

Witness Name: Paul Tisi

Statement No.: 1

Exhibits: 75

Dated: 10 April 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PAUL TISI

I, Paul Tisi, of Bedford Hospital, Kempston Road, Bedford MK42 9DJ, will say as follows:-

1. I make this statement in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules, 2006, dated 17 December 2023 in relation to Module 3 of the Inquiry. I am the Medical Director for Bedfordshire Hospitals NHS Foundation Trust which incorporates Bedford Hospital (the subject of this Rule 9 request) and Luton and Dunstable University Hospital. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

Background to Bedford Hospital and the population it serves

2. Bedford Hospital ("the hospital") is a district general hospital which has a catchment population of approximately 270,000 (as of 1 March 2020), covering north Bedfordshire, Bedford, Kempston and parts of central Bedfordshire. Prior to 1 April 2020 this was the sole acute hospital for Bedford Hospital NHS Trust. From 1 April 2020, the trust was acquired by Luton and Dunstable University Hospital NHS Foundation Trust ("the merger"), forming Bedfordshire Hospitals NHS Foundation Trust (the "trust").

3. Detailed demographics for Bedford Borough and Central Bedfordshire which are the main local authorities serving Bedford Hospital's catchment population are exhibited as **PT/01 – INQ000410156**.
4. For Bedford Borough, the population on census day 21 March 2021 was 185,225. 16.7% of the population are aged 65 or over. The population is more ethnically diverse than the East of England with 75.7% identifying as white (compared to 86.5% for the East of England), 12.6% identifying as Asian or Asian British, 5.3% black or black British, 4.6% mixed race and 1.8% identifying as another ethnic group. In terms of deprivation, Bedford Borough is ranked at 140 out of all 317 lower tier and unitary authorities in England. The mid 2022 estimate of population shows a 10% increase since 2015, mainly driven by international immigration.
5. For Central Bedfordshire, the population on census day was 294,252, noting that this population is also served by other acute hospitals. 18.0% were aged 65 or over. Compared to Bedford Borough, Central Bedfordshire has a less ethnically diverse population with 90.2% identifying as white, 3.5% identifying as Asian or Asian British, 2.4% black or black British, 3.0% mixed race and 0.8% identifying as another ethnic group. Central Bedfordshire is also less deprived than Bedford Borough and ranked 236 out of all 317 lower tier and unitary authorities. The mid 2022 population estimate has shown an increase of 11% from 2015, mainly driven by internal migration.
6. Bedford Hospital provides the full breadth of district general hospital services including an Emergency Department (which is a designated Trauma Unit), consultant-led maternity services, paediatrics, a level 1 neonatal unit (special care baby unit) and a range of routine and acute medical and surgical services, including being the designated arterial centre for the Bedfordshire, Luton and Milton Keynes ("**BLMK**") vascular network.
7. The hospital has a Critical Care Unit (see below) which has both level 3 (ventilated) and level 2 (high dependency) patients. It has an elective surgical day case unit, a cardiac catheterisation laboratory (for routine and inpatient treatment), a high volume endoscopy unit and a plastic surgery day case and LASER unit. The bed

base within the hospital as of March 2020 was 336 general and acute (“G&A”) beds plus 30 escalation beds with up to 39 contingency beds available across 17 wards. This excludes maternity and paediatric beds.

8. As of March 2020, Bedford Hospital employed 3039 staff (2684 whole time equivalents).

The impact of Covid-19 on clinical staffing

9. As the relevant period extends over 28 months, this witness statement outlines the issues in general terms rather than commenting on a week by week basis although a considerable amount of detail is provided. Prior to the pandemic, as a small acute hospital there were areas where substantive recruitment was difficult, particularly in some medical shortage specialties such as histopathology, haematology and microbiology. Vacancies were covered by locum agency staff. This was identified as one of the benefits from the merger in April 2020 i.e. recruiting to a larger organisation. Recruitment in the early part of the pandemic effectively ceased as all resources were diverted to managing the pandemic. From the point of view of key specialities needed to manage the Covid-19 response, there were sufficient clinical staff in intensive care, emergency medicine and acute/respiratory medicine, although the latter included temporary bank and agency locum staff.
10. The initial announcement from the Prime Minister on 23 March 2020 that people should only leave their houses and travel to and from work where absolutely necessary, created an immediate need for urgent action to ensure that the hospital was safely staffed. The hospital sent out the following message to all staff on 24 March 2020 which is reproduced in full as this sets out how the hospital responded to the beginning of the pandemic:
11. “In light of latest national guidance from the Prime Minister, stating that people should only leave their houses and travel to and from work where absolutely necessary, as a hospital providing essential services to our local population, it is critical that the hospital continues to run - this means that both clinical and non-

clinical services must be resiliently staffed. We are therefore asking all line managers to follow the below approach (where possible) with their teams at the earliest opportunity. Line managers should take the time that they need to work with their teams to consider ways in which their department can work with the smallest possible number of staff onsite at any one time, whilst protecting all necessary services; all staff in patient facing areas and clinical staff rostered for duty should continue attend work as planned until the required team discussions with line management has taken place and they receive subsequent instructions and guidance from their manager; examples of different approaches that team leaders might take in order to minimise the number of their staff onsite at any one time could be: flexible shift patterns, combinations of days at home and days onsite etc. ; all staff who are able to work effectively from home and have had discussions with your line manager with remote access granted – the Information Governance team have put together a helpful Home Working guidance sheet for all staff which can be downloaded from the dedicated COVID-19 intranet page. Home working will create more office space and we encourage all staff to follow the principles of social distancing. Wherever possible, plan to use office space, following these principles. Discuss with your line manager for further options.”

12. As the pandemic progressed, there was clearly an impact on clinical staffing at all levels from those symptomatic and absent from work due to Covid-19, those self-isolating due to household contacts or asymptomatic positive tests (see below) and those needing to formally shield due to medical issues; this was particularly of concern prior to the vaccination programme being implemented. Senior medical staff who were shielding were able to work remotely where possible, for example undertaking virtual (video or telephone) clinics. At the peak of the first wave of the pandemic at Bedford Hospital in terms of inpatient numbers, of the 3017 staff headcount at that time, 358 were absent due to respiratory sickness, shielding or isolation (11.9%) including 63 doctors, 124 nurses and midwives and 10 allied health professionals [staffing absence exhibited as **PT/02 – INQ000410157**]. The 14 day quarantine requirements introduced in July 2020 also had an impact on staff wishing to travel overseas to see families as well as on international staff recruitment, as there was no exemption for health care professionals. Managing the return back to work in staff following the national pause in shielding from 1 April

2021 was challenging and required further individual and workplace risk assessments.

13. In terms of the impact of Covid-19 testing on workforce capacity, Polymerase Chain Reaction (“**PCR**”) testing (a laboratory-based test to diagnose Covid-19 from a nasal and/or throat swab) and subsequent twice weekly lateral flow testing (a rapid self-administered test) was implemented which led to asymptomatic and otherwise well frontline staff being required to self-isolate and not return to work in line with national guidance in force at that time.
14. The trust did undertake one round of Covid-19 antibody testing (a blood test to confirm a previous Covid-19 infection) following publication of government guidance on 22 May 2020 and a letter from the National Medical Director and the National Director for Emergency & Elective Care, NHS England and NHS Improvement (“**NHSE/I**”) on 25 May 2020. An email from the Regional Medical Director on 28 May 2020 requested my personal support with a target for completion of staff screening of 5 June 2020; the Regional Director also wrote to the Chief Executive the same day so clearly there was a degree of urgency to implement this. The deadline was then extended by the region such that all staff should have been offered testing by 30 June 2020 with completion by 10 July 2020. Testing commenced at Luton and Dunstable Hospital on 27 May 2020 with an initial validation sample of 50 staff with previous confirmed Covid-19 infection which was supported by industry (Roche). Bedford Hospital testing commenced 29 May 2020 with samples initially sent to Luton for processing and subsequently on site. There were capacity constraints in terms of physical space and additional staff required to undertake these blood tests. Covid-19 antibodies were detected in 32.7% of 1744 members of staff tested. Antibody testing had no effect on workforce capacity, although a positive antibody test may have led to some degree of reassurance for some members of staff. However it should be noted that this predated circulation of any new Covid-19 variants. Managing staff anxiety about variants including disease severity, transmission rates and subsequently the effectiveness of vaccination became an increasing concern.

15. Although there were creation of temporary registers for doctors, nurses, midwives and pharmacists through their relevant professional bodies, this did not have a material effect on staffing. There was no return of retired doctors into direct Covid-19 patient facing work at Bedford Hospital despite some initial expressions of interest. I am aware that The General Medical Council (“**GMC**”) contacted all doctors who had relinquished their licence to practice within 3 years; this was a nationally coordinated plan with the aim of deployment at regional level in line with need. In terms of the Nursing and Midwifery Council (“**NMC**”) temporary register, the hospital had a small number of enquiries from former registrants; however these were retired specialist nurses who only wanted to return to their former specialist roles, rather than working in clinical areas needed for the Covid-19 response. No retired nurses joined the hospital to work in their former specialist roles. For midwifery, existing registrants increased their working hours on the trust ‘bank’. One helpful element was the accelerated registration for final year student nurses and midwives. This extended hybrid work placement approach supported the need for increased staffing but also helped individuals transition from student to registrant. 42 aspirant nurses and 10 aspirant midwives went through this process. In addition, I note that the Home Office granted temporary visa extensions for international workers as well as allowing applications for tier 2 visas to be processed from the UK rather than a clinical worker having to return to their home country to apply. The hospital also employed two medical students (funded by Public Health England (“**PHE**”) for a maximum of 15 hours per week) to support with Covid-19 data collection and returns. In December 2020 there was announcement of national funding for Medical Support Workers (“**MSW**”) as well as support for international nurse recruitment. The hospital did employ one MSW.
16. Where there were vacancies or rota gaps due to shielding or self-isolation, temporary additional staffing was sought to cover where needed although noting that the market for temporary/locum staff was very difficult. Although staffing concerns would have been discussed at regional NHS England level there was no direct support available which could address this. At no stage to my knowledge were key clinical areas not able to be staffed. However during the relevant period (and as part of normal operational pressures with opening of escalation areas and managing staff sickness) there will frequently be a variance between expected

staffing and actual staffing. Without an in depth analysis shift by shift, in every clinical area and in every staff group (medical, nursing, midwifery, allied health professions) during the relevant period it is not possible to quantify this.

17. The trust did not deploy any staff to other hospitals nor to any Nightingale hospital during this period. There were discussions at regional NHS England level in April 2020 about the possibility of staff transfer to critical care units within the region (surge centres) although this did not happen. There was a further request from the Regional Director on 26 October 2020 [exhibited as **PT/03 – INQ000410158**] to release staff to these surge centres but no staff were released due to surge pressures within Bedford Hospital, the increasing prevalence of Covid-19 and the impact on staff morale and wellbeing. The hospital would however have sought to consult staff around deployment to the regional surge centre had all other options for those centres been exhausted.
18. Internally, plans were put in place to upskill and redeploy senior medical staff (where routine work had been cancelled) to other specialist teams. It was recognised that there needed to be a move to shift working at consultant level. Planning commenced on 18 March 2020 with a formal request for information sent to all consultants establishing a) whether there was any previous experience in critical care and b) any relevant practical skills. Daily training was established from 24 March 2020 to 10 April 2020 to cover oxygen therapy, airway management, assessment of a Covid-19 patient and continuous positive airways pressure (“CPAP”) training. A draft redeployment rota is exhibited as **PT/04 – INQ000410159**.
19. There was also redeployment of junior doctors to support inpatient Covid-19 admissions. In March 2020, following discussions with Health Education East of England, doctors were redeployed from foundation training posts (the first two years of postgraduate training) in psychiatry back into the acute hospitals. Hospitals were given discretion to move trainees within the hospital but were required to notify the Deputy Postgraduate Dean of any such move.

20. A detailed Nursing, Midwifery and Allied Health Professional (“**AHP**”) internal workforce plan was circulated on 30 March 2020 [exhibited as **PT/05 – INQ000410160**]. This was based on the premise that 25-50% of the workforce might be out of action at any one time due to sickness or self-isolation. This included redeployment of specialist nurses and use of non-clinical staff as well as volunteers.
21. I do not believe that any staff were required to undertake clinical duties for which they were not capable. The hospital did send out communication to all clinical staff on 25 March 2020 to provide assurance that all staff who were required to work differently would have the support of the trust [exhibited as **PT06/ – INQ000410161**]. However, there was clearly a high degree of anxiety early on in the pandemic about working with patients with Covid-19 due to the unpredictable effects of the disease as well perceived personal risk e.g. undertaking endotracheal intubation. There was a degree of burn out from teams working in intensive care and in the Emergency Department during the peaks in attendances and admissions. For trainees, Health Education East of England made their Professional Support and Wellbeing service available to all.
22. As regards the impact of long Covid on staffing at Bedford Hospital, data collated from the Electronic Staff Record shows 58 members of staff absent with prolonged Covid symptoms of more than 4 weeks duration during the relevant period with a mean absence of 67 days; this would include ongoing symptomatic Covid and post-Covid syndrome (symptoms of more than 12 weeks). The main staff groups affected were nursing and midwifery, additional clinical services (mainly clinical support workers) and administrative and clerical; other staff groups were in single digit figures. This clearly had an impact on running of the hospital although it should be noted that only one doctor was in this group.
23. Sadly there were three deaths in members of staff at Bedford Hospital. Two colleagues worked in the Estates Department, one in the maintenance team and one as an electrician. One colleague was a Clinical Support Worker in the Radiology department. Clearly these deaths had a very profound effect on friends

and colleagues within the hospital. The Chief Executive Officer (“CEO”) paid tribute to these members of staff in all staff email messages.

24. The Department of Health and Social Care (“DHSC”) announced a policy for vaccination as a condition of deployment (“VCOD”) for healthcare workers in a letter dated 10 November 2021, with a planned implementation date of 1 April 2022, subject to parliamentary processes. The hospital noted the Phase 1 guidance and resources published on 6 December 2021 by NHSE/I, followed by the Phase 2 guidance published on 14 January 2022. The approach taken was for line managers to have 1:1 conversations with hesitant members of staff with signposting to other sources of information e.g. the vaccine team as appropriate. The intention was then to progress with an initial formal review meeting week commencing 7 February 2022 chaired by a manager with HR representation; staff would have been encouraged to attend with a work colleague or union representative. A further review meeting would then take place 2 weeks later where notice would be served if they were not able to provide evidence of vaccination. No formal VCOD policy was in place although detailed briefing information was provided for all managers and a communications plan implemented including FAQ for staff [exhibited as **PT/07 – INQ000410162**]. The trust handled the whole process as sensitively as possible, whilst noting that this was a national directive and not for any local decision making. There were concerns about the impact of losing significant numbers of staff due to this process. As of 28 January 2022, 56 staff at Bedford Hospital who were not exempt had chosen not to be vaccinated or were undecided. This was across professional groups with the highest number in nursing and midwifery. This clearly had an impact on staff morale and was reflected in feedback from staff in Q&A sessions in the monthly staff briefing. There were undoubtedly some tensions within individual teams between vaccinated and unvaccinated staff and this would have been managed at individual service line level. On 31 January 2022 the government announced its intention to reconsider this decision and go out to consultation. The CEO communicated this to all staff on 1 February 2022. All trust processes were paused and then ceased following the amended legislation; no formal review meetings were therefore held.

25. In terms of other impact on staffing, although outside of the brief of this Module, the on-site Covid-19 vaccination programme and the Covid Medicines Delivery Unit (“**CMDU**”) relied on bank staff, redeployed staff, staff working additional hours and those undertaking this work in addition to their normal ‘day’ job. Whilst this was challenging in terms of staffing it was undoubtedly beneficial for both staff and patients.

The impact of Covid-19 on the operational running of the hospital

Bed capacity

26. In terms of bed capacity, the letter of 17 March 2020 from NHSE/I required hospitals to free up inpatient and critical care capacity by postponing all non-urgent elective operations from 15 April 2020, with local discretion to wind down over the next 30 days as well as to urgently discharge all hospital patients who were medically fit to leave. This was dealt with by the Deputy CEO at the time. All non-urgent surgery at Bedford Hospital was cancelled in the week beginning 16 March 2020, following which a communication was sent to all staff on 20 March 2020 requesting cancellation (deferral) of all routine inpatient and outpatient work. As of 17 March 2020, there were 359 G&A beds and six intensive care beds occupied; the position as of 24 March 2020 following receipt of this guidance was 259 G&A beds and 10 intensive care beds; the position at 31 March 2020 was then 248 inpatient beds and 13 intensive care beds occupied.
27. In December 2021, as inpatient numbers increased due to the emergence of the Omicron Covid-19 variant, the regional team at NHSE/I asked the trust (both hospitals) to identify a) whether there was an existing clinical facility that could accommodate 50-100 patients; b) could a non-clinical facility be converted to accommodate 50-100 patients and c) could a temporary structure be built for these numbers of patients. Data returns were required to be submitted to the region. The hospital explored this including the potential use of clinically unsuitable environments such as a basement education centre but this was not practicable and the constraints were too great in terms of clinical safety. It was also noted that

30-40% of staff could potentially be impacted due to isolation at this time and therefore staffing these temporary areas in addition to all open escalation areas would be likely impossible.

Intensive care

28. In terms of intensive care capacity, pre-pandemic Bedford Hospital was funded to take a maximum of eight level 3 (i.e. ventilated) and two level 2 (high dependency) patients, although there were 12 physical bed spaces. At the peak of the pandemic intensive care was expanded to 17 ventilated patients which were located in Critical Care (12 beds) and Theatre Recovery (five patients) i.e. an expansion of 9 spaces. The decision to expand critical care on both hospital sites was made at trust level and was supported by the East of England Critical Care Operational Delivery Network (“ODN”). A ceiling limit of 18 intensive care beds was set for the hospital on 09 April 2020. It was challenging to staff these additional beds; however nurses currently working on critical care were supplemented by Operating Department Practitioners, physiotherapists and nurses with previous critical care experience (for example, nurses working in a corporate role). In terms of medical staffing, consultants worked a shift system in which they were resident on-call and this was supplemented by increased numbers of junior medical staff. There was provisional plans in place in March 2020 for a Nightingale hospital in Hertfordshire to enable critical care expansion across the region but this plan was put on hold on 2 April 2020. The subsequent plan was to use ‘super-surge’ capacity in Cambridge and Norwich with an estimated 394 intensive care beds (which would have required some transfer of staff) followed by use of the Nightingale hospital at the ExCel in London as per the letter from Regional Director (East of England) [exhibited as **PT/08 – INQ000410163**]. In January 2021, the ODN surge suggested the maximum surge plan on the Bedford Hospital site should be set at 10 level 3 and four level 2 patients.

29. As elective (routine) surgical activity had been stood down, ventilators and monitors (i.e. anaesthetic machines) were redeployed from theatres to support the expansion in intensive care although the technical specification was sub-optimal compared to usual intensive care equipment. It should be noted that the trust had

a sufficient supply of ventilators i.e. 12 intensive care ventilators, five portable ventilators (normally used for patient transfer) and 18 anaesthetic machines (although some were required for emergency or urgent surgery); to clarify the hospital had nine operating theatres (excluding maternity) and routine elective activity was stood down. I note the letter from the national Strategic Incident Director on 25 March 2020 highlighting national procurement, allocation and distribution of ventilators. A further challenge for critical care patients treated in theatre recovery was reliance on paper notes and medication charts as the Critical Care Unit itself used an electronic system (MetaVision).

30. The Inquiry has requested a response to actions undertaken where critical care capacity reached 85%, 92% and 100%. There were no specific actions taken at these individual capacity limits as this was (at peak times) a very dynamic situation with new admissions (more than three per day), discharges to a lower level of care and deaths. The additional capacity in the main critical care unit was filled prior to opening up theatre recovery; the trust at times did operate with 17 patients in critical care compared to the funded pre-pandemic baseline of eight beds. The hospital had/has strong operational processes in place where critical care capacity is specifically addressed at the bed management meetings (three times daily) and there was evidence of excellent team working to ensure patient safety. I am not aware of any patients in whom critical care was deemed appropriate that were denied admission due to capacity concerns within the unit.
31. The East of England Critical Care ODN set up a Critical Patient Resource Management Centre (“**CPRMC**”) which was activated on 17 April 2020 [exhibited as **PT/09 – INQ000410164**]. The hospital took part in daily calls which were attended by representatives of all intensive care units in the region with the discussion focussed on capacity, transfers and repatriation. As a merged trust we were also able to use our other acute site (Luton and Dunstable University Hospital) for non-clinical transfers.
32. During the relevant period (01 March 2020 to 28 June 2022) there were 26 transfers of patients from Bedford Hospital to an intensive care at another hospital, all of which were in the first 24 months. Twelve transfers were to tertiary centres

for clinical reasons, specifically 10 transfers to the Royal Papworth Hospital for extracorporeal membrane oxygenation (“**ECMO**”) (a specialist treatment to enable the heart and lungs to recover from serious illness), one for paediatric intensive care and one for preterm maternal delivery and neonatal care. Fourteen transfers were for non-clinical reasons; two of these were out of region (Midlands) and 12 were within the critical care network, of which four were internal trust transfers to Luton and Dunstable University Hospital. During the same time period there were 19 transfers to Bedford Hospital from other intensive care units, of which one was from out of region (Midlands).

Infrastructure and equipment

33. In terms of infrastructure, oxygen consumption across the hospital was a concern from expansion in intensive care beds, non-invasive ventilation (CPAP) on the respiratory ward (with very high oxygen flow rates of 40-80 litres/minute) and piped oxygen in general ward beds for those patients not requiring ventilator support. Although the technical aspects of this are beyond my area of expertise (and would require expert comment from an engineer), there were concerns about reduced oxygen pressure and ‘back end freezing’ of the Vacuum Insulated Evaporator (“**VIE**”) which could have risked liquid oxygen being pulled through the control panel and into the hospital. The estates and medical devices team had informed the executive team following advice from the gas supplier, BOC UK (“**BOC**”) on 7 April 2020 that a flow rate of 800 litres/minute should be used to calculate the maximum flow rate available within the hospital. Following an incident at another hospital in the region, the critical care network advised operating at 80% of this maximum capacity i.e. 640 litres/minute to avoid issues with the VIE. This required careful managing of consumption and enhanced governance around oxygen usage with senior clinical staff acting as ‘oxygen guardians’, ensuring the correct prescription and administration of oxygen, setting target oxygen saturations in line with national guidance and ensuring that there was no wastage. The hospital had the ability to monitor oxygen consumption across the hospital in real time and this was continuously displayed in the trust operational control room. At one stage, three intensive care patients were transferred to another intensive care unit in the

East of England due to concerns that we would breach the maximum safe oxygen flow rate across the hospital.

34. I joined a webinar on 08 April 2020 where the UK lead for the Oxygen and Equipment Covid-19 response outlined the national position i.e. overall oxygen storage was 83-84% of maximum capacity with flow rates being an issue which could be addressed by the gas supplier adjusting pressure settings (for Bedford Hospital this was 0.5 bar). Following new information from BOC, which was based on trust returns on maximum documented flow rates, the Medical Devices Manager advised by email that an upper limit of 916 litres/minute set by BOC was now safe which effectively ended the concern about critical oxygen usage at that time. However on 30 April 2020, BOC telemetry noted a discrepancy with the flow rate of 1111 litres/minute (121% of upper maximum flow rate) compared to the oxygen guardian's figure of 427 litres/minute. Immediate mitigations were put into place to make the hospital safe including limiting new admissions to intensive care by transferring out if required, ensuring backup cylinders were available, use of oxygen concentrators on the ward environments (see below) and alerting the ambulance service and regional incident command. Oxygen leaks were noted and repairs initiated but on 6 May 2020 significant concerns were raised with a peak measured flow rate of 1300 litres/ minute and ice build-up of the VIE. Urgent de-icing of the VIE took place and further urgent repairs were arranged which required localised shut downs of supply, using oxygen cylinders as back-up, whilst repairs were undertaken. A standard operating procedure for hypoxic patients was urgently circulated on 6 May 2020 in order to reduce oxygen usage and prevent a critical failure of supply [exhibited as **PT/10 – INQ000410165**]. Three patients were transferred out to Luton and Dunstable University Hospital and CPAP was ceased on the respiratory ward and moved to intensive care, where there was lower oxygen usage needed for non-invasive ventilation; these measures reduced consumption to safe levels.

35. As regards other equipment availability, due to an increase in requirement for non-invasive ventilation on the respiratory ward for patients not requiring intensive care and noting the constraints on oxygen supply in general, the hospital was allocated 34 oxygen concentrators by the region (NHSE/I) on 9 April 2020 which arrived

within 24 hours. These were able to provide an oxygen concentration of around 90% at a flow rate of up to 5 litres/minute which meant that patients with lower oxygen requirements did not need to use piped oxygen, ensuring high flow oxygen was available for patients most at need. The hospital was also able to procure new CPAP machines (Philips V60) in April 2020, which were delivered in June 2020; the lag was undoubtedly due to national demand. These machines could deliver maximum oxygen flow rates of 40 litres/minute.

36. During the third wave of the pandemic, the hospital entered a further critical period in oxygen use on 8 January 2021. This was at the time of peak Covid-19 occupancy with 190 Covid-19 inpatients, 12 patients on critical care and 12 patients on non-invasive ventilation. This was urgently escalated to the Regional Medical Director, NHSE/I and immediate actions were required of all consultant staff to ensure appropriate oxygen prescription and use. Further clarification from BOC at this stage confirmed that the hospital had two 50m³hr oxygen banks each rated at 916 l/min; running in parallel this would give a maximum flow rate of 1667 l/min. Due to concerns about icing, and noting the ambient weather, running at 80% of this capacity was advised i.e. 1333 l/min [exhibited as **PT/11 – INQ000410166**]. This coincided with national concerns about oxygen - guidance and supporting information had been circulated through the Emergency Preparedness, Resilience and Response (“**EPRR**”) route. Upgrades were then made to the oxygen VIE in 2021, with a maximum flow rate of 3000 litres/min; running at 80% capacity gave a maximum flow rate of 2400 litres/min which provided greater resilience in winter 2021 as oxygen consumption increased with increasing caseload.

37. There were no other shortages of intensive care equipment such as haemofiltration machines (renal replacement) nor any shortages of anaesthetic or palliative care drugs. I note there was a national shortage of haemofiltration fluid which was highlighted in an email from the critical care network on 17 April 2020. This did not affect the ability of Bedford Hospital to treat patients to my knowledge.

Use of the independent sector

38. As regards the Government's agreement with the independent sector to support the Covid-19 response, Bedford Hospital did not receive any equipment such as ventilators from private hospitals, nor was there any transfer of staff to Bedford Hospital. In April 2020 plans were in place to use one independent hospital, The Manor Hospital, Bedford (BMI Healthcare, subsequently Circle Health Group) as a step-down facility for 'green' (not infectious) patients with medical oversight from community services. However the criteria set by the independent hospital in terms of patient suitability were such that no step down patients were accepted despite contracts in place; this was escalated at regional level. A draft memorandum of understanding was only received from the independent hospital on 12 May 2020.
39. There were three independent hospitals to which the trust contracted routine work later in the relevant period: The Manor Hospital, Pinehill Hospital in Hertfordshire (Ramsay Health Care) and Spire Harpenden Hospital, Hertfordshire. During the relevant period 572 patients from Bedford Hospital were treated in the independent sector, 388 in 2020, 105 in 2021 and 79 in 2022 (up to 28 June 2022). This was predominantly day case and short stay patients, with the main specialties being urology (39.3%), orthopaedics (33.7%) and general surgery (23.6%).

Virtual wards

40. Covid-19 virtual wards were introduced in January 2021 to support admission avoidance and earlier discharge. 450 pulse oximeters were received through the national supply chain to support oxygen monitoring at home for these patients [patient leaflet exhibited as **PT/12 – INQ000410167**]. As the Omicron variant emerged in December 2021 there was renewed expectation from all providers to provide increased capacity with an expectation that Covid-19 virtual wards would be able to manage at least 15% of Covid-19 inpatient numbers. National guidance was provided to support this but included other acute respiratory and frailty pathways.

Management of infection prevention and control during the pandemic

41. Throughout the relevant period the trust followed national guidance in relation to infection prevention and control (“**IPC**”) including testing, isolation, step-down and IPC preventative measures including Personal Protective Equipment (“**PPE**”) use. The only deviation from guidance was taking a more cautious (i.e. safer) approach around staff and patient testing. The rationale for this was on the basis of discussions at executive level, guided by the Director of IPC and in the context of local epidemiology. Details and frequency of staff and patient testing are covered further in this witness statement.
42. There was variability in how hospitals were updated about any change in guidance during the relevant period. Guidance was frequently issued from NHSE/I National Incident Coordination Centre through the EPRR route, with cascade to down to region (Incident Coordination Centre (East of England), then to the Integrated Care System (BLMK Clinical Commissioning Group (“**CCG**”) which evolved into the Integrated Care Board) and finally down to the trust Incident Command inbox which was then shared across both hospital sites. This inbox was monitored by the on-call senior operational manager on the Luton and Dunstable Hospital site at a minimum of every four hours between 08:00-22:00, seven days per week. The target audience for cascaded information was highlighted in each individual message although it was not always clear cut e.g. ‘trust Covid leads’. The cascade process will of course have inherent delays unless all inboxes ‘upstream’ are monitored and forwarded immediately. In addition, other sources of professional information were through national incident webinars and by my personal searching for information on gov.uk and other sites.
43. Any changes to national guidance were discussed at daily (weekday) operational Covid-19 calls attended by myself, the CEO, Chief Operating Officer, Chief Nurse, Director of IPC, Deputy Medical Director, Head of Communications, Head of EPRR & Business Continuity and other executives as required (prior to the merger of two trusts on 1 April 2020, a Covid-19 Strategic Incident Control Group was set up with attendance from executives of both hospitals with effect from 4 March 2020). As the pandemic progressed, the frequency of these was decreased to three times

weekly and then increased back to daily as required depending on the national, regional and local picture. Guidance was then disseminated in a number of different ways; an all staff Covid-19 e-briefing which was sent by email every weekday from 13 March 2020 to 28 April 2020 followed by further emails throughout the relevant period whenever there was new information to convey; targeted emails to specific staff groups as appropriate; daily Covid-19 operational briefings at times of peak concern; monthly all staff briefings (Microsoft Teams); the weekly trust newsletter 'The Week'; a dedicated Covid-19 section on the hospital Intranet and a dedicated Covid-19 email inbox for individual questions which were directed to the relevant person for response, usually by an executive director and often from myself as Medical Director.

44. Cascaded guidance sent to the EPRR inbox out of hours would be dealt with by the senior manager on-call monitoring the inbox as above and cascaded through the normal operational management route for both hospital sites and up to executive on-call as required if this needed very urgent action. Otherwise this was reviewed at the next operational incident meeting. 1936 emails relating to Covid-19 were received through the EPRR email inbox during the relevant period of which 218 were received between 17:00 on a Friday and 08:00 on a Monday. An example of guidance received outside of normal working hours was a directive published 18:50 on 5 June 2020 (Friday evening) directing that face masks and coverings should be worn by all staff and visitors as of 15 June 2020. This required careful managing as the hospital already had in place mandatory mask wearing in clinical areas. A further major update on IPC guidance published by the UK Health Security Agency (“**UKHSA**”) and a ‘next steps’ letter from NHSE/I was cascaded by the national team on Thursday 14 April 2022 at 17:52 which was immediately ahead of the Easter Bank Holiday weekend. This was a significant change.
45. The hospital had anticipated and implemented guidance at times in advance of national published guidance (including Central Alerting System cascades) but remained in line with this [an example Covid-19 daily staff e-briefing is exhibited as **PT/13 – INQ000410168**. A summary of all the IPC changes relating to the Living with Covid guidance was communicated to all staff on 27 April 2022 [exhibited as **PT/14 – INQ000410169**].

46. It is my opinion that most of the guidance received was relatively straightforward in terms of messaging, although there were some important exceptions to this which are outlined below. Implementation of guidance however was challenging at times particularly in March/April 2020 and later in December 2021, where large volumes of guidance were received from multiple different sources.
47. One area where there was a definite lack of clarity was around the government's introduction of 'Track and Trace', specifically a) whether this applied to NHS frontline staff and b) if so, the concern that this would significantly impact on the ability to safely staff the hospital. This was subsequently covered in a government publication (Management of Exposed Healthcare Workers and Patients in Hospital Settings, 2 June 2020) which made it clear that positive contacts outside of work would require self-isolation. Contacts within work were only required to self-isolate if PPE had not been worn or social distancing in place. Asymptomatic members of staff testing positive were required to isolate for seven days (duration in place at that time). Operationally this was very challenging to manage, in particular as further updates as regards to contact tracing were then published. This required the hospital to clarify messaging to all staff. In line with national guidance, the hospital introduced QR codes in public areas in September 2020 to support Track and Trace but we needed to ensure that staff were aware that this would not apply whilst using PPE as well as advising that 'contact tracing' should be disabled on the NHS Covid-19 app whilst using PPE; this was reinforced by national messaging. The announcement of the second national lockdown on 5 November 2020, followed by the third on 6 January 2021 again provided challenges in terms of managing staff anxiety as well as ensuring safe staffing and the ability to deliver emergency services.
48. A further example of conflicting guidance in December 2020 was the reduction in isolation period following Covid-19 exposure to 10 days for the public whilst keeping the isolation period for 14 days for healthcare workers. The initial version of this issued guidance was conflicting and I then escalated this up through the regional IPC lead, NHSE/I who then escalated up to the national PHE team. The regional EPRR team then advised that this had been discussed with the Chief

Nursing Officer, NHSE/I. National guidance was then amended 72 hours later. I note however that Track and Trace had contacted several staff midway through their isolation period and advised them to reduce to 10 days isolation; this required direct input from the hospital to those staff to ensure that the correct isolation period was followed.

49. In recognition of the fact that the need to isolate following positive contacts through Track and Trace was having an impact on health and social care staffing, the hospital noted the briefing note from PHE (2021/05) and the letter from NHSE/I, both published 19 July 2021. This allowed fully vaccinated health care workers, if notified as a contact by Track and Trace, to return to work after a negative PCR test followed by daily lateral flow testing for 10 days; outside of work there was still a legal requirement to continue with 10 days isolation. This was intended to be used in exceptional circumstances to allow key frontline staff to return to work but importantly excluded those with a household positive contact. The messaging as a result of this was difficult to manage. The hospital approached this by requesting that senior leaders make individual requests to the executive team outlining why specific staff needed to be brought back with formal approval required. For hospital staff with a contact outside of the household, as above a negative PCR test was required with subsequent lateral flow testing. Managers were required to undertake a risk assessment to ensure staff could safely return required [exhibited as **PT/15 – INQ000410170**]. This guidance then changed on 16 August 2021 when the public were no longer required to self-isolate when contacted by Track and Trace if fully vaccinated.

50. The key decision making group in respect of guidance received was the daily Covid-19 operational call as outlined above; one purpose was to review all guidance received, clarify where needed with subject matter experts and agree the implementation plan. There was a requirement for central control of messaging to ensure managers and staff received the correct advice. Some staff had reported concerns that they were seeing too many new documents, which is understandable given the nature of the pandemic and the pace of response that was required. Other staff at times circulated information to peers which created a degree of ambiguity; this was actively managed at executive level to ensure the

right information was provided to the right staff at the right time [example exhibited as **PT/16 – INQ000410172**].

51. It should be noted that whilst preparing the response for this inquiry many hyperlinks to gov.uk guidance no longer work as guidance was frequently updated and subsequently withdrawn.

52. The inquiry are aware of a press report arising from Bedford Borough Health Overview and Scrutiny Committee (“**HOSC**”) on 12 October 2020 where it was reported by a councillor that there was no social distancing in the CT scan department ‘last week’ and that an elderly patient removed her mask as she was feeling unwell (it is important to note that not every patient is able to tolerate a mask) [exhibited as **PT/17 – INQ000410870**]. I noted at this virtual meeting that infection prevention and control is the responsibility of every member of staff. The Chief Nurse who attended this scheduled meeting with me noted that she would take an action for the infection prevention and control team to address this area. The two metre social distancing rule was in place and in addition communication had been sent to all staff on 16 June 2020 outlining the expectation that all members of the public should wear a mask or face covering; face masks were provided at main hospital entrances for those without a mask and staff were asked to engage, explain and encourage those who were not wearing a mask. This was challenging at times as members of the public were not always compliant with this. During the third national lockdown additional hospital entrances were closed and main entrances were manned by security with mask stations in order to reduce footfall through the hospital. As government restrictions around wearing of face masks in public were eased in July 2021, the hospital maintained a more cautious approach with external messaging on websites and media outlets [exhibited as **PT/18 – INQ000410173**].

53. In terms of the physical estate and the ability to maintain infection prevention and control practices, Bedford Hospital has a total of 59 side rooms in the bed base, excluding maternity and paediatrics. Individual Covid-19 patient isolation was not possible from a very early stage. Cohorting of patients in bays and subsequently whole wards was required as the pandemic progressed. At the peak of the first

wave on 7 April 2020, there were 67 inpatients with Covid-19 located in 11 clinical areas including intensive care. At the peak of the second wave on 8 January 2021, there were 190 inpatients with Covid-19 located in 15 clinical areas including intensive care and the delivery suite. Most patients were cohorted into whole 'red' (indicating infection) wards during this peak. In this wave there were more than 100 inpatients with Covid-19 for 47 consecutive days from 27 December 2020 (mean 159 Covid-19 patients). In March 2020, the Emergency Department was split into 'red' (i.e. hot/ possible Covid-19) and 'green' (non-Covid presentation) areas [High Level Covid-19 Business Continuity Plan, exhibited as **PT/19 – INQ000410174**]. There was redevelopment of the Emergency Department during the relevant period; a new Paediatric Emergency Department with a separate entrance opened in July 2021. Intensive care throughout the pandemic were able to split 'red' from 'green' patients. As regards operating theatres, the layout of the main theatre complex is such that separate 'red' and 'green' areas could be maintained with separated entrances, changing facilities and patient recovery areas. This was implemented on 19 June 2020. In terms of the general access through the hospital corridors etc it was not possible to implement one way traffic although there was signage in place to allow for separation of opposing traffic streams.

54. As regards staffing ratios for general wards there was no change. If patients were cohorted in 'red' and 'green' areas on the ward then staffing was kept separate for the full duration of the shift. Enhanced staffing ratios were put into place on the respiratory ward (Pilgrim Ward) in view of the significant increase and pathway change for patients needing non-invasive ventilation for Covid-19 patients. A standard operating procedure was drafted in April 2020 [exhibited as **PT/20 – INQ000410175**] and a quality impact assessment undertaken. For Critical Care during April 2020, the staff to patient ratio ranged from 1:1 to 1:2.5 (at the time of peak critical care occupancy on 8 April 2020). It should be noted that there was a different skill mix during this time compared to normal critical care staffing.
55. Ventilation of ward areas was a high priority for the hospital and this was led by the Director of IPC and the IPC nursing team. In the early part of the relevant period this was based on staff opening windows in clinical areas to ensure natural

ventilation. The hospital then deployed 36 Rensair machines in August 2020 which are portable air-purifying machines with a high-efficiency particulate absorbing (“HEPA”) filter. These were allocated to clinical areas by the IPC team based on risk assessment, including Covid-19 wards, ward bays where there was exposure to respiratory infections and areas (inpatient and outpatient) where aerosol generating procedures (“AGP”) were performed. In order to create additional isolation capacity the hospital also deployed eight RediRooms from May 2022 which effectively creates isolation ‘rooms’ within a patient bay on the ward. The RediRoom has a built-in HEPA filter delivering 12 air changes per hour.

56. A Covid-19 workplace assessment was introduced in June 2020 to address IPC issues in the working environment [exhibited as **PT/21 – INQ000410176**]. Social distancing in areas such as shared offices and rest rooms was a particular challenge. Maximum occupancy for specific rooms was addressed by the use of laminated notices. Guidance on managing workspaces, specifically use of masks, distancing and cleaning and disinfection of workspaces was issued to all staff in June 2020 [exhibited as **PT/22 – INQ000410177**]. Mask wearing in offices was on the basis of a local risk assessment. In line with updated national guidance released on 9 September 2020, this was strengthened to state that facemasks must now be worn by all staff in any area in addition to social distancing and hand hygiene protocols i.e. even if working in an office with other colleagues, a mask should be worn even if social distancing could be achieved. The only exclusion would be where there were health related difficulties in relation to wearing a mask or where staff were working alone in an office. A further challenge was created by the Prime Minister’s announcement on 8 December 2021 that people should work from home where possible with effect from 13 December 2021. As a hospital we were required to balance the need to staff our clinical areas and ensure enough senior staff were available on site so this required careful communication. Social distancing of two metres (rather than one metre) was reintroduced and other IPC measures reinforced. This was communicated to senior staff [exhibited as **PT/23 – INQ000410178**]. Mandatory mask wearing in non-clinical areas was then removed in April 2022.

57. An important infection prevention and control measure throughout the relevant period was to implement patient and staff testing for Covid-19 in line with national guidance. In general terms, hospital policy adhered to all guidance, apart from some deviation during the relevant period, where there was increased testing in response to triggers such as local outbreaks, management of operational flow within the hospital (with particular regard to near patient testing in the Emergency Department) and response to changes in local epidemiology. At no stage did the hospital reduce staff or patient testing below recommended national guidance. On the contrary the hospital proactively undertook measures such as screening of asymptomatic staff based on local intelligence, ahead of any national guidance.

Patient testing – urgent and emergency care

58. The first guidance on symptomatic testing that I am aware of dated back to 27 January 2020, before the relevant period, and was issued by Public Health England. At this stage any patients presenting with a relevant travel history and potential Covid-19 symptoms were required to be discussed with the local health protection team and arrangements made for testing at the laboratory at PHE Colindale. As of 11 February 2020, PCR testing for Covid-19 then became available in the PHE Regional Public Health Laboratory in Cambridge [exhibited as **PT/24 – INQ000410179**].

59. As of 2 March 2020, following a letter from the National Strategic Incident Director, all patients admitted to the intensive care unit with a community acquired respiratory infection irrespective of any relevant travel history or links to other cases were tested for Covid-19 with samples sent to the PHE laboratory in Cambridge as above.

60. The testing landscape was dynamic early in the relevant period as national capacity increased and eligibility for testing changed. Community samples were sent to the hospital for forwarding to Cambridge for testing, along with hospital samples, with results being sent back to Bedford Hospital for action. It was recognised that this escalation in testing was putting pressure on the hospital's microbiology laboratory, particularly around communication of community positive

results and the action required. This was subsequently clarified in an email from the PHE Health Protection team explaining the process to be followed [exhibited as **PT/25 – INQ000410180**]. This initial process of community symptomatic testing then ceased on 13 March 2020.

61. On 4 March 2020, pathology networks were required to identify an NHS hub laboratory to provide a minimum capacity of 500 tests per day. Bedford Hospital is part of the ME5 Pathology Network. Bedfordshire Hospitals NHS Foundation Trust produced a network support plan on 7 March 2020 (centred at Luton and Dunstable University Hospital) to provide network capacity [exhibited as **PT/26 – INQ000410181**]. It should be noted that at this time laboratory services at Bedford Hospital were provided by a private company (Viapath) which then transitioned back to a cross-site NHS service on 1 July 2020. Luton and Dunstable University Hospital commenced with validation of PCR testing on 8 April 2020. However this laboratory did not process samples from Bedford Hospital which were sent to other laboratories. Capacity of testing in Luton was sufficient only for that hospital.
62. There was a national instruction on 24 April 2020 to expand Covid-19 testing to all non-elective (i.e. emergency admission) patients including those without symptoms. The rationale for testing asymptomatic patients was a recognition that high viral loads may be present in the 48-72 hours before becoming symptomatic. This guidance was sent through on a Friday evening from the national team at 20:56; this was finally cascaded to all teams on 27 April 2020 and is a further example of where this should have been cascaded earlier to enable more rapid implementation.
63. Weekly PCR testing of all inpatients then commenced on 22 June 2020. Prior to processing of samples at Bedford Hospital, there were delays in results being available due to processing in external laboratories (PHE Cambridge initially, Peterborough City Hospital and then subsequently where samples were sent to Source Bioscience in Nottingham (a private laboratory). This impacted on elective admissions as well as discharge of patients back to a care home who required a negative Covid-19 result. At times delays up to seven days from the sample taken to receiving a result were reported.

64. Due to concerns about increasing number of Covid-19 cases in Bedford Borough and the turnaround time for PCR testing of patients in the Emergency Department, plans were put in place from 23 June 2020 to move eight SAMBA II machines (Simple Amplification Based Assay) from Luton and Dunstable University Hospital to Bedford Hospital. This is an automated point of care test with results available in 90 to 120 minutes. Each machine was able to process 12 tests in a 24 hour period with a total capacity therefore of 96 tests. A dedicated location adjacent to the Emergency Department was set up and a staffing rota put in place to run the tests 24/7 - a single staff member is required for processing these samples. Testing commenced on 28 June 2020. However, due to peaks and troughs in the workload during the working day and a need to ensure rapid testing without delay, a further four SAMBA II machines were transferred on 10 July 2020 leading to a capacity of 144 tests per day. These machines were in continuous use and at times required urgent maintenance due to inconsistent results. Confirmatory laboratory PCR samples were also taken in case of false positives; a field safety notice from the manufacturer was noted where positive results from the tablet module did not match visual inspection of the testing cartridge.
65. Bedford Hospital's laboratory then began processing PCR samples on 9 July 2020 with a capacity of up to 900 tests per day. This obviated the need for sending samples elsewhere and provided quicker turnaround. Following publication of the NICE 'COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services' on 27 July 2020, the hospital translated this into local guidance reducing patient isolation time pre-operatively with a PCR test 72 hours before admission and no further need for household isolation.
66. From winter 2020, lateral flow testing was also used to support patient flow in the Emergency Department, as per national guidance issued 24 December 2020 as well as maternity services.
67. In May 2021 the hospital started sending PCR samples for genetic sequencing which contributed to providing local and regional mapping of circulating Covid-19 variants (Alpha, Delta and subsequently Omicron variants).

68. During a period of high numbers of cases in the hospital in January 2022, the hospital undertook daily lateral flow testing of all inpatients which replaced PCR testing every 72 hours.

69. The hospital noted the standard operating procedure 'Testing for inpatients', published 4 April 2022 but took a different approach to this i.e. PCR tests continued to be undertaken on admission and at day three and day five rather than moving to lateral flow tests for subsequent testing. Clinically vulnerable patients also continued to be tested with PCR every 72 hours after day five. For patients being discharged to a care home, a negative PCR was still required although noting that a Covid-19 positive patient could be discharged if the care home could manage them safely with appropriate IPC precautions. This was a more cautious approach which was communicated to all staff on 6 April 2022.

Patient testing – elective admissions and outpatients

70. Pre-operative testing of patients for routine admissions and procedures commenced in early May 2020. Initially, patients were required to self-isolate along for 7 days with a PCR test planned 72 hours before admission. Following national guidance this was extended to 14 days household isolation and PCR testing 72 hours before admission. In the transition period clinical teams were supported in risk assessing patients with existing bookings to avoid cancellations where possible. A dedicated drive through location for pre-operative patients was in place from 26 May 2020. As the pandemic progressed the duration of the pre-procedure isolation changed. Restrictions were then relaxed in October 2021 with the removal of mandatory three day isolation before a procedure, moving to an advisory recommendation. Whilst pre-operative PCR remained for theatre procedures, patients undergoing outpatient procedures, endoscopy and dental procedures required a pre-operative lateral flow test only [exhibited as **PT/27 – INQ000410182**].

71. As part of the outpatient recovery programme and the need to maintain a Covid-19 safe environment in high footfall areas, a programme of community supervised

lateral flow testing prior to attending a hospital appointment was set up in Bedford Borough in spring 2021. This was funded by the DHSC but it was noted in June 2021 that the numbers of patient attending community testing centres was reducing. The hospital subsequently moved to requiring patients to self-test and report through the online NHS platform. The requirement for outpatient testing ceased in April 2022.

72. The hospital noted the standard operating procedure 'Testing for elective care pre-admission patient pathways', published 4 April 2022. Except for high risk patients or procedures, the requirement for pre-procedure PCR testing was removed with patients required to test with lateral flow and report through the gov.uk portal 72 hours before the procedure and the evening before with evidence required on admission. The 72 hour test was important as if positive this would allow time for another patient to be scheduled in order to avoid wastage of a theatre slot.

73. As treatments for Covid-19 evolved (which are outside of the brief for this module of the Inquiry), the hospital began testing for spike antibodies in summer 2021. The cohort tested were those admitted with Covid-19 aged over 50 or aged 12-49 with impaired immunity i.e. immunocompromised. Those testing negative for these natural antibodies, which would protect against infection, would then have been eligible for targeted treatment with monoclonal antibodies (casirivimab and imdevimab).

Staff testing

74. As patient testing capacity increased in the system, the hospital received a letter from the Chief Operating Officer, NHSE/I on 29 March 2020 indicating that some testing capacity could be used to test symptomatic household contacts of staff to enable release of staff from self-isolation and be deployed back to high priority clinical areas. This was discussed in the trust's Strategic Incident Control Group meeting on 30 March 2020 and a plan enacted to test early in the 14 day isolation period to achieve maximum benefit of return to work. This guidance was published on 3 April 2020 [exhibited as **PT/28 – INQ000410183**] and widened to include symptomatic staff. Testing was achieved through 'drive through' testing of staff

and/or household contacts in critical roles as identified by their general manager. This was available seven days a week. From 16 April 2020 there was also an option to refer key staff for testing at several sites in the community which was provided by East London NHS Foundation Trust and which was supported by a military logistics expert. However staff were preferentially signposted to the hospital based testing as this linked to Occupational Health. Due to samples needing to be sent off site to Cambridge for processing there were frequently delays of several days in receiving results.

75. The hospital took part in a national point prevalence pilot of testing asymptomatic staff and patients on 29 April 2020 which was on a voluntary basis. The prevalence positivity rate was 6.2% (195 staff tested).
76. Weekly testing of asymptomatic staff working in 'super green' pathways commenced end May 2020 which enabled safe return of elective activity - also noting that patients required a negative swab prior to admission. In addition, a rotational programme of staff screening in other clinical areas was implemented in June 2020 as well as temperature-checking of all staff prior to a shift [FAQ for senior staff are exhibited as **PT/29 – INQ000410184**]. It is important to note that this local guidance predated national guidance on asymptomatic staff testing using spare capacity which was published on 24 June 2020.
77. Following a rise in Covid-19 cases in Bedford Borough in July/ August 2020 and a directive from NHSE/I, Bedford Hospital undertook point prevalence testing of all hospital staff from 7 August 2020 [email to all staff exhibited as **PT/30 – INQ000410185**]. Only one positive case was identified through the first tranche of testing. Positivity rates then remained low in August/September 2020 with a significant spike in October/November 2020, coinciding with the beginning of the second wave. From 9 August 2020 to 27 December 2020 there were 113 cases detected out of 17786 staff samples screened with PCR (0.64%). The hospital's testing predated the letter of 29 October 2020 from the National Medical Director and Chief Nursing Officer, NHSE/I covering staff testing in areas of high community infection rates.

78. Screening of patient-facing staff then moved from PCR testing to Lateral Flow Device (“LFD”) testing. The Novel coronavirus (COVID-19) standard operating procedure for asymptomatic staff testing dated 16 November 2020 was received on 17 November 2020 along with a user guide for staff on the LFD. Within seven days the trust (both hospital sites) set up an online reporting system for logging results. LFD kits were available on 26 November 2020 and piloted on the acute medicine unit at Bedford Hospital. Communication was then sent out on 30 November 2020 from the Deputy Chief Executive and Chief Nurse to patient-facing staff for twice weekly swabbing and reporting [exhibited as **PT/31 – INQ000410187**]. It is important to note that this was voluntary although clinical staff were encouraged to take part in this. There were adverse reports in the media about the effectiveness of this test but the importance of this was reinforced to staff. Those who returned a positive lateral flow test were required to isolate but then take a confirmatory PCR test to confirm infection. This approach was taken to ensure that only those staff who needed to isolate were away from work but this requirement was then removed in April 2022. The use of testing was expanded to all hospital staff in February 2021. The hospital was notified by the Head of Commissioning for Acute Specialised Services, NHSE/I on 16 June 2021 that as of 5 July 2021 staff would need to order LFD kits through the national web site and report through the gov.uk reporting portal (noting the updated standard operating procedure “Use of lateral flow devices for asymptomatic staff testing”, 2 July 2021). The hospital’s internal LFD reporting portal was disabled on 19 July 2021 and staff redirected to the gov.uk portal. There were no shortages of LFD kits available for those requiring them when procured by the hospital; however on 16 December 2021 a message was cascaded down through the EPRR route noting issues with online ordering which was stated to be a logistics issue due to delivery slots [exhibited as **PT/32 – INQ000410193**].

79. With the emergence of the Omicron variant in November 2021, further guidance was issued to staff around return from international travel. For those returning from ‘red list’ countries (mainly southern Africa) staff were required to isolate at home for 10 days with PCR testing on days two and eight; travel from countries not on the red list required staff to undertake a PCR before returning to work with lateral flow testing for 10 days. Further restrictions were then put in place from 28

November 2021 requiring all travellers returning from an expanded list of 'red list' countries to stay in managed quarantine hotels; one member of staff was affected by this.

80. The guidance in terms of self-isolation following a positive PCR test changed in December 2021, allowing clinical staff to return to work on day eight as long as they had negative lateral flow tests on days six and seven. A UKHSA Health Protection Briefing notice on 14 January 2022 then amended this to allow return if negative lateral flow tests on days five and six but staff were required to continue testing until day 10. The same information was provided in a letter from NHSE/I that day which is another example of duplication.

81. The government changed the requirements for international travel on 11 February 2022, removing the requirements for quarantine. The hospital requested all vaccinated staff to take a lateral flow test before returning to work after international travel and to continue testing for seven days [exhibited as **PT/33 – INQ000410194**].

82. A further key milestone was the government's announcement of the Living with Covid-19 plan following an announcement on 22 February 2022. This raised questions and concerns from staff before details of the plan were announced, particularly around the public messaging that isolation was no longer a legal requirement but instead moved to advisory. NHSE/I wrote with an initial update on 23 February 2022 outlining areas which were due to be reviewed and others that were likely unchanged. The standard operating procedure 'Symptomatic and asymptomatic staff testing' was then published on 26 April 2022.

Shortage of testing supplies

83. Early in the relevant period there was a shortage of reagents for PCR testing but this predated testing undertaken on the Bedford Hospital site. Multiple testing systems were eventually in place across the two hospitals which helped manage demand. As of December 2020, Bedford Hospital was allocated reagents for 2000 tests per week for the Hologic Panther platform but the demand was up to 2600

tests per week. It was noted that there was a national shortage of reagents for this platform. Patient testing was preserved at Bedford Hospital, but staff samples were then sent to Luton and Dunstable University Hospital, which used a different testing platform and therefore was not affected by this shortage. There was a turnaround time of 48 hours for results, although it should be noted that lateral flow testing was in place [exhibited as **PT/34 – INQ000410195**]. The microbiology service for the trust was subsequently centralised at Bedford Hospital in November 2021. I also note that there was a shortage of swabs for testing in early June 2020.

Nosocomial infection

84. Nosocomial infection (indeterminate, possible or definite hospital-acquired infection (“**HAI**”) is an inevitable consequence of managing high numbers of patients in a hospital estate not consisting solely of individual side rooms in the context of a pandemic and evolution of new variants. Although robust testing regimes for patients and staff were in place (see above) the nature of the disease i.e. incubation period before symptoms and asymptomatic disease in some individuals does mean that transmission can occur despite good adherence to all infection prevention and control practices. This was a specific issue earlier in the relevant period where samples were sent off site for processing with delays of up to seven days in receiving results reported, as outlined in paragraph 63. Symptomatic patients and/or staff were managed as if they were Covid-19 positive until such time as results were available. The main impact of this delay was in discharge to care homes for those requiring a negative test. Nosocomial infection was also a significant issue in the second wave of the pandemic where 50% of inpatient beds were occupied by patients with Covid-19. The trust numbers of nosocomial infections were not dissimilar to other hospitals across the East of England and across the country (which was also reported by the Health Service Journal. A regional HAI sitrep was regularly circulated by the Regional Chief Nurse [example exhibited as **PT/35 – INQ000410196**]. The hospital was sighted on draft national guidance from NHSE/I patient safety team published (undated) at end February 2021 which outlined the minimum response to reporting, reviewing and investigating hospital-onset Covid-19 deaths between February 2021 and May

2021 [exhibited as **PT/36 – INQ000410197**]; this was in line with the approach the hospital had taken.

85. The trust adopted all national guidance in relation to Covid-19 and translated this into local guidance that was shared across both our hospital sites, including Bedford Hospital. Clarity on isolation requirements for patients continuing to test positive after 14 days was an issue which required discussion with PHE. Each nosocomial outbreak was reported on the trust's incident reporting system and investigated by the hospital's infection prevention and control team. Where outbreaks were in place an Incident Management Team was set up which was attended by the infection control team at the hospital, regional infection control colleagues and public health. Immediate actions included enhanced staff and patient testing, reinforcing guidance, cohorting patients and closing bays or wards and working closely with the operational management team.
86. The inquiry are aware of a media report [exhibited as **PT/37 – INQ000410198**] from February 2021 into patients awaiting discharge who died from nosocomial Covid - 19 infection. The report was based on information tabled at Bedfordshire Hospitals NHS Foundation Trust public board meeting held on 3 February 2021 by video conference [exhibited as **PT/38 – INQ000410199**, page 71]. Six serious incidents in relation to nosocomial Covid-19 deaths were reported between October and December 2020. In addition to external reporting of all Covid-19 related deaths through the Covid Patient Notification System ("**CPNS**"), internal trust governance around reporting of nosocomial deaths was as follows. Deaths were initially subjected to Medical Examiner scrutiny. Where concerns, such as nosocomial infection, were identified this was highlighted to me as Medical Director and cases were then discussed at the trust serious incident panel (Post Event Action Review for Learning). Cases declared as serious incidents were then reported through the national Strategic Executive Information System ("**StEIS**") and an investigation commenced. As part of each investigation a Covid-19 root cause analysis was undertaken by the infection prevention and control team covering demographics, clinical presentation, chronology, isolation and sampling, treatment for Covid-19, environmental factors, organisational issues, optimisation of Covid-19 control in the hospital, lessons learned and a judgement on preventability. The Covid-19

RCA template is exhibited as **PT/39 – INQ000410200**. These fed into the serious incident reports.

87. Findings arising from investigation of these six deaths were as follows; a) a delay in transfer of patients to the community for rehabilitation and/or ongoing pathways of care led to exposure to Covid-19 which might have been prevented had the patients been discharged before Covid-19 exposure (three patients). This would have included bed availability and the requirement that care homes needed a negative Covid-19 test prior to accepting a patient; b) delays in transfer to community care was also noted in one patient who contracted Covid-19 before being fit for discharge with subsequent deterioration; this would not have affected the outcome as the patient would have been transferred back to hospital from the community when there was a deterioration c) exposures in patients with other significant health problems who subsequently contracted Covid-19 from another patient in a ward bay (two patients) d) there were no identified lapses in infection control practices by staff and no evidence of staff to patient transmission; e) all patients were screened for Covid-19 on admission and there was in place a schedule of regular inpatient screening to detect new onset asymptomatic Covid-19 for those who had a negative screen on arrival in the Emergency Department. There was some variation in the frequency of screening but this would not have affected outcome. It was also recognised that the near-patient rapid Covid-19 PCR test used in the Emergency Department (SAMBA II) could potentially produce a negative result in some patients without symptoms. This testing was used to ensure that patients were placed in correct 'red' or 'green' clinical areas. All actions were undertaken internally to minimise the risk of nosocomial infection, including reinforcement of IPC processes, but capacity in the community for rehabilitation and ongoing care pathways and the requirement for a negative Covid-19 test prior to discharge to a care home was outside of the direct control of the hospital. As part of normal operational processes, regular engagement with system partners to facilitate discharge was in place.
88. Any serious incidents involving community healthcare services (East London NHS Foundation Trust) were investigated jointly and learning and feedback shared. There was no regional or national support required for these investigations as

these were part of normal clinical governance processes. The hospital was supported by BLMK CCG (as was) in terms of reviewing these cases and actions arising.

Supply and use of personal protective equipment (“PPE”) during the pandemic

Supply of PPE

89. Procurement and supply of PPE was clearly a fundamental part of the pandemic response. The hospital followed all appropriate procurement options to ensure a supply of PPE. To my knowledge the hospital at no stage ran out of PPE but supplies were low at times, including Filtering Face Piece 3 (“**FFP3**”) masks, surgical masks and long-sleeved gowns.

90. Initially in the relevant period, the hospital bought PPE directly from suppliers. It was recognised on national webinars that supply and delivery was ‘just in time’. As of 11 April 2020, four different FFP3 masks were in stock. As the pandemic progressed, further fit testing (see below) was required with alternative masks due to non-availability of some masks (for example, the hospital was down to the last 50 3M 8833 masks on 26 May 2020). An example of escalation to the East of England regional Covid-19 hub when supplies were low (16 March 2020) is exhibited as **PT/40 – INQ000410201**. This was escalated by region to the NHS Supply Chain. I also note a request to the NHS Shared Business Services national stock centre on 15 April 2020 for 2000 FFP3 masks when procurement through usual channels had failed. Availability of long-sleeved gowns was an issue and I note a letter from the Regional Director, NHSE/I on 16 April 2020 regarding stringent measures to be put into place to preserve stocks and directing that national PPE guidance should be followed [exhibited as **PT/41 – INQ000410202**]. The situation at Bedford Hospital as of 17 April 2020 was two days stock of non-sterile fluid resistance gowns and three days of sterile gowns. This was a national issue due shortages in the global market. It was noted that the UK government had not previously stockpiled gowns for a pandemic. A further letter was received on 20 April 2020 from the Regional Director on contingency options for PPE,

including the possibility of re-use [exhibited as **PT/42 – INQ000410203**]. For Bedford Hospital, the supply chain position improved by 24 April 2020.

91. As regards distribution within the hospital, PPE was released to the ward areas from a central hospital location. This may have led to an impression from some clinical areas that stocks were low as large volumes were not stocked in individual clinical areas but it was imperative to manage this resource centrally. As a merged trust we were also able to transfer PPE between hospital sites if required. There were no requests to other hospitals or NHS Trusts for PPE to my knowledge.
92. I note the Department of Health and Social Care “**DHSC**”) Covid-19: Personal Protective Equipment (PPE) Plan which was published on 10 April 2020. This was followed by a letter on 1 May 2020 indicating a move to national procurement of supplies relating to the pandemic including PPE. I have been advised that following national procurement, supply through the NHS Supply Chain and Foundry portal was more visible and standardised in terms of delivery time (48 hours) and product lines available. The National Supply Disruption Response mechanism was used for emergency orders on five occasions (isolation gowns, heavy duty aprons, fit test kits, Type IIR surgical masks and FFP3 masks) and was effective when utilised with delivery within 24 hours.
93. In the early part of the relevant period, there were offers of internationally sourced PPE through individual staff contacts but these were not taken up due to lack of assurance of quality. As of 15 April 2020 a process was set up for any PPE donations to be handled by the hospital charity, to include plastic visors and goggles but excluding any face masks. No PPE from these sources was used in practice at Bedford Hospital; had there been a requirement to use due to shortages in the NHS supply chain this would have been assessed by the IPC team and approved by the executive directors. Local organisations were also involved in producing scrubs for individuals. Gowns were due to be produced via a contact within the hospital charity, but having contacted the Government website (coronavirus-support-from-business) and considering advice from the Health and Safety Executive and the Medicines Healthcare Regulatory Agency (which

required formal testing and approval) this was not pursued but was reserved in the event that this was required for future emergency use only .

94. The issue of PPE shelf life was addressed in a letter from the Strategic Incident Director on 20 March 2020. This provided an explanation of relabelled use-by and/or expiration dates on supplies which had been part of a pandemic stockpile. Internally staff had raised concerns about this and this required circulation of the government's messaging on this. The letter did not contain sufficient detail as to why expiry dates had been extended. I am sighted on an email from the NHS Supply Chain which provides further explanation i.e. 3M mask shelf life can be extended from 2019 to 2021 in view of the fact that these had been stored in temperature-controlled warehouses as part of a pandemic stockpile and that the UK had used an 11 year storage maximum in comparison to 17 years in the USA. There were a number of occasions where PPE of insufficient standard was received. As one example, isolation and recall of 'Tiger' goggles was required on 10 May 2020. 140 pairs were retrieved from clinical areas and stocks of 16,500 isolated and returned. In all there were 15 recalls of items not fit for purpose in the relevant period of which five lines were stocked by the hospital, specifically aprons, face visors, FFP3 masks and clear type IIR surgical face masks. Inadequate quality PPE from a non-NHS gown supplier was also returned. Although the hospital considered use of FFP2 masks when FFP3 supplies were short, these would also require fit testing and the advice from the Health and Safety Manager was that these would not meet Health and Safety Executive requirements [exhibited as **PT/43 – INQ000410204**].

95. As the pandemic progressed it was noted that FFP3 resilience had improved and this was confirmed in a letter from DHSC on 17 June 2021.

Fit testing

96. At the start of the relevant period, clinical staff working with patients with Covid-19 (medical, nursing and physiotherapy) and those required to undertake aerosol-generating procedures were prioritised for fit testing. Sessions were undertaken in person for staff working on the acute medical wards, Emergency Department and

paediatrics. This was followed by direct bookable appointments through Occupational Health which was communicated to all staff on 27 March 2020. There were concerns about lack of availability of fit test solutions at the end of March 2020 which would have been a direct consequence of a massive increase in demand across the country and globally, as mentioned on a national call on 26 March 2020. Alternative sources were considered by Occupational Health although no supplies were then received; I noted from a national webinar that fit testing solution was then being manufactured at Porton Down. From February 2021, two full-time equivalent fit testers were provided across both hospital sites by Ashfield Healthcare, through the NHS Supply Chain. Further communication was received from the DHSC on 25 October 2021 requiring hospitals to take a number actions: increase the number of masks an individual was fit tested against, to allow these to be used interchangeably (noting that nationally 14 different masks of suitable quality were available); to ensure that results of fit testing were documented in the Electronic Staff Record; and to ensure a programme of fit testing was implemented for new starters. A data return was required to be submitted to the national team at NHSE/I [exhibited as **PT/44 – INQ000410205**]. As of March 2022, the hospital stocked 10 different FFP3 masks.

The impact of PPE availability and use on staff

97. Although the hospital did not run out of suitable PPE, there was a perception from anxious staff having to manage large numbers of patients in a challenging situation that supplies were not available. An example is an incident report submitted from the Emergency Department highlighting these concerns [exhibited as **PT/45 – INQ000410206**]. Regular communication was sent to staff assuring that supplies were in place.
98. In addition, some staff drew attention to differing guidance between PHE and the Center for Disease Control (“**CDC**”) in the USA which early on recommended a higher level of PPE for healthcare workers and this led to concerns about the safety of PPE in use. In a national call on 26 March 2020, it was stated that PPE required for suspected or confirmed Covid-19 patients within one metre required a surgical mask, apron, gloves and eye protection if there was a risk of splashing. It was

stated that Covid-19 was not airborne, which was the opinion at that time. It was noted that advice was being provided to the government by the New and Emerging Respiratory Virus Threats Advisory Group (“**NERVTAG**”). In a further PPE specific national call on 27 March 2020, the Deputy Director of the National Infection Service, PHE stated that the approach to PPE should be as for pandemic influenza with additional precautions for aerosol generating procedures. In April 2020, national guidance for non-Covid areas again recommended surgical face masks whereas some staff felt that all patient interactions should be protected with an FFP3 mask; this was particularly the case with some surgical specialties. The tension therefore was to manage these staff concerns in the context of a) adhering to national guidance and b) ensuring FFP3 masks remained available for higher risk areas. Individual issues where staff were choosing to use enhanced PPE for low risk environments were dealt with sensitively. Staff anxiety was also increased by sometimes contradictory information in the press and social media as well as concerns highlighted by other organisations such as the British Medical Association (“**BMA**”) which were cascaded down to local level and subsequently addressed through productive discussion [email from BMA Local Negotiating Committee chair exhibited as **PT/46 – INQ000410207**).

99. Management of cardiac arrests with patients with known or suspected Covid-19 in terms of PPE was also an early concern. When initiating a cardiac arrest call, as of 20 March 2020 staff were instructed to ensure that the message “adult cardiac arrest PPE required” was sent out to ensure those attending were alerted to this. As of 6 April 2020, any cardiac arrest within the hospital was treated as a suspected Covid-19 positive patient in line with the Resuscitation Council UK guidance.

100. As supply of FFP3 masks stabilised, an interim change to PPE guidance for the theatre environment was made on 6 May 2020, allowing surgeons and scrub staff use of FFP3 for all general anaesthetic and local anaesthetic cases where there was aerosol generation, ensuring that a single mask was used for each session (half day) and minimising the number of people in the operating theatre to essential staff only [exhibited as **PT/47 – INQ000410208**]. The ‘COVID-19: Guidance for the remobilisation of services within health and care settings’

published 20 August 2020 then recommended that patients were managed in three pathways i.e. high risk, medium risk and low risk. For the latter, this reverted back to standard IPC precautions for surgery; again this undoubtedly caused anxiety with those preferring to use a higher level of PPE.

101. For staff working in Covid-19 and/ or high risk areas who were unable to use an FFP3 mask due to health conditions, significant claustrophobia, pressure sores from prolonged mask use, failed fit testing and those with facial hair who were unwilling to be clean shaven for religious reasons (it should be noted that correct fitting of an FFP3 mask requires tight skin contact), alternative PPE was provided once this was able to be sourced. This included respirators (reusable masks with filters such as the JSP Force 8) and Powered Air Purifying Respirators (“PAPRs”) i.e. powered hoods. Both were commercially procured as these were not available through the NHS Supply Chain and were on site from 7 May 2020. However, a National Patient Safety Alert was received on 25 August 2021 regarding valved FFP3 masks and PAPRs due to the risk of patient exposure to contaminated air in a surgical environment. This was managed by removal of products where alternative FFP options were available and risk-assessing individual staff members where no other PPE was suitable in terms of the physical environment and work undertaken [risk assessment 19 October 2021, exhibited as **PT/48 – INQ000410209**].

102. A PHE/ HSE alert was received on 24 June 2020 recognising the risk of heat stress due to the use of PPE which was in the context of a period of hot weather. Heat undoubtedly had an impact on staff delivering care in this challenging environment.

103. The hospital managed anxieties around PPE supply and use through repeated communication at organisational level and also with individual staff communication through a dedicated Covid-19 email inbox. During the second wave of the pandemic the hospital issued communication to clinical leaders on use of PPE, recognising staff anxiety about this issue and ensuring that staff felt safe at work [exhibited as **PT/49 – INQ000410210**]. In my opinion, the issues outlined above did not have any effect on patient safety or well-being.

The impact of visiting restrictions during Covid-19

104. I note the visiting guidance issued by NHS England on 16 March 2020 stating that all visiting was to be suspended except for very specific circumstances. Prior to this guidance being issued, on 13 March 2020 the hospital restricted ward visitors to one visitor per patient at a time; this was then restricted to one visitor per patient per day for one hour on 16 March 2020 followed by a restriction to zero visitors on 24 March 2020 except for end of life care, maternity (one birthing partner allowed) and children (one parent allowed). NHS England posters in regards to visiting were displayed in all ward areas. For end of life patients with Covid-19 on intensive care and on the general wards, a flowchart was produced to help staff navigate infection control concerns and the steps needed to reduce the risk to the visiting relative e.g. PPE use and advice on isolation as well as signposting for bereavement processes [exhibited as **PT/50 – INQ000410211**]. Further local guidance in May 2020 recognised the impact on dying patients not being able to see their loved ones as well as the impact on families themselves [exhibited as **PT/51 – INQ000410212**]. Although one visitor per patient was in place it was recognised that where social distancing was possible and where beneficial to the dying patient then a second visitor could be allowed. It was important to ensure that visitors at personal high risk from Covid-19 or those who should be self-isolating did not visit and that appropriate PPE was used for the visit. It was not possible to fit test visitors for FFP3 masks however.

105. Where visiting was not possible a number of methods of facilitating contact with patients and their loved ones was put into place. The hospital set up a Next of Kin ("**NOK**") liaison service/helpline. This commenced at the end of March 2020 and operated 7 days a week from 09:00-17:00. The Standard Operating Procedure for the helpline altered as the pandemic progressed and any changes were kept in line with national guidance at the time (for example, version 2 of the NHS England guidance, 16 March 2021). The liaison service provided a daily update to the patient's family/NOK. Patients were also encouraged where possible to keep in contact using their own mobile devices. Where this was not possible the hospital

provided use of an iPad for video calling with staff assisting patients to use this technology. This was of particular importance for patients on intensive care – either those deteriorating who needed to speak with families or those who were recovering from their critical illness. All changes to visiting were publicised on the trust’s social media platforms (Facebook page, X (previously Twitter)).

106. The visiting guidance enabled patients at the end of life or those with cognitive impairment to receive visits from family members/carers to ensure their comfort whilst in hospital and also ensure good communication with the treating clinical team.

107. Clearly the inability for families to visit loved ones was an intolerable burden for families and would have contributed to the moral distress of staff looking after those patients. In particular, families would not have been able to say goodbye where a patient had rapidly deteriorated. However, this had to be balanced against the risk of transmission from visitors with Covid in an incubation phase to other patients and staff and the risk of transmission to visitors with unknown underlying risk factors. In this situation there was no right or wrong approach. The hospital considered and facilitated if possible every exceptional request for visiting.

108. The hospital noted the ‘Living with Covid-19 – visiting healthcare inpatient settings’ update, published 8 March 2022. From 4 April 2022, two visitors per patient for one hour were allowed with removal of the requirement for lateral flow testing although face masks were still mandated.

The impact of Covid-19 on patient care and treatment

Non-Covid conditions

109. Throughout the relevant period, there was a significant impact on all patients with non-Covid conditions. The hospital continues to manage recovery of elective services which has also been constrained by industrial action in

2023/2024. I will focus on the impact on outpatients, routine surgery (using colorectal services as an example) and treatment of ischaemic heart disease.

110. In terms of outpatient work, routine face to face consultations were suspended in March 2020 but the hospital introduced the Attend Anywhere video consultation platform which was first communicated to staff on 25 March 2020. This innovation has remained in place as an alternative to face to face appointments. Throughout several points in the relevant period the hospital was required to identify high risk patients in the outpatient cohort (clinically extremely vulnerable) at specialty level, in terms of those needing to follow government advice on shielding, eligibility for vaccination and for delivery of Covid-19 treatments to prevent hospital admission through the CMDU.

111. Bedford Hospital initially cancelled all non-urgent elective surgical procedures on 16 March 2020. Planning for recovery of non-Covid work with a specific focus on cancer and other urgent work commenced on 24 April 2020, following the peak of the first wave of the pandemic. This was followed by the "Second phase of NHS response to Covid19" letter on 29 April 2020 from the CEO and Chief Operating Officer setting out expectations around fully stepping up non-Covid-19 urgent services over the following six weeks with planning of some routine care, whilst retaining the ability to "surge" should numbers of Covid-19 cases increase. The independent sector was used to provide non-Covid routine surgical work during the relevant period, commencing May 2020. For patients undergoing elective surgery in the 'super green' pathways, pre-operative isolation and PCR testing was implemented as outlined above. Communication in this regard was sent to all patients on the waiting list. The NHS Phase 3 letter of 31 July 2020 required hospitals to accelerate the 'return to near-normal levels of non-Covid services' ahead of the usual winter pressures.

112. For colorectal cancer services, it was noted that patients with concerning symptoms could not access general practice and either withheld symptoms or presented with advanced disease to the Emergency Department. In the initial months of the pandemic routine endoscopy services were completely suspended, as these were presumed to be aerosol generating and therefore a significant risk;

emergency procedures however continued with appropriate PPE. Virtual consultations were used and patients triaged to alternative diagnostics including CT scan (increasing pressure on this service) and faecal calprotectin (a protein measurement in faeces indicating bowel disease). In terms of elective colorectal cancer surgery, it was recognised that Covid was a high risk factor for mortality and routine procedures were therefore suspended early in the pandemic. Some clinical pathways were changed e.g. referral of patients with rectal cancer for chemotherapy and/or radiotherapy prior to delayed surgery and other procedures were deferred with monitoring by CT scan and/or MRI scan for signs of progression. The routine service recommenced in June 2020 using the established 'red' and 'green' pathways. Further brief pauses in the service took place in February 2021 and June 2021. No patients became inoperable in this period and therefore harm was low. In terms of the impact of Covid on surgical technique, laparoscopy (keyhole surgery) was considered a risk early in the pandemic in terms of aerosol generation; mitigations were put into place. In addition practice changed with the use of more stomas (bowel brought out to the skin) to protect anastomoses (where bowel is joined to bowel).

113. Covid-19 had a significant impact on elective orthopaedic surgery, particularly patients awaiting joint replacement. All routine orthopaedic procedures were suspended on 16 March 2020 as outlined above although emergency care continued. The risk to patients and staff on operating in a high risk environment was considerable; this was balanced against the fact that the majority of these patients did not have life or limb threatening problems but pain and poor mobility so the patient harm from cessation of procedures was low. As outlined earlier in the witness statement the independent sector was used to treat patients, commencing June 2020, but this was limited to those without significant co-morbidity. Following the initial phase of Covid-19, elective procedures were resumed and were focussed on urgent patients (for example, revision hip surgery where there was a risk of imminent failure of the prosthesis or infection) but also those who had been waiting more than 78 weeks for treatment. Fewer elective orthopaedic operating sessions were available (10 sessions per week) compared to 15 sessions pre-pandemic. This was due to the reconfiguration of the theatre environment into 'red' and 'green' pathways. Trauma continued in the 'red'

pathway. Following removal of the red/green split, 12 sessions were available for routine work. Due to the significant increase in waiting time for many patients, a waiting list validation exercise was undertaken by questionnaire. The purpose of this was to assess whether they would be prepared to have their treatment elsewhere (either in the independent sector or Luton and Dunstable University Hospital which had more capacity), and to capture information regarding their current clinical condition such as whether they had deteriorated and were in need of urgent clinical review.

114. As regards treatment of patients with ischaemic heart disease, routine outpatient work was reduced to prioritise use of consultant time to help out on the wards during Covid-19 peaks. It was noted that the impact of patients referred who had not been seen face to face in primary care or undergone basic assessment was significant; inappropriate referrals (respiratory conditions being referred to cardiology), patients referred without a clinical examination, blood pressure measurement and ECG, and patients presenting late with cardiovascular disease (delayed presentation and wait time). Clinics were redesigned to meet IPC precautions using staggered appointments, spacing in waiting areas and virtual appointments where appropriate. The cardiac catheterisation laboratory (which is for diagnosis and treatment of patients with coronary artery disease) continued to operate as normal, treating routine and urgent patients. However efficiency was impacted, particularly where Covid-19 positive patients required treatment. The service did notice a reduction in patients presenting for treatment following a heart attack. There was an impact on DC cardioversions (treatment for irregular heart rates), exercise testing and trans-oesophageal echocardiograms which were effectively suspended for a period of time; there was a significant impact on 24 hour 'tapes' (an outpatient test which monitors the heart rate over a 24 hour period). At times the Coronary Care Unit ("CCU") was closed due to Covid-19 admissions; this impacted on non-Covid patients requiring this higher level of care (e.g. cardiac monitoring) which is more challenging to deliver on a non-specialist ward. There was also an impact on inpatients who required transfer to the local tertiary centre for cardiac surgery with extended wait times due to the need to ensure transferred patients were Covid-19 negative; there was also a risk of

nosocomial infection. The impact of the pandemic continues to be felt in terms of the increased outpatient workload.

115. Despite increasing Covid-19 prevalence in November 2021, emergence of the Omicron variant and a move back to a Level 4 National Incident on 13 December 2021, there was still a requirement to ensure management of patients with non-Covid conditions. There was a directive from the National Director of Emergency and Elective Care on 3 December 2021 requiring hospitals to ensure that all patients waiting more than 104 weeks for treatment were reviewed every three months as well as removal of the 'P5' code from January 2022, which was used for patients who chose to defer treatment due to concerns about Covid-19.

Maternity services

116. As regards changes to maternity services during the relevant period, IPC guidance was applied in line with the rest of the hospital. The hospital noted the NHS 'Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic released on 9 April 2020, followed by "Delivering midwifery intrapartum care where local Covid-19 protocols are required to be enacted', 20 July 2020. Recognising the impact of Covid-19 on Black, Asian and Minority Ethnic ("BAME") individuals, the hospital noted the letter from NHSE/I dated 24 June 2020 regarding support for BAME women during the pandemic. In terms of visiting, from 20 March 2020 only one birthing partner per woman in labour was allowed. From 12 April 2021, a single visitor per day was permitted on the maternity ward. These restrictions were in place until June 2022 when two birthing partners were allowed.
117. In terms of antenatal care, from 1 September 2020 partners were able to accompany women at their 20 weeks scan appointment. From 26 March 2021, this was relaxed with partners also able to accompany women at their 12 week appointment; the hospital did note the letter from NHS England 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers', 14 December 2020 around use of lateral flow testing to support safe attendance.

118. There was also a significant change in community maternity care. From 24 March 2020, community antenatal and post-natal appointments were reconfigured to different venues as midwives were no longer able to work from clinics in GP surgeries which had effectively closed to face to face appointments. The antenatal schedule was adjusted from 2 April 2020 with an initial appointment for blood pressure, height, weight and urine analysis followed by a full booking appointment with the midwife via phone by 10 weeks. For postnatal mothers an initial triage phone call was followed up by appointments at day five and day 10 in priority order. From January 2021, day three postnatal appointments at home were reinstated for women who had undergone Caesarean section. All other postnatal women were given a face to face day three assessment in a postnatal clinic at the hospital. All latest guidance and updates were communicated to women by the Bedford Hospital Maternity Facebook page. Education around reduced fetal movement was an important priority. At booking all women were provided with a QR code to link to the 'Feeling your baby move is a sign that they are well' leaflet developed by Tommy's and NHS England with support from other charities. These leaflets were available in a number of languages which was helpful for our diverse local population. In line with national guidance, vaccination in pregnancy was promoted.
119. It was recognized through the hospital's Patient Advice and Liaison ("PALS") and complaints team, and the Maternity Neonatal Voices Partnership ("MNVP") that some service users reported the negative impact of visiting restrictions. During the early stages of the pandemic a regular meeting was set up between Heads of Midwifery / Directors of Midwifery and MNVP groups across the Bedfordshire, Luton and Milton Keynes system to aid service user experience during the pandemic and ensure input into any patient communication. In response to the negative effects of visiting restrictions during Covid-19 and as part of the hospital's ambition to respond to the findings from the Ockenden reports, a dedicated Patient Experience Midwife was appointed in January 2022. This helped improve communication between service users and staff.

120. The hospital noted the 'Living with COVID-19: supporting pregnant women using maternity services and access for parents of babies in neonatal units' action for NHS trusts, published 1 April 2022.

Impact on ambulance handover times

121. In terms of ambulance handover times (the main metric being off load times of less than 15 minutes), there was no noticeable change throughout the relevant period and specifically no difference at the peak of each wave of Covid-19. Daily numbers of ambulances and handover figures during this time are exhibited as **PT/52 – INQ000410213**. I do not hold the data for waiting times for ambulance conveyance as this would be held by East of England Ambulance Service NHS Trust. In terms of actions taken to reduce handover times, this was and remains a key function of the hospital's operational team. The ambulance service's Hospital Ambulance Liaison Officer ("HALO") attends the daily morning bed meeting and has a key role in managing offload delays by taking handovers from paramedics conveying a patient. Any offload delays are frequently due to reduced 'flow' in the hospital which is a function of discharge delays of medically fit patients. Bedford Hospital frequently has the best offload delay performance across the East of England and the performance in this area has been highlighted as one of three exemplar sites following a visit by the NHS England Urgent and Emergency Care team and the Emergency Care Improvement Support Team in 2022. This was also noted again following an NHS England Urgent and Emergency Care peer review visit in 2023.

Decision making and ethical considerations

122. Due to very significant concerns that the hospital would be overwhelmed early in the pandemic and that difficult ethical decisions would need to be made, a Bedford Hospital Covid-19 Ethics Committee was set up in March 2020. Terms of reference were agreed. The purpose and scope are exhibited to this statement as **PT/53 – INQ000410214**. The meetings were chaired by a Critical Care consultant and included senior medical and nursing representation, a non-executive director and subsequently the Communication & Public Engagement Officer from

Healthwatch Bedford Borough. An example of meeting papers from 7 April 2020 are exhibited as **PT/54 – INQ000410215**. This latter exhibit includes a discussion paper in regards to management of cardiac arrests in patients with Covid-19 and is based on the algorithm produced by the Resuscitation Council UK which is included.

123. To my knowledge there was no national decision making tool released for use in the event that the NHS became overwhelmed and unable to provide emergency care. In my opinion there should have been national guidance to provide support for those in all clinical professional groups who may have had to make those very difficult and emotionally challenging decisions. The National Institute for Health and Care Excellence (“**NICE**”) published the ‘*COVID-19 rapid guideline: critical care*’ on 20 March 2020. This has been replaced by the ‘*NICE COVID-19 rapid guideline NG191*’. Although this does cover a number of helpful areas, it was clear that the responsibility was on individual clinicians to make appropriate decisions of which they would be answerable to their professional regulator. The East of England Clinical Senate did produce a helpful document in December 2020 exploring ethical issues in relation to Covid-19 [exhibited as **PT/55 – INQ000410216**]. The Royal College of Physicians also produced a similar document.

124. The criteria for admission to intensive care did not change during the relevant period compared to pre-pandemic. Had the hospital, critical care network and country been overwhelmed, despite using any national capacity in the Nightingale hospitals, then this would have needed to be considered. Any such approach would have been taken through the hospital ethics committee and ensuring that all regulators (NHSE/I, GMC, NMC and the Care Quality Commission) were fully informed of the decision-making behind this. This would also have been escalated urgently to the trust board. It should be noted however that early in the pandemic intubation was associated with a high mortality and therefore as knowledge about the condition was gained, other options such as awake proning (lying on the patient’s front rather than the back) and non-invasive ventilation were used. There was no rationing of oxygen in the hospital (including

non-invasive ventilation) but appropriate governance on correct prescribing and setting the right target oxygen saturation as outlined above.

125. As there was no rationing of care at Bedford Hospital, the ethical problems and moral injury relating to this did not apply. However I believe the effect on clinical staff particularly early in the pandemic when the course of the disease was unknown, when there were limited treatment options other than intubation and supportive measures and personal anxiety, cannot be underestimated and in my view this could have an impact for a number of years to come.

126. In relation to 'Do Not Attempt Cardiopulmonary Resuscitation' ("DNACPR") notices, Bedford Hospital had a Treatment Escalation Plan and Cardiopulmonary Resuscitation policy in place [exhibited as **PT/56 – INQ000410217**]. This includes a copy of the hospital's Treatment Escalation Plan ("TEP") and Cardio Pulmonary Resuscitation ("CPR") decision form (Appendix 3 of this document). At this time the hospital did not use the ReSPECT form but recognised this as valid if a patient was admitted with one.

127. The TEP sets out the limits for treatment, including a resuscitation decision and whether admission to intensive care will be considered or whether ward based care only is appropriate. Withholding oxygen in symptomatic patients with Covid-19 was not considered under any circumstances unless this was part of a clear end of life plan and causing distress to a dying patient. The hospital policy also covers in detail requirements under the Mental Capacity Act for patients who lack capacity. For patients discharged from hospital with a TEP form in place this remains valid whilst in the care of the ambulance service; a paper copy of the form is provided to accompany the patient transfer which is then destroyed on arrival as this then becomes void. Where a community DNACPR order is needed a stand-alone form is completed before discharge (Appendix 4 of the policy) and communicated to the GP. The policy also covers in detail communication with the patient, family and carers and includes a copy of the information leaflet 'Decisions regarding your treatment: a guide for patients and their relatives' in Appendix 2. It should be noted that due to IPC precautions more conversations took place by

phone rather than in person. In addition the hospital set up a next of kin service as a way of communicating to and from families and carers.

128. The policy did not change during the relevant period and it was communicated to clinical staff during face to face training that a TEP/DNACPR decision should not be made solely on the basis of a Covid-19 diagnosis. The Medical Examiner scrutiny of deaths also provided an independent review of the appropriateness of TEP decisions. In 2021, there were spot check audits by the resuscitation training team [an example is exhibited as **PT/57 – INQ000410218**] and teaching provided to nursing staff to ensure appropriate escalation. Following discharge from hospital all patient documentation is scanned onto the electronic patient record (Electronic Document and Records Management System – the system used is MediViewer) and the paper copies destroyed after a defined time frame.

129. I am not aware of any concerns that prior to admission, community DNACPR notices had been issued disproportionately to patients with protected characteristics, such as age, ethnicity or disability nor that clinically inappropriate decisions were being made in the community regarding end of life care in patients with Covid-19. Although I do not hold the detail of the number of patients arriving at hospital with a community DNACPR order in place, I am not aware of any concerns raised with regards to this.

Inequality considerations

130. In terms of the impact on measures adopted by the hospital on patients with language difficulties, impaired hearing or learning difficulties, all appropriate actions were taken to mitigate this although recognising the challenges. Use of clear face masks were proposed as an option for communication with deaf patients in order to enable lip reading; however these masks did not meet infection prevention and control standards and those supplied through procurement were subsequently recalled. I note a subsequent communication from the DHSC on 8 October 2021 making reference to the transparent face mask technical specification and suggesting that organisations should undertake their own due

diligence to ensure that any masks met this specification with protection equivalent to a type IIR surgical face mask [exhibited as **PT/58 – INQ000410219**]. Bedford Hospital did not use clear masks although continued to assess products which became available. In addition, I note that plastic face shields alone provided insufficient protection from Covid-19 and therefore could not be used as an alternative. In terms of the impact of visiting restrictions on patients with limited English the hospital's visiting policies were applied uniformly with exceptions as outlined above in this statement. Face to face interpreters were not available during the pandemic but telephone interpretation was used. Information leaflets were also available in other languages.

The impact of Covid-19 on hospital staff

Wellbeing

131. Covid-19 clearly had a significant effect on wellbeing for those staff working in front line clinical services and staff managing the pandemic response. The physical impact of those working extremely long hours in challenging environments using PPE was considerable. This would have been compounded by the lack of normal 'down time' in personal and family life including exercise and social and leisure activities. Concerns about family and friends and the risk of transmitting infection acquired at work was a significant worry; the hospital sourced local hotel accommodation to enable staff to work whilst protecting their families if they wished. I note that the team approach from all staff was exceptional.
132. Bedford Hospital has a diverse workforce and employs a large number of staff with family overseas, particularly the Indian subcontinent. There was a great deal of anxiety when Covid-19 rates and deaths were peaking in India and that health system was becoming overwhelmed. The hospital provided a supportive webinar for affected staff as well as organising sessions with faith leaders. I also note that more than a year on from the pandemic, a new intake of junior doctors in August 2021 (Foundation Year 1) expressed anxiety about working in 'red' clinical

areas due to perceived risk to family members at home, despite PPE use and vaccination.

133. Overall, the effect on mental health was significant and I believe that many staff will continue to suffer from this. I am not qualified to comment fully on the psychological effects of dealing with the pandemic within the hospital. However, the moral injury experienced by some frontline staff dealing with large numbers of extremely sick, often young and otherwise previously fit patients and the feeling of helplessness associated with the fact that early in the pandemic there were very few options for treatment other than supportive measures, should not be underestimated. Similar moral distress was seen in those managing the pandemic response, up to and including directors e.g. review of Covid-19 deaths, nosocomial outbreaks, concern for staff wellbeing, looking at planning assumptions for deaths (including stepping up a mortuary at RAF Henlow) etc.

134. A further impact on anxiety would have been when staff were asked to work differently during the pandemic, such as a change in clinical area and/or a change in working pattern. The hospital produced a document to allow managers to work through this with individual staff members [exhibited as **PT/59 – INQ000410220**]. This would have been particularly of concern to newly registered staff.

135. Bedford Hospital launched an employee assistance programme (provided by CiC) on 18 March 2020 which allowed employees access to an independent, free and confidential telephone advice service, staffed by highly experienced counsellors who could provide practical and emotional support with work or personal issues. This was felt to be particularly important in the environment at that time. The programme was able to refer staff for counselling if needed. The first iteration of a wellbeing pack containing all offers of support was in place from March 2020 and regularly updated.

136. A national wellbeing support offer for staff (phone, 24/7 text support, free access to mental health and wellbeing apps and a dedicated web site to manage personal health and wellbeing whilst looking after others) was launched on 8 April 2020 although this was publicised in the media first rather than being circulated

through HR Directors. This was circulated to all staff the same day and on further briefings.

137. Support was also provided by our local mental health providers (East London NHS Foundation Trust and Essex Partnership University NHS Foundation Trust) who offered Covid-19 related mental health first aid support, accessible through Occupational Health teams. 1:1 support from a Clinical Psychologist was also offered to staff commencing 30 April 2020. Recognising the importance of clinical psychology, the hospital with support from NHS Charities Together then agreed funding for a full time Clinical Psychologist (2 posts, 0.6 + 0.4 whole time equivalents); the first Psychologist was in post in April 2021. The brief was to focus on the development and delivery of psychologically informed staff wellbeing interventions. These included individual as well as team-wide initiatives that were both responsive to staff needs (mild-moderate level common mental health difficulties including moral distress) and aimed to prevent distress by enhancing wellbeing through teaching and health promotion initiatives. In addition there was consultation and specialist assessments via referral from Occupational Health. The hospital developed a network of staff trained in mental health first aid, the purpose of which was to provide immediate support to affected staff and which was overseen by the Clinical Psychologist(s). BLMK Clinical Commissioning Group (as was) also provided a wellbeing offer from January 2021 [exhibited as **PT/60 – INQ000410221**].

138. I am not aware of any usage of NHS virtual common rooms. However, hospital department and staff groups created their own networks to remain in touch and provide pastoral support to each other.

139. Recognising the need for staff to have somewhere safe to go in order to focus on their own wellbeing, Bedford Hospital had a large area (existing coffee shop) temporarily converted into a wellbeing space with ambient lighting, calming décor and furnishings, music, reclining chairs, drinks, snacks and wellbeing gifts. This was well received and appreciated by staff. These spaces were initially created and supported with donations of food and drink from our local communities. The spaces included information on health and wellbeing (posters

and information leaflets), and advice on how to access additional support if required. In early 2021, the hospital created a permanent health and wellbeing space. A review of all existing rest spaces for staff took place in April/May 2021 which led to investment across wards and departments, as well as picnic benches and tables to allow staff to enjoy outdoor space.

140. An art and wellbeing initiative (take heART) was established to promote wellbeing through the arts. This was set up by staff who collaborated with a range of community partners such as local artists, schools and a local university. Projects have focused on staff wellbeing and have included staff workshops, away days and art installations with an emphasis on accessibility.

141. It is difficult to give a global assessment as to whether these initiatives were of practical assistance to individual staff members but the breadth and extent of the investment in wellbeing is more than I have seen previously in my long career in the NHS. This investment in wellbeing has continued post-pandemic and sessions on promotion of wellbeing are regularly delivered to new staff.

142. During the relevant period many staff were referred to Occupational Health with Covid-19 related issues and supported according to their needs; this included both physical and mental health issues. Advice and guidance was provided including adjustments to work and referral to specialist services as appropriate. Staff were managed in line with Bedford Hospital's sickness absence policy. I am unable to state how many staff formally met the diagnostic criteria for post-Covid syndrome (signs and symptoms persisting beyond 12 weeks) but 12 members of staff were absent for more than 12 weeks as a consequence of Covid-19. The hospital itself not provide a long Covid specialist service but the individual's GP will have been able to refer to specific services as needed.

143. Although only indirectly related to wellbeing, the hospital planned for and delivered a staff vaccination programme which commenced January 2021. This allowed staff to access vaccination on the hospital site and was very well received by those administering and delivering the programme and those being vaccinated.

Risk assessment

144. A manager's checklist was published internally in early April 2020, following earlier drafts in March 2020. The purpose of this was to address whether extremely vulnerable staff needed to be formally shielded (noting the government's advice for high risk individuals) and whether vulnerable higher risk staff needed to move to lower risk clinical areas or be redeployed to non-patient facing work [exhibited to this statement as **PT/61 – INQ000410222**]. It was recognised early in the pandemic that poor physical health and certain protected characteristics would increase the risk from Covid-19, specifically age, gender, ethnicity and pregnancy. Following a national webinar, communication was sent out to pregnant staff before any national guidance had been released, specifically to move staff in the 1st and 2nd trimesters to lower risk clinical areas and to move staff in the 3rd trimester to non-patient facing areas. It is noted that there were concerns as to why individuals of BAME origin were disproportionally affected by Covid-19 and this was part of a rapid review led by Public Health England to better understand how different factors such as ethnicity, deprivation, age, gender and obesity could impact on how people are affected by Covid-19. The British Association of Physicians of Indian Origin (“**BAPIO**”) wrote to all CEOs of acute trusts on 22 April 2020 expressing concerns and proposing recommendations on risk assessments, PPE and use of Vitamin D. Individual staff from BAME backgrounds also raised concerns that enhanced PPE should be used for all patient facing staff of BAME origin.

145. In early May 2020, the hospital piloted a staff risk assessment framework through Occupational Health which was based on PHE and other guidance. The Health Service Journal published an article on this issue on 6 May 2020 based on sight of a draft document from NHSE/I; the Covid-19 BAME Mortality Disparity Advisory Panel (NHSE/I) then published a document on 19 May 2020. The hospital drafted a briefing paper dated 29 May 2020 outlining the principles of a risk assessment framework, including details of a BAME ‘task and finish’ group which was constituted as part of the response and provided input into the framework. This is exhibited to this statement as **PT/62 – INQ000410223**. As evidence of the trust board's acknowledgement of concerns highlighted by BAME staff, the CEO

wrote to the 'task and finish' group on 3 August 2020 outlining the steps that had been taken [exhibited to this statement as **PT/63 – INQ000410224**]. A number of amendments were made throughout 2020 and a cross-site version adopted in January 2021. This was later amended in April 2021 taking into account vaccination and using principles set out by the Association of Local Authority Medical Advisors ("**ALAMA**") which is based on Occupational Health Physician opinion and calculates a 'Covid age'. There was undoubtedly considerable difficulty at times managing the significant numbers of staff who were advised by Occupational Health to move to lower risk clinical areas with the resulting impact on staffing of higher risk areas..

146. Following the introduction of Covid-19 vaccination in December 2020, it was recognised that the risk to vulnerable individuals after two doses of vaccine would for a number of staff reduce their personal risk. The hospital produced return to work guidance in January 2021 [exhibited to this statement as **PT/64 – INQ000410225**].

147. The trust did not formally undertake Equality Impact Assessments as regards to IPC guidance, fit testing or staff risk assessments. This was a dynamic situation at times and agile actions and responses were required. As outlined previously in the witness statement, Covid-19 related business was dealt with in a daily operational call attended by all key executives as well as the Director of IPC.

148. The inquiry has asked that I set out any issues around the unequal impact of measures adopted by the hospital in response to the pandemic with particular reference to protected characteristics under the Equality Act 2010. In my view no measures initiated by the hospital had any adverse impact on equality. The hospital was sensitive to religious beliefs as regards use of PPE during periods of fasting during Ramadan and provision of alternative PPE (respirators or powered hoods) for those unwilling to be clean shaven due to religious reasons. As regards pregnancy the hospital took a very cautious approach; the position as of June 2021 was that the majority of those staff in the 3rd trimester would continue to stay at home unless they could work in non-patient facing roles and maintain social distancing. The hospital's approach to this was benchmarked with a number of

other hospitals in the region in April 2021 [exhibited as **PT/65 – INQ000410226**]. Further guidance was then issued across the trust in March 2022 which allowed those in the 3rd trimester to work in low risk clinical areas [exhibited as **PT/66 – INQ000410227**].

Communication and external relationships

149. In terms of channels of communication within the hospital, as outlined above the trust managed the pandemic across both hospital sites with cross-site policies and guidance. The nature of the operational structure with a flat hierarchy meant that each clinical service line had direct engagement with the executive team for two way communication. In addition, for issues affecting more than one clinical service line the trust had in place a number of cross-cutting boards. For example the Theatres Board reviewed and implemented guidance on surgical prioritisation during the pandemic (see below).

150. The inquiry has asked whether there was sufficient support for hospital staff and management from national bodies or decision-makers such as the DHSC, NHSE/I, the medical Royal Colleges and Public Health England. To my knowledge there was no specific direct input from the DHSC to the hospital individually and no mechanism of feeding back directly on the feasibility of implementation of any new published guidance. I cannot comment as to whether national guidance was formulated with awareness of the realities of implementation. There was an offer of support from the Cabinet Office to public service executive leaders on 3 April 2020 [exhibited as **PT/67 – INQ000410228**]. Throughout the relevant period there were letters to the medical profession from NHSE/I, the GMC and other stakeholders which were supportive. The GMC also produced the document 'COVID 19: assessing the risk to public protection posed by a doctor as a result of concerns about their practice during the pandemic'. This was a concise but detailed document which set out how the GMC would approach fitness to practice concerns raised against a doctor whilst working during the pandemic and considering mitigating circumstances. This was intended to be supportive but in

my opinion would also have caused anxiety to those working in such challenging circumstances.

151. In terms of national input from NHS England, frequent webinars took place throughout the pandemic, mainly hosted by the National Medical Director and Chief Nursing Officer, England. The focus of the webinars changed throughout the relevant period depending on current issues. These were a useful source of information. At a more local level, there were weekly regional Medical Director meetings (held virtually by Microsoft Teams) which commenced in April 2020, chaired by the Regional Medical Director. This was a useful two-way meeting to highlight local issues for feedback to the national team as well as to receive information for implementation. In addition it was a useful forum for peer support from other Medical Director colleagues dealing with similar issues. Once per month the call was extended to regional Chief Nurses. A regional situation update with a focus on nosocomial infections was circulated by the Regional Chief Nurse as outlined earlier in the statement.

152. The Federation of Surgical Specialty Associations (“**FSSA**”) provided helpful guidance during the pandemic including: ‘Guidelines for pre-operative COVID-19 testing for elective cancer surgery (April 2020); ‘Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic’; ‘Developing Safe Surgical Services for the Covid 19 Era’; ‘Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic’ and ‘Patient waiting times between confirmed COVID-19 infection and elective surgery’ (FSSA in conjunction with the Association of Anaesthetists, Royal College of Anaesthetists, Centre for Perioperative Care and the Royal College of Surgeons of England). The Academy of Medical Royal Colleges in conjunction with NHSE/I also published guidance on the management of essential cancer surgery. The above provided practical help on managing surgical services during the relevant period and were translated into local guidance which was adopted across both hospitals within the trust.

153. The hospital had significant engagement with and help from Public Health England throughout the relevant period. Due to increasing incidence of laboratory-confirmed cases of Covid-19 in Bedford Borough in June 2020, which showed a

significant variance with the East of England region [exhibited as **PT/68 – INQ000410229**], a collaborative investigation was undertaken with the project set out as below (text is a direct extract from the PHE proposal). The investigation was undertaken by Bedford Borough Council, Public Health England, the Joint Biosecurity Centre (“**JBC**”), Bedfordshire, Luton and Milton Keynes CCG and Bedfordshire Hospitals NHS Foundation Trust.

154. *“Purpose:* A collaborative multi-agency approach to strengthen effective and appropriate control measures through enhanced understanding of the risks/pattern of infections. *Situation:* There are increasing concerns about how the coronavirus pattern has manifested across Bedford Borough UTLA. Bedford Borough has the highest cumulative crude case rate/100K in the East of England region. A Project Team has been established from Bedford Borough, Bedford Hospital, CCG/NHS, PHE and JBC to conduct some causal analysis through epidemiology and local engagement activities, with a view to generating a list of recommendations for preventive and mitigation actions that will assist with controlling outbreaks and help prevent recurrence. Overall, Bedford has had a higher peak and commensurately slower return to baseline than other areas within the region. It appears that transmission is ongoing at rates higher than in the general population of the region and whilst it is not clear why this occurred, there are however hypotheses including: increased severe disease, and thence detection of illness, due to higher proportions of highly susceptible (e.g. older/BAME) individuals; transmission associated with infection prevention and control practices in complex settings such as hospital and care homes; population dynamics associated with transmission due to nature non-care settings - housing, businesses, and transport networks; differential human behaviour relative to the rest of the country (e.g. compliance with the control measures including lock down). *Proposed Task:* Considering the complexities involved in controlling the virus, a collaborative deep dive approach with Bedford Borough, Bedford Hospital, CCG/NHS, PHE and JBC is proposed – and to help understand the differential contribution of these possibilities and to institute new, or strengthen existing interventions, for effective control of the virus in the borough. *Outcomes:* The main scope will be towards providing a better understanding of the amplifiers and drivers

of the transmission and action required to reduce the spread of CV-19 across Bedford Borough.”

155. The investigation was managed through a Deep Dive Delivery group, of which I was a member in addition to the Chief Nurse for the hospital. The project required significant input from the clinical information and operational teams in provision of data. An interim report was published in July 2020 and a final report published 4 August 2020 [exhibited as **PT/69 – INQ000178389**]. In addition a separate epidemiology report was published [exhibited as **PT/70 – INQ000410231**] which described the actions taken by the hospital, including development of an innovative inpatient Covid-19 tracking situation report (including ward moves, swab results etc.) as well as a cumulative nosocomial report [example report from 09 October 2020 exhibited as **PT/71 – INQ000410232**]. At the Bedford Borough Deep Dive Delivery Group Meeting of 31 July 2020 [exhibited as **PT/72 – INQ000410233**], it was noted that all documentation relating to this deep dive would be stored in Bedford Borough Council’s information systems.

156. Following on from this a Bedford Borough Local Outbreak Control Group (“**LOGG**”) was set up from 5 August 2020. This was initially chaired by the Chief Executive for Bedford Borough Council but subsequently by the Director of Public Health and Chief Officer for Public Health. I attended as the hospital representative. The function of the group was to: deliver the Bedford Borough Local Outbreak Control Plan and Deep Dive recommendations; to act on data and local intelligence; to engage with communities to prevent transmission; to have oversight of local contact tracing and outbreak management; to coordinate the support offer with the Community Hub; to advise on or enforce closure of premises in line with statutory powers; to coordinate cross-border issues with the Joint Health Protection Advisory Group (“**JHPAG**”) and to escalate requests for flexible testing capacity and mutual aid through the JHPAG [an example is exhibited as **PT/73 – INQ000410234**]. The group initially met weekly until February 2022 (with additional twice weekly Incident Management Team meetings chaired by PHE), fortnightly until April 2022 and then monthly during the relevant period. From the hospital perspective I shared information about Covid-19 inpatient numbers and intensive care occupancy as well as details of any outbreaks as well as patient and

staff testing. Information received included details on community Covid-19 numbers, details of new variants, outbreaks in care homes and vaccination and this information was fed back into operational planning within the hospital.

157. An example of a review of household clusters linked to Bedford Hospital is exhibited as **PT/74 – INQ000410235**. This paper was covered at the initial LOCG meeting. From 31 July 2020, I was also copied into a daily report from the PHE Field Service, East of England which covered testing, cases, outbreaks and contact tracing across the region; this continued throughout the relevant period.

158. In September 2020, a Cabinet Office Covid-19 Task Force Field Team visited Bedford Borough in line with the approach in other areas in the country with high Covid-19 prevalence; however Bedford Borough had been stepped down from the government's 'watch list' as of 21 August 2020. This included a visit to Bedford Hospital which I attended as well as visits to Covid testing centres in the borough followed by an outcome report [exhibited as **PT/75 – INQ000410236**]. There was a further visit to Bedford Borough from the task force in June 2021 in view of high rates of infection and the emergence of the Delta variant.

Personal recommendations to the inquiry

159. The inquiry has asked for any recommendations that I would make regarding responding to a future pandemic. There should be a review of the communication strategy through the EPRR route for time sensitive guidance. The need to cascade through region, Integrated Care System and then acute trusts can incur delays. It was not uncommon that information about new guidance would be highlighted through televised government briefings or through the national press before it had been formally communicated. Where significant changes in guidance are being introduced, a time-limited period of consultation/feedback (even if 24 hours for urgent updates) with those required to deliver this on the ground would be important to ensure the practicalities of implementation. This would be particularly important where a) there is a change in infection prevention and control requirements which would have an immediate impact on the

operational running of the hospital and b) there is a change to staff risk assessments or shielding recommendations which would have an immediate and significant effect on the workforce.


160. A more coordinated release of guidance would be more appropriate i.e. jointly from DHSC, UKHSA and NHSE/I; this would avoid duplication, reduce the numbers of documents to review and ensure a single consistent approach. Guidance should also not be released 'out of hours' particularly before bank holiday weekends.
161. The Track and Trace system in terms of the applicability to health care workers whilst using PPE should be reconsidered for any future pandemic response. The lack of clarity on what counted as a true positive contact was operationally extremely difficult to manage and advice was conflicting in terms of what guidance applied to the public vs what applied to healthcare workers.
162. The impact on wider health of the pandemic response, including lockdown and social isolation needs to be considered for any future response, including but not limited to mental health, drug and alcohol usage, childhood development, child obesity and safeguarding concerns, including domestic violence.
163. Aside from the direct effect on education, the impact of school closures on the clinical workforce in healthcare where there is no alternative childcare provision would need to be addressed.
164. The continued impact on personal and working lives on all who have worked through the pandemic should not be underestimated and it is my opinion that we have yet still to see the full impact in terms of the physical and mental health of our staff.

Contributions to the witness statement

165. The following individuals (by role) contributed information used in this witness statement; Admissions Service Manager; Associate Director of HR – Services; Associate Director of Nursing; Clinical Director for Cardiology; Clinical Director for Critical Care; Clinical Lead for Colorectal Surgery; Deputy Chief Executive/ Chief Operating Officer; Deputy Chief Nurse; Deputy Director of Nursing; Director of Human Resources; Director of Infection Prevention and Control; Director of Culture and Organisational Development; Head of Information Development & Data Assurance; General Manager, Trauma & Orthopaedics; Head of Organisation Resilience; Head of Midwifery; Head of Operations; Head of Quality Governance; Lead Nurse for Cardiac Arrest Prevention; Senior Clinical Nurse Specialist – Infection Control; Senior Public Health Officer (Population Analyst), Bedford Borough; Supply Chain Manager, Procurement.

Statement of Truth

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

Signed:  _____
Personal Data

Dated: 10 April 2024