as Trust only documents as the national guidelines are often disparate and not integrated. It is important as clinicians are recruited to access and treat patients, they have access to comprehensive and clear guidance. There also needs to be mechanisms to disseminate these effectively across the organisation.

219. The Trust would also have the following recommendations in respect of managing a pandemic at a national level in respect of healthcare:

a. A future pandemic may be more or less lethal, and it is also possible that it may also involve a more transmissible pathogen. The ability to provide all Trust staff with PPE early is key. This may involve stockpiling of PPE including FFP3 masks and the development of manufacturing facilities within the UK.

b. Changes to national emergency planning guidance have since moved towards an all-hazard pandemic planning approach and the Trust has updated its protocols based on this and internal learning from the COVID pandemic response. These updates to national guidance could be strengthened by mandating further simulation exercises be held at Trust level and regional level on a regular basis, akin to the timeline that Trusts are required to exercise their response to major or mass casualty incidents.

c. Testing is very important early in the pandemic, particularly when there are no treatments/vaccines available. Testing is the only way to reduce infections and understand the early pandemic. It is crucial to ensure that testing is de-centralised early and that point of care capacity testing is developed.

d. Manufacturing of Point of Care Testing within the UK would be useful to allow rapid development and adoption.

e. It is problematic when major decisions occur late in the week leading to difficulty in disseminating messages. In addition, messaging needs to be clear some of the messages that came out from government bodies were conflicting.

f. National guidance on PPE was too late. Initially the HCID centres were being asked for advice and in essence trying to educate the whole country's ICUs. Even when the scale of the pandemic became apparent there was a delay to the production of national guidance which led to national bodies competing to produce the first guidance e.g. AAGBI, RCOA, FICM. These pieces of guidance were dissimilar, causing confusion, and were then rapidly superseded by national guidance.

220. Statement of Truth

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

SIGNED:……LUCIA PAREJA-CEBRIAN.

DATE: 23.05.2024…