**Witness Name: Jonathan Simpson**

**Statement No.: 1**

**Exhibits: 21**

**Dated: May 2024**

**UK COVID-19 INQUIRY**

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**WITNESS STATEMENT OF JONATHAN SIMPSON**

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I, JONATHAN SIMPSON, Consultant Respiratory Physician, MRI, M13 9WL, will say as follows: -

1. I was the Medical Director at MRI ("the hospital"), within the Manchester University NHS Foundation Trust ("the Trust"), a position that I held between January 2018 – August 2022. I qualified as a doctor in 1989 having attended St Andrews University (1983-86) and Manchester University (1986-89). I completed my postgraduate training in the Northwest of England in respiratory and general internal medicine and hold the following professional qualifications BSc MB ChB AFOM MD FRCP (GMC number 3289190).

2. The statement is intended as a response by the Medical Director for the Manchester Royal Infirmary (MRI) which is part of the Manchester University Hospitals NHS Foundation Trust (MFT). The statement has been prepared with input from several key individuals. This statement has also been through a verification exercise to check the accuracy of the information contained herein. In providing this statement, I have received assurances from the key contributors and via the verification exercise that where information is not in my direct knowledge, it is accurate to the best of the knowledge and belief of the Trust, and in signing the statement of truth at the end of this statement I reasonably rely on those assurances.

## Introduction

3. I served as the Medical Director for MRI during the relevant period. This role involved providing leadership within the MRI team of Directors in the delivery of safe, effective, and responsive care for patients and staff within the hospital and wider Trust/System. In

this role I provided professional leadership for the medical workforce within the hospital, leading and providing oversight and assurance for the hospital governance structures and processes, in partnership with the MRI Director of Nursing. In this role I was formally accountable to the MRI Chief Executive Officer and professionally accountable to the MFT Group Medical Director.

4. I was appointed as a Consultant in Respiratory and General Medicine in 1999 at Stockport NHS Foundation Trust and then as a Consultant in Respiratory and General Internal Medicine at MRI in 2001. I am currently a Consultant Respiratory Physician at MRI, a role I have held since appointment in 2001.

5. I am providing this witness statement as the Medical Director of the MRI during the specified time to support the Module 3 process, and the examination of the impact of the Covid-19 pandemic on the care and management of patients presenting at hospital, as well as on the hospital staff and management.

6. MRI does not lead the delivery of Critical Care Services for adults within the MFT Group model, these services are managed through the Clinical & Scientific Managed Clinical Service. The adult critical care provision is located within the MRI estate footprint and there are established partnership relationships to ensure safe and effective delivery of care for this group of patients.

7. I have consulted with the Clinical & Scientific Services (CSS) Leadership Team via the CSS Chief Executive Officer to provide the specific details to assist with my statement related to critical care services.

8. I have also consulted with the MFT Director of Procurement to provide specific details to assist in my statement related to Personal Protective Equipment and Respiratory Protective Equipment.

9. I have also consulted with the MRI Director of Nursing to provide specific details to assist in my statement related to nurse staffing, visiting and infection prevention and control.

10. I am unable to comment on changes to maternity services within MFT as this care is provided by St Mary's Managed Clinical Service.

**Background**

11. MFT is an Acute Foundation Trust, which operates 10 hospitals across 7 sites, alongside community services which are provided through the Manchester Local Care Organisation and Trafford Local Care Organisation. The Trust structure is made up of three entities:

Hospital Sites, Managed Clinical Services (MCS) and the Manchester and Trafford Local Care Organisations (LCO) whose role is to ensure the delivery of safe clinical service. Managed Clinical Services (MCS) are sites and/or services with a single management team. Their role is the delivery of services across all sites within the Trust and, for services that are provided on a Greater Manchester or Northwest basis, outside the Trust. This is illustrated in the MFT Group Model illustration at JS2 / **INQ000475241**

12. The MFT Group organisational composition, supports the delivery of the MFT vision and aims through a devolved leadership and accountability structure to a local hospital/managed clinical service level, with Group oversight for delivery through the Group Executive structures. Each Hospital/MCS is led by the Chief Executive role, who is supported by a leadership team, as illustrated in the MFT Group Organisational Structure at JS3 / INQ000475242.

13. In March 2020 MFT established their Covid–19 pandemic incident management and governance arrangements aligned to Major Incident/Emergency Preparedness Response and Recovery principles establishing Strategic, Tactical and Operational principles to enable the management and oversight of the Trust's response, as illustrated at JS4 / INQ000475243.

14. These MFT management and governance arrangements ensured that there was appropriate oversight and assurance of the Trust's response to the pandemic across all hospitals and clinical services, including the MRI.

15. There were three key elements of the MFT governance arrangements which were chaired and led by the Trust Executive Directors through which all decisions and implementation of guidance and policy was managed: Infection Prevention and Control (IPC) expert group, Clinical Advisory Group (CAG); and a Strategic Command Group (Response and Recovery).

16. At Greater Manchester (GM) level it was agreed in March 2020 that all Trusts within the conurbation would use the existing Provider Federation Board (PFB) structures to establish the Greater Manchester (GM) Cell as instructed by NHS England (NHSE).

17. Prior to the relevant period, PFB was an established GM structure, which created was part of the GM Health and Care devolution arrangements. This meeting was the forum for collaborative working and, where appropriate, collective decision-making by NHS Provider Trusts in GM. The membership of PFB was made up of the Chief Executives

of the respective NHS trusts in GM, MFT represented by the Group Chief Executive.

18. At the onset of the relevant period, the NHS Northwest Regional Office requested that GM establish Hospital Cell arrangements to provide the governance arrangements for collective decision making across the GM system during the response to the pandemic, including in key areas such as escalation arrangements and mutual aid across providers and wider services.

19. In GM, the existing PFB structures were used to establish the Hospital Cell, with the frequency of meeting of the Hospital Cell moving to weekly during the relevant period. In addition, a GM Hospital Gold Command was established as part of the Hospital Cell to oversee and manage collective decision-making daily. The core membership of GM Gold Command was made up of the Medical Directors and Directors of Operations of each provider trust, in addition to other executive-level attendees who attended in relation to specific topics planned for discussion.

20. MFT was the host organisation for the Nightingale Northwest, which was registered as a location with the Care Quality Commission (CQC) under the governance of MFT.

21. The MRI provides hospital services for people living in Central Manchester and parts of Trafford, Salford, and Tameside, alongside a number of regional and national specialist services, such as renal transplant and adult Haematology services. It has a local catchment population for general hospital services of about 300,000 people aged 16 or over.

22. The Hospital is based on the Oxford Road Campus (ORC), with an estate footprint which means that the MRI sits alongside the Royal Eye Hospital, St Mary's Hospital for Women and Babies and the Royal Manchester Children's Hospital with discrete dedicated but linked estate. The ORC services have multiple entrance and access points to support accessibility and maintain the individual identity of each hospital.

23. The MFT ORC site plan at JS5 / INQ000475244 provides a pictorial representation for context purpose.

24. The population in Manchester is diverse, recent census data for the City of Manchester estimated a population that was 56.8% White, 20.9% Asian or Asian British, 11.9% Black, Black British, Caribbean, or African, 5.3% Mixed or Multiple ethnic groups, 5.1% Other ethnic groups. 50.3% of the population were female and the population is relatively young with a median age of 31 at this time.

25. There are high levels of deprivation and according to the 2019 Index of Multiple Deprivation (IMD), Manchester ranks 6 out of 326 local authorities in England.

26. The organogram at JS6 / INQ000475245 gives a pictorial representation of the MRI Directors team as of March 2020 which was the commencement of the relevant period.

27. The MRI provides emergency care services, including being a Major Trauma Centre. The hospital has a full range of general and specialist hospital services for patients over 16-year-old. The hospital is also a recognised provider of a number of regional specialised services for Greater Manchester and (for some) for the wider North West of England, including cardiology and cardiac surgery; complex ear, nose and throat (ENT), oral & maxillofacial and head & neck cancer surgery; complex gastroenterology and liver medicine; specialised haematology, including bone marrow transplantation; liver and pancreas surgery; certain specialised urological surgery; renal medicine; renal, pancreas and islet cell transplantation, specialised rheumatology; specialised diabetes and endocrinology; sexual health services; and vascular surgery.

28. The MRI Clinical Services Unit structure (JS7 / INQ000475246), which was in place during the relevant period, represents how the services were arranged.

29. During the relevant period the MRI managed four waves of significantly increased patient admissions due to Covid-19. The time periods for each wave are detailed in the table below:

| **MRI Covid-19 Pandemic Waves** | | |
|---|---|---|
| | **Time Period** | **Peak In Patient Number (excluding Critical Care)** |
| Wave 1 | March 2020-July 2020 | 185 |
| Wave 2 | Sept 2020-Dec 2020 | 132 |
| Wave 3 | Jan 2021-Feb 2021 | 223 |
| Wave 4 | June 2021-Sept 2021 | 122 |

30. In March 2020, the hospital had 30 acute wards, including 10 specialist wards such as a dedicated Haematology Unit and Renal Transplant ward. The number of beds being used during the relevant period varied considerably, depending on the level of Covid-19 demand and infection prevention (social distancing) policies, for example in March 2021 the hospital had 654 beds, compared to early 2022 when there were 767 beds.

31. The hospital was also supported by a variable number of critical care beds depending on the patient's actual and anticipated need both for Covid-19 and non-Covid-19 related illness management and care. During the relevant period, this varied between 52 to 100 beds within the Critical Care Services based on the MRI site.

32. The hospital's workforce numbers fluctuated between 3450 - 3530 whole time equivalents over the relevant period within the MRI. Within Critical Care Services across MFT, an example of the increase in workforce related to nursing staff, was from 712.8 whole time equivalents to 1003.4 whole time equivalent over the relevant period.

33. Workforce redeployment took place across MFT, for example theatres staff were redeployed to Critical Care Services, corporate nursing teams to wards, and MFT welcomed University medical colleagues, student nurses, midwives, and medical students into clinical areas as members of our clinical teams.

**The Workforce**

34. The MFT Strategic Group received daily workforce availability reports in relation to the hospital/sites workforce position and provided a point for escalation of any mutual aid between sites and services in the Trust. This enabled the MRI to have access to Group support to obtain additional staff where required which was especially important during wave 2 (September 2020-December 2020), wave 3 (January 2021-March 2021 where the largest patient numbers were seen) and the final wave 4 (June 2021-September 2021).

35. This structure enabled decisions about redeployment of staff to be made in a phased manner. For example, staff moving from MRI theatres and ward areas to Critical Care to support critical care demand, followed by staff moving from Royal Eye Hospital and University Dental Hospital to the MRI to support ward clinical areas. I am aware that in response to Omicron (Wave 2), 34 staff volunteered and were rapidly deployed, including 8 Administration & Clerical Staff, 11 Registered Nurses, and 15 Doctors (including 2 colleagues from the university) to work within the MRI.

36. At MFT the decision was made that hospital leadership teams should continue to come into work, if they were risk assessed as able to do so, to provide 'on the spot' leadership and visibility for staff. This was greatly appreciated at the MRI and helped swift decision making. Microsoft Teams was introduced as the 'modus operandi' for meetings to limit 'face to face' contact. This greatly assisted with large numbers of staff being able to hear the same message at the same time, including the 'daily huddles' which we introduced

to keep staff informed, but also provide support. I was very pleased that the one meeting we did keep 'face to face' was the MRI 'Hospital Leadership Forum' held in May 2020 where we get together to share and learn from each other. This was carried out in controlled setting with maximum numbers, social distancing strictly adhered to and mandated mask wearing. This was greatly appreciated by our teams, it enhanced learning through shared experiences and led to a greater level of trust and confidence in the decisions made together.

37. Communication within the hospital was key to ensure that staff were briefed and there was a process for two-way communication. In the MRI, we established 'huddles', which were rapid action focused meetings where relevant individuals got together for 15-30 minutes to provide key update messages and agree actions and associated delivery timescales.

38. By May 2020 the hospital command and control structure had been further enhanced with Directors, Managers and Administration staff working a 7-day working week to provide on-site senior managerial support throughout the day and on-call overnight support to clinical teams.

39. The leadership teams in the MRI worked hard on a command and control structure which was compassionate and created an appropriate culture. We used our existing managerial and leadership structure to support and engage with all staff. Executive Directors of the hospital were accessible and visible on the hospital site over the 7-day period.

40. Regular formal and informal communication to listen to staff as well as discuss and explain the plan to respond to the various waves and challenges during the Pandemic was key to maintaining staff engagement. To reinforce this we held sharing, learning and reflection events.

41. As part of the MRI Covid-19 response, the MRI developed a Workforce Escalation Plan in response to increased absence which operated alongside MRI Tactical processes. The Workforce Escalation Plan was agreed (JS8 / INQ000475247) and a Workforce Availability Hub established to support the appropriate allocation of staff across the MRI 7 days a week.

42. This was because MFT and Greater Manchester in general were particularly affected by higher numbers of people with Covid-19, which had the additional impact of affecting our workforce. For example, in April 2020 MRI absence was at 12% when the national average was 6.3%, hitting a peak of 15% in January 2022, and by March 2022 MRI

absence had only reduced to 9.3% with 35% of absenteeism being Covid-19 related. I do not have data to allow me to breakdown absence figures by specialism or job role.

43. The MRI Workforce Escalation Plan (JS8 / INQ000475247) worked alongside the MRI Covid-19 Escalation plan, which clearly detailed the MRI plans to respond to the actual and predicted demand during the relevant period. The MRI Workforce Escalation Plan ensured that workforce availability and responses to gaps was aligned to service delivery.

44. A Standard Operating Procedure (SOP) was developed and shared with Clinical Service Unit teams through the MRI Daily briefing huddles, which clearly outlined the responsibilities of the MRI Workforce Availability Hub which included:

    - Providing a centralised point for requests of workforce support needed within the Clinical Service Units
    - Providing a centralised point to collate staff who were/could be available to support other areas.
    - Tracking the redeployment of staff across the MRI in response to requests and additional hours / shifts being worked, including coordinating the movement and re-deployment of staff to the opening of wards in response to increased numbers of Covid-19 positive patients.

45. For example, I am aware that the Workforce Availability Hub coordinated new and different roles undertaken by Administration and Clerical staff deployed from corporate teams e.g., Personal Assistants and Graduate Trainees were trained in supporting with family liaison role, discharge from hospital processes and providing resilience within wards as ward clerks, often working additional hours for example to pick up patient correspondence typing backlogs.

46. Whilst as a hospital we had times where it was difficult to provide the required staff in different clinical areas there were no specific high-level incidents during the relevant period. The MRI and MFT workforce processes were developed to mitigate the impact of staffing challenges on care delivery. The responsive nature of the MFT Strategic Group and hospital command and control process provided routes to gain support and guidance where specific staffing challenges were identified.

47. During wave 1 (March 2020 – July 2020), the stepping down of elective activity, the changes in the numbers of acute presentation to ED, and redeployment of staff across the hospital and Trust resulted in minimal staffing challenges during this period.

48. As a hospital we recognised that as the relevant period progressed and the hospital was managing subsequent waves, alongside recommencing elective activity and services, staffing areas became more challenging.

49. The coordination and oversight of the MRI Medical Workforce Response and medical staff within the MRI was led by the Associate Medical Directors, who ensured safe and appropriate staffing levels within the clinical areas. This was managed daily through the redistribution of staff as required where unexpected absence had occurred resulting in gaps in workforce in a specific area.

50. The clinical teams in each ward were led by a consultant who was familiar with the area and was supported by senior clinical colleagues who may have been redeployed from other areas. This enabled the ward area to have a consistent team of medical staff who worked with nursing and allied health professional staff to plan and deliver the care to patients.

51. The Associate Medical Directors established a regular Junior Doctors Forum, recognising the need to ensure that this group within the workforce had specific support as a number were in training, as well as having a means to receive updates and provide feedback. This forum was initially held in the Doctors Mess and moved to being held virtually from April 2020 onwards to enable effective social distancing and reduce risk of transmission of Covid-19 within the workforce.

52. The Junior Doctor's Forum was accompanied by daily ward walk rounds by the Associate Medical Directors to gain assurance of the impact of any agreed plans and address any shortfalls. These walk rounds also provided an opportunity for all staff within the clinical areas to access senior clinical leaders, which was an important part of ensuring staff felt supported during the relevant period.

53. It was recognised by the Associate Medical Directors that several specialty services delivered by the hospital (i.e., haematology and renal medicine) required continued service delivery. The Associate Medical Director's ensured that these areas continued to have the appropriate skilled workforce to deliver the service requirements for these groups of patients.

54. The surgical ward bed base was staffed by the surgical consultants and juniors appropriate to their specialty. For the remaining medicine ward bed base, the available workforce was allocated to work in specific ward areas. Each ward area was led by a respiratory, care of elderly or general physician consultant who had a team of medical

staff, many of whom were redeployed from specialty work from such areas as Sexual Health Services, the Royal Eye Hospital or Saint Mary's Hospital. This led to a collaborative, dynamic team working approach using the various skills of the team members to deliver the care patients required.

55. Within the nursing workforce the MFT Chief Nurse commissioned the development of a Pandemic Safer Staffing Guidance – In patient Ward Areas Version 1 which was implemented in December 2020 in response to the increasing impact of staff absence on delivery of the nursing workforce requirements.

56. The aim of this guidance document was to provide clarity on the monitoring and management of nurse staffing levels across adult and paediatric wards and departments in MFT ensuring safety was maintained for both patients and staff during the pandemic. The guidance outlined the process for monitoring and risk assessing roles and responsibilities across the Trust such that in the event of a serious outbreak, the organisation could coordinate and manage a safe and effective response to managing nurse staffing on the wards. The guidelines were refreshed as the national pandemic emergency receded and ceased in January 2022. At this point the MFT Safe Staffing guidance superseded any Pandemic Safer Staffing Guidance.

57. Within the MRI I am aware that the MRI Director of Nursing, or her Deputy, chaired twice daily MRI Nurse Staffing meetings to review the ward-by-ward nurse staffing position across the hospital and implement appropriate actions to address staffing challenges. This often involved the movement of staff from one area to another or the escalation of staffing challenges that could not be rectified at a hospital level to the MFT Strategic Group.

58. Within the MRI the Director of Nursing worked with Clinical Service Unit nurse leaders to undertake a further review of all non-ward-based nursing or clinical staff which enabled a further 15-20 nursing staff to be identified to work in ward areas.

59. For the MRI, during the initial period staffing challenges were minimal as redeployed staff were available to mitigate the gaps in workforce due to absence or shielding risk assessment outcomes. As time progressed over the relevant period, staffing requirements became more challenging, as several staff who had been redeployed returned to services to support the recommencement of these services during summer 2020. As the hospital recommenced specific services, the available staff who could be redeployed was reduced. An example of this was within the Sexual Health Services, as

staff who had been redeployed to support ward care in April 2020, were returned to this usual role July/August 2020.

60. Ensuring that there was a defined process and training in place to support nursing staff who were redeployed from services was key to the hospital workforce response. Through the MFT Strategic Group meetings, a Group level response was provided which utilised Trust education staff to provide upskilling education clinical sessions from March 2020, for staff who had not worked in a ward-based setting for a period.

61. The MRI Director of Nursing has advised me that there were various training sessions including refresher training in clinical skills for registered nurses (such as venepuncture, Electrocardiogram (ECG) recording and cannulation) for staff who had not worked within a ward setting, and specific training for ward staff on the management of respiratory illness. Training sessions for dental nursing staff who were redeployed to ward areas is a specific example where this was needed to ensure both the competence and support the confidence of these staff. All training was responsive and flexible, being altered to meet the needs of staff and changing patient requirements as the pandemic evolved.

62. The Critical Care Education Team established a similar upskilling process to support staff in gaining skills and knowledge to work within a ward-based setting or theatre staff who were redeployed to critical care during the pandemic. The programme of training was based on the National NHS Adult Critical Care Staffing Framework published in March 2020. The training and development interventions supported staff to re-familiarise themselves with changes within practice before they started within the clinical setting, reducing to some extent anxieties that staff had expressed about working in a ward or critical care base setting. This was a two-day training session which included the skills and knowledge to enable staff to work in a critical care setting. Topics included the management of the equipment used for a critical care patient, (for example, ventilators or respiratory support equipment) as well as sessions to support staff in refreshing and extending their skills in the management of a deteriorating patient. Staff deployed to the critical care areas worked within a team of staff to care for patients, which ensured that staff always had access to a senior nurse with critical care skills to provide guidance and support.

63. Within the MRI, upskilling training was particularly important for the over 20 theatre staff who moved to work within critical care and over 60 Clinical Nurse Specialist and Sexual Health nursing staff who moved from their services to work within the ward areas. There were many examples of buddy systems and bespoke training packages which were used

to ensure that staff unfamiliar with specific patient cohort or environments received appropriate support and guidance.

64. The ability to draw on staff from different professional groups and specialties across MRI and MFT, for redeployment with appropriate training and support meant that we did not experience significant staff shortages which impacted on patient care. I recognise there was an impact on the staff who were redeployed into critical care, I comment on the impact of this, and the actions taken by the hospital to support redeployed staff, in the section on Impact on Our Workforce.

65. The key areas where staff were required included ED, Critical Care Units, the medical wards and highly Specialised Services (for example transplantation and renal dialysis). The development of clinical pathways to support and guide care, discussed later in this statement in the section on 'Patient Treatment and Care', were developed and approved through the Clinical Advisory Group and supported the hospital to ensure that defined areas had staff with appropriate skills and knowledge to provide the care patients required. Care pathways and models evolved with successive waves to enable more planned or elective care to carry on whilst treating Covid-19 related illness.

66. An example of this was the establishment within the MRI of a Respiratory High Care areas in Covid-19 and non-Covid-19 areas, to support the care of patients requiring respiratory care which could be managed outside of a critical care setting but required medical, nursing, and allied health professional with specific respiratory knowledge and skills. These areas required a collaborative approach to staffing, drawing staff with the required skills from across the hospital to work in these areas.

67. MFT developed a SOP which was approved in April 2020 through MFT Strategic Group to enable hospitals/sites to bring retired employees back into the workforce quickly with the appropriate governance. This process enabled hospitals to recruit retirees to fixed term contracts. The MRI was provided with a list of staff who had retired in the last 18 months, who were then contacted to see if they were able, or wished, to return to work on a fixed term basis to support the hospital. Any retiree expressing a wish to return was then fast tracked through a recruitment process, enabling them to commence work within maximum of one week.

68. We were grateful to welcome several retired staff who returned to work to support the relevant period. Some of these staff had independently contacted their service to offer their time and they expressed a real desire to help. Their contribution was significant,

providing senior experience and guidance to, often junior staff, within the clinical areas.

69. The arrangements for final year Nursing and Medical students joining the workforce were coordinated by Group partnership working with local Higher Education Institutes which enabled a total of 642 student nurses and midwives 48 medical students to be deployed to MFT during the relevant period.

70. The deployment of student nurses and midwives was undertaken in line with the Health Education England (HEE) guidance which required all students deployed to be added to the relevant professional temporary registers, receive a contract and payment within the Agenda for Change framework pay scales.

71. Within the MRI we welcomed over 100 student nurses and 30 medical students into the workforce from April to September 2020 whose contribution within the workforce was welcomed and recognised by the clinical teams.

72. Post pandemic it has been recognised that this interruption in training has impacted on some individual's progression, requiring adaptions to the preceptorship and induction process in practice to support these individuals in gaining confidence and skills in areas that they were not exposed to during this time, such as communicating and managing families and visitors.

73. Whilst it is difficult to specifically identify deficit in care delivery, I am aware of the physical and psychological impact working during the relevant period had on staff. Staff recount periods where workload demands caused distress, for example one of the Care of the Elderly consultants leading a team looking after two wards during wave 1 explained that during a four-day period, the ward experienced 5/6 deaths per day (across the two wards). For most nursing and medical staff a patient death is something that they may only experience once every 1-2 weeks (depending on their role and speciality) and some staff such as those redeployed from non-ward areas may not have experienced for several years.

74. The support and management of staff was a key area of focus for MFT and the hospital. Within the MRI, members of the MRI Corporate Human Resources team were redeployed to the MFT central 'call-centre' to manage absence. Administration staff (including those who could not work clinically) were set up to work remotely with equipment (laptops) provided to enable them to work from home. MFT resources and 'keeping in touch' resources were provided for managers to ensure that staff were supported as 'working from home' was not part of MFT culture in 2020.

75. A priority for MFT and the MRI was ensuring that we could keep our staff safe at work. MFT established a staff risk assessment process to enable staff and their managers to assess their risk of working with the hospital setting. This process was structured and considered several evidenced-based factors, which were known to place individuals at increased risk of illness if they contracted Covid-19, (for example, current/underlying health conditions, age, ethnicity, and work environment was considered).

76. Through the MFT Strategic Group, as a hospital we received a briefing in March 2020, on our approach to manage the risk to our staff of Covid-19 illness, which included a section on staff well-being. Efforts were made to keep staff well in work through flexible working, out of hours/weekends, working in a different location, or from home with the appropriate facilities available. Managers were expected to ensure that everyone had an individual risk assessment to guide how they worked and the support they needed. Managers were supported by Human Resources, and advice on complex cases provided by the MFT Employee Health and Well-being Service. Risk assessments were recorded centrally and reported to ensure the safety and well-being of staff.

77. The risk assessment was updated at that time for women who were more than 28 weeks pregnant, or had underlying health conditions, in that they should avoid direct patient contact. Before 28 weeks women in patient facing roles should practice 'social distancing'. This did have an impact on staffing levels which were addressed through the MRI Workforce availability hub, however it was absolutely the right thing to do.

78. I am also aware that GPs issued letters to those with the most complex health needs advising 'shielding' initially for 12 weeks. Managers were encouraged, through discussion with staff, to offer alternatives through flexible working/working from home. The hospital received over 100 laptops to enable staff to work from home which ensured that staff had the appropriate equipment to support safe working from home.

79. The MRI monitored compliance with completion of staff risk assessment on a weekly basis, supporting managers to complete these where this was required. The hospital had access to data which showed compliance with the risk assessment process for staff. In May 2020, this demonstrated that 96.21% of the MRI staff had been supported to complete a risk assessment.

80. In addition to individual risk assessments, risk assessments of office space and staff rest areas were carried out using safer working guidance, as not everyone could work remotely. All areas in the MRI were assessed for the maximum numbers of staff at any

one time, and notices displayed to state numbers permitted. Guidance was issued for staggered breaks and mask wearing. Offices were re-designed to ensure staff worked 'back-to-back' and desks were partitioned, using fixed screens. This was challenging for some staff who did not want to move their desks or work in different ways. Audits were carried out to ensure these remained in place.

81. Covid 19 diagnostic testing for staff was introduced following agreement at MFT Strategic group in November 2020 and was implemented within the MRI. This process was supported for all staff through Lateral Flow Testing twice a week, with specific staff groups working in high-risk areas (haematology) supported to undertake testing through the formal laboratory setting rather than lateral flow testing. I am aware that we introduced a process for monitoring the distribution of lateral flow testing kits through a central administration supply and recording hub within the hospital. We encouraged and supported staff to feel confident to undertake asymptomatic testing by regular communication and helping those who felt less confident.

82. MRI staff appreciated the staff testing process to support their work and personally to ensure that they could keep family members safe. Staff expressed a real fear of taking the virus home to their families, and many gave examples of not entering the family home in clothes they had worn at work and/or not having family contact until they showered. A number of staff moved out of the family home altogether as they were fearful or lived with vulnerable family members.

83. MFT guidance was followed for testing and appropriate action for positive results in symptomatic and asymptomatic staff alike often resulting in short notice absence. The overall impact of staff testing on the workforce capacity is difficult to untangle because of the recurrent waves of Covid-19.

84. From an operational perspective in critical care shift patterns were changed and staff were paid for additional work. In some areas (for example critical care) we reduced the ratio of nursing staff to patients in line with the British Association of Critical Care Nursing (BACCN). For example, BACCN guidelines state that a ventilated, sedated patient requires 1 registered nurse with critical care skills training dedicated to their care who is then supported by another member of staff whose role is to provide equipment or resources to the registered nurse in order that they do not leave the patients. During the relevant period the critical care team had to look at other models of care as there was insufficient registered nursing staff with critical care skills. As described in paragraphs 62 and 63, the service moved to use a team model of caring for patients, which meant

that the ventilated patient would always have a skills nurse with them, but the registered nurse with extended critical care skills would support 2-3 registered nurses who had undertaken the critical care upskilling training in a co-located area. The team of staff were supported by additional staff as 'runners', as the process of removing and replacing personal protective equipment was lengthy, therefore staff did not leave rooms or patient bed areas and equipment and resources were brought to them from outside the area. I am unaware of any patient safety incidents on the critical care unit related to this model of working.

85. There was an enormous amount of good will and flexibility across all staff groups, as an example Consultants became resident overnight to support junior doctors and for some specialities worked independently of juniors' doctors who were then released to support Covid-19 wards.

86. In late March 2020, as concerns grew that Covid-19 had the potential to overwhelm NHS critical care capacity, a new group of seven emergency/temporary hospitals were rapidly constructed in non-NHS settings which became referred to nationally as Nightingale facilities.

87. The Greater Manchester Nightingale Facility was developed over a thirteen-day period starting at the end of March 2020. The Manchester Central Convention Centre was converted into a 648-bed capacity facility, the Nightingale Northwest Hospital (NNW), capable of providing step down care to patients from critical care units across the Northwest of England. Staffing the Nightingale Hospital was coordinated through the Group Chief Nurse and Group Medical Directors with a contribution of staff from hospital/sites.

88. For the MRI this was an additional challenge in terms of staffing resource and contributed to some staffing pressures, an example being the ability to provide the Junior Doctor resource for the Nightingale alongside meeting the requirements of the hospital. The hospital released approximately 8 nursing staff and a Matron to support the Nightingale Hospital and consultant time of an average of 2 whole time equivalents. This meant that these staff were unavailable to the MRI to support MRI workforce requirements.

89. These staff moved to work at the Nightingale Hospital until March 2021. The Nightingale Hospital provided care to 350 patients from around the GM region. I recall that the Nightingale Hospital had minimal impact on releasing bed capacity for MRI with approximately 20-30 patients transferred to the facility from within the hospital during the

period.

90. The EHW team started collaborative working with a Respiratory Consultant at the MRI and Specialist Lead Nurse at the GM Long-Covid Clinic to set up appropriate referral pathways for complex cases. Workforce data was shared to understand the number of staff who may require specialist support and it was estimated that there were approximately 150 staff across MFT, both attending and absent from work, who were struggling with symptoms (what was known at the time) of Long-COVID. Clinician expertise was commissioned from the GM Long-COVID clinic using a multi-disciplinary team model of care. The model ensured that case management information was shared, in line with GDPR requirements, to enable ongoing advice with respect to fitness for work and rehabilitation plans.

91. The hospital had a few staff reporting long Covid-19 causing absence and a change in role. I have not been able to quantify the numbers of staff as this data is difficult to obtain as often staff initially report absence due to a specific symptom and the diagnosis of long Covid-19 take place at a later stage and was not always captured. This has affected service delivery and meant there has been an increased workload and pressure for those staff in work covering the work of their absent colleagues.

92. Within the MRI, one of the technicians in the Disinfection and Sterilisation Services (DSD) in the MRI sadly passed away. The DSD services are away from the hospital ward and patient areas and provide the sterilisation service for theatre trays and other equipment which requires sterilisation. The hospital was unsure at the time that the reason for their death was related to Covid-19, but later learnt that this individual had been Covid-19 positive at the time of their death, although how the individual contracted Covid-19 is unknown. When colleagues learnt about this, this caused much upset and sadness, and staff support services were provided using the MFT Employee Health and Well Being resources and MRI senior staff.

93. Whilst there were no deaths amongst Oxford Road critical care staff, they did care for healthcare staff and staff relatives from across MFT and Manchester, not all of whom survived, which caused significant distress and anxiety. Again, MFT Employee Health and Well-Being and leadership teams supported the staff during this time and subsequently.

94. Overwhelmingly staff were grateful to be offered the opportunity to be vaccinated and the steps taken at a Hospital and Group level to enable this with an onsite vaccination

programme. One ED consultant exclaimed that it was the best Christmas present ever with other staff welcoming vaccination in order that they could return home from hotel accommodation which they had been using to protect family members.

95. As a hospital we started tracking Covid-19 vaccination data from early February 2021. This became increasingly important with the introduction of the National Vaccination as a Condition of Employment Policy (VCOD). The tracked data included numbers of staff who had received their vaccination, those who refused to have the vaccine and any who were exempt. For example, by 28th January 2022, we had 188 staff who were unvaccinated and 158 staff partially vaccinated. Of the 188 unvaccinated staff, 138 declined. As the last date for receiving the vaccine was 3rd February, staff and managers were very concerned. 71 staff were Nursing Assistants, 34 Administration and Clerical, 32 Registered Nurses and 1 Doctor. Following MFT guidance, the MRI implemented a supportive process, where staff who were reluctant to be vaccinated were asked to attend a wellbeing meeting with their manager to explore their concerns and discuss the importance of having their vaccine. This was done at a Clinical Service Unit level by a clinical professional and/or a member of the leadership teams. This was followed up by a further meeting with an MRI Director if they still refused to have the vaccine to explore further and explain the consequences regarding their employment. In some cases, these were difficult conversations, and some staff were very frightened of having the vaccine.

96. This process enabled a supportive discussion with staff and specific support was provided from expert resources within MFT to support staff to make informed decisions. Female staff who were planning pregnancy or pregnant were able to access Saint Mary's Hospital obstetrician could individually counsel these staff about any concerns related to pregnancy they might have. We were also able to support staff with vaccination allergies to access expert allergy consultant advice which enabled several staff to be supported to receive their vaccine.

97. The hospital reviewed this data regularly split by staff group and clinical area to ensure progress with the process and potential impact on staffing could be predicted when the VCOD policy to terminate unvaccinated staff was implemented.

98. As a hospital the 138 MRI employed staff who declined to have their vaccination during the process of implementing VCOD. These staff received a letter in line with the MFT VCOD policy detailing the risk that their employment would cease by 31 March 2021 if they continued to decline to receive their vaccination.

99. Some staff reported feeling upset and angry following their meeting with their managers or once they had been written to about their job being at risk. I recall that staff felt that their individual right to make decisions about their health had been removed and the mandatory position of the VCOD national policy did not recognise the contribution that they made to the services. The implementation of the VCOD policy in the care home sector in advance of the hospital sector caused significant distress to staff many of whom had colleagues and friends who lost employment as a result.

100. However, before the deadline for all staff to have their vaccine, unless exempt, we were informed that the national decision had been overturned (on 15 March 2022) and the MRI did not progress this further. Whilst this decision was greatly welcomed by the hospital the additional work and distress that the VCOD policy caused during the relevant period cannot be underestimated.

101. Whilst there were a few concerns raised by staff about colleagues not wearing a face mask (stating this was negligent and put staff and patients at risk) this was not the case for vaccination status. This was probably because this was not as obvious or widely discussed or the efficacy of vaccination at this stage was not widely known as it is currently.

102. The MFT VCOD policy implemented in the MRI was in keeping with national policy and had been written, consulted upon, and agreed at a Group level. Following the reversal of national policy, the Trust did not proceed with terminating employment, however we are aware that some staff may have resigned in anticipation rather than have their vaccine. Exact numbers are not known as staff may not have disclosed their reason for leaving as being due to the VCOD policy.

103. If the VCOD policy had remained in place, it would have impacted service delivery, we would have encountered further difficulties with individual staff members and groups, and it may have impacted on our ability to recruit to vacant roles. There were not specific areas for the MRI which would have been impacted on individually but the overall mandatory concept of the VCOD policy had to some extent a negative impact on the NHS as an employer.

104. I recall the conflicted feelings of supporting the VCOD policy alongside recognising that for some staff, many of whom had worked within the MRI for several years that their position in not having a vaccine would have meant that their contract with the hospital would have ceased if the policy had not been revoked.

**Creating bed capacity to support patient care**

105. The MFT Strategic Group oversaw the hospital/site responses to the pandemic. During February/March 2020, the MRI developed clear hospital escalation processes to enable bed capacity to support the care and treatment of patients admitted with Covid-19 or other acute illness in appropriate areas. Patients with Covid-19 were treated in specific ward areas, isolated from other patients to ensure appropriate infection control guidance could be met.

106. The MRI Covid-19 Escalation Plan was approved at the MFT Strategic Group in March 2020 and was reviewed and revised regularly as national guidance and increased knowledge about Covid-19 was available. The MRI Covid-19 Escalation Plan provided clear plans to enable the hospital to create dedicated Covid-19 isolation bed capacity aligned to Greater Manchester modelling predictions for demand.

107. The escalation plan used a series of escalation flow charts which detailed the wards in the hospital and how the hospital would progress conversion of wards to become dedicated Covid-19 isolation areas as the numbers of patients requiring admission increased. An example of one of the MRI escalation flow charts for the December 2020 is provided at JS9 / **INQ000475248**

108. The escalation plan included changes to clinical pathways to create respiratory and non-respiratory patient pathways to ensure early identification and isolation of a suspected, or confirmed, Covid-19 patients. The plans detailed the changes to the ED introducing streaming processes and the configuration of the department. All patients attending the ED complied with wearing surgical face masks. Specific ward areas were identified as the Covid-19 isolation wards (defined as blue wards), with the plan detailing how this bed capacity would be increased based on specific patient number triggers to ensure that isolation bed capacity was available aligned to demand. Other wards supported patients who had been admitted following a negative initial Covid-19 screen (defined as green wards).

109. For the MRI, the need to reconfigure the bed base and increase Covid-19 capacity became a priority during February and March of 2020 (wave 1). As the volume of covid-19 positive patients increased, the number of dedicated Covid-19 ward areas increased from 2 areas in March 2020 to 9 areas by June 2020. The hospital used this approach during subsequent waves reviewing the initial Covid-19 escalation plan in June/July 2020 as part of a hospital wide learning process to using learning to inform subsequent

planning. This is demonstrated by JS10 / INQ000475229.

110. The revised plan was supported by the reconfiguration of 23 out of the 30 ward areas which involved the move of 23 wards from one ward area to another. This process was coordinated during July/August 2020 to ensure that ward moves were undertaken safely, and staff were familiarized with the new ward environment. Ward moves had to be undertaken in a planned manner as the hospital continued to provide care in all ward areas for patients whose move to the new ward area had to be facilitated.

111. The MRI reconfiguration enabled the hospital to co-locate wards which in the Covid-19 escalation plan would support the care of Covid-19 patients together and ensure the protection of specific areas where high risk patients were cared for such as renal transplant patients. Hospital staff were responsive to this process, but it was recognised that moving a ward area and the team was disruptive to the team and often took a couple of weeks for the ward team to settle into the area.

112. For the MRI to implement the required Covid-19 and non-Covid-19 pathways in line with IPC requirements, the ED and 23 out of 30 wards needed to be reconfigured to enable the following:

- Provision of an additional respiratory resuscitation area as well as a non-respiratory resuscitation area located in ED. (Implemented March 2020)
- Expansion of ED footprint into Ambulatory Care Unit to accommodate the new resuscitation area. (Implemented March 2020)
- Marquee at the front of ED to enable social distancing for self-presenting patients to wait. (Implemented April 2020)
- Establishment of an additional undifferentiated respiratory receiving unit.
- Covid-19 renal / dialysis patient pathway. (Implemented April 2020)
- Circa 60 beds (compared to 19/20 pre-pandemic levels) were removed at the height of the waves to enable social distancing, predominately within the receiving/assessment units and high-risk patient groups (i.e., haematology, respiratory). This meant that the assessment/receiving unit bed base required to manage the demand was provided across 6 wards rather than the 4 previous areas (Implemented May 2020)

113. The MRI ED was reconfigured to enable the segregation of the department into zones to support the isolation of patients who had respiratory symptoms from those who had no respiratory symptoms. In line with the MRI escalation plan, the MRI ED implemented a

rapid front door streaming process to ensure any patients with respiratory symptoms were immediately redirected to the respiratory area of the department. Patients with respiratory symptoms were identified through a process of streaming for those who self-presented. This involved a senior nurse undertaking a rapid review of the patients in terms of establishing whether they had any Covid-19 symptoms to direct their pathway of care to the right zone within the department. For patients who arrived at the department via ambulance, the Northwest Ambulance Service undertook this initial review and patients were then transferred from the ambulance to the relevant area of the department.

114. The zoning of the MRI ED required the duplication of areas, for example the ED usually has one resuscitation area to receive and provide care for the most critically ill patients attending the department. During the relevant period there had to be two separate resuscitation areas (one for respiratory patients and one for non-respiratory patients) which required additional staff and resources to support.

115. To increase capacity in the ED for patients attending and awaiting treatment, and to enable the service to adhere to social distancing guidance, the hospital installed a marquee to provide additional waiting space and facilitate nursing staff to undertake an initial assessment of patients. Whilst this environment extended the department, on cold and windy days despite there being heating in the area this was often cold and unwelcoming for our patients, and for staff it was difficult to ensure privacy of discussions with patients.

116. To enable the hospital to continue urgent life-threatening surgery such as time critical cancer surgery, the hospital established and maintained a dedicated elective ward area (defined as 'super green'). This meant that patients being admitted to this area were screened 7 days prior to admission, and then asked to shield at home before being rescreened for Covid-19 within 24 hours prior to the patients' scheduled admission. This helped ensure that patients having this surgery had not been exposed to Covid-19 during the immediate period prior to surgery.

117. There was an establishment of Covid-19 virtual ward to support the ambulatory pathway and safely manage this patient cohort within the community. The Covid-19 virtual ward commenced during April 2020. During the pandemic due to reduction in service demand this was provided by the Chronic Obstructive Pulmonary Disease home care service staff under the supervision of a consultant respiratory physician. This allowed patients who presented with Covid-19 respiratory symptoms who could be discharged and managed

at home to go home with equipment to enable them to monitor their condition using pulse oximetry and access support and advice from the Covid-19 virtual ward team. Pulse oximetry is a finger device which measure the levels of oxygen in a person's blood, an indicator of increasing illness due to Covid-19 is a reduction in the levels of oxygen in an individual's blood. By patients monitoring their oxygen levels at home they were able to recover in their own homes but had a mechanism for identifying when they needed to seek advice and guidance from a member of the Covid-19 virtual ward team.

118. There was the provision of Respiratory High Care area within the hospital to support early and safe step down from Critical Care or avoid admission to critical care during Waves 2, 3 and 4. This was as key element of ensuring that Critical Care Capacity was available for those patients whose care could only be delivered in a critical care setting.

119. Within the MRI we are very proud of the fact that we established a Clinical Medicines Delivery Unit to enable the treatment of specific high-risk patients with Neutralising monoclonal antibodies (nMABs). The purpose of this service, which was GM wide was to enable a defined group of high-risk patients to be screened and if appropriate access the use of nMABs therapy. This is used to neutralise the impact of Covid-19 on the patient by binding the protein of the virus preventing it from replicating, hence reducing the risk of serious illness. Dependent on the patient this therapy after a clinical triage process could be oral medication or for some patients required a short attendance at the hospital to receive intravenous medication. The capacity for this treatment area was created on one of the Covid-19 wards and has continued to be provided until the service ceased at end March 2024

120. Capacity in the wave 1 (March 2020-June 2020) was created by a combination of reducing/stopping elective activity and a drive to discharge patients through intensive daily reviews of patients suitable for discharge or approaching discharge. This was supported through a partnership process with the Manchester Local Care Organisation (where appropriate) supported by the NHS England/Improvement's National Discharge Policy introduced on the 17th March 2020. The hospital followed the MFT Patient Covid-19 Screening Guidelines which required the screening of any patient being transferred to a nursing home 24 hours before transfer to confirm that at the point of screen that they were Covid-19 negative.

121. The Manchester Local Care Organisation facilitated the rapid discharge of over 100 patients from MFT in preparation for the surge in Covid-19 demand April 2020. Patients with length of stay over 14 and 21 days remained low, proportionally as well as

absolutely. This was greatly aided by national policy to suspend choice and means testing for care home placements. This process involved the Manchester Local Care Organisation leading the coordination and planning of the discharge of identified patients, who had already been identified as medically fit discharge, within the hospitals across MFT. The Manchester Local Care Organisation utilised a team of senior nurses as a 'care home liaison team' to ensure that the process of discharge to a care home was planned to take into account any potential risks for the patient such as infection control requirements, PPE and any training for the nursing home to meet the patients' needs on discharge.

122. In addition, in wave 1 there was a significant reduction in attendance to the ED because of a change in public behaviour in accessing health care. The impact of these three factors (reduced/ceased elective activity, rapid discharge and reduced ED attendances) was felt quickly and it is difficult to separate the impact of each of these factors in the first wave.

123. During wave 2 the hospital escalation plans identified the need to consider additional bed capacity outside of the MRI allocated estate. Partnership working with the senior leadership teams for Royal Eye Hospital, Saint Mary's Hospital and Royal Manchester Children's Hospital enabled the MRI to access two wards within the Oxford Campus in Saint Mary's Hospital with the Saint Mary's services moving into empty capacity within the Royal Manchester Children's Hospital.

124. The MRI had a core (Physical) bed capacity on 17th March 2020 of 832 beds. These beds were configured within the hospital to provide 77 receiving/assessment beds for patients whose Covid-19 status was undifferentiated as they were waiting for Covid-19 swab results. The hospital had 124 beds identified for the care of Covid-19 positive patients and 631 beds for the care of patients determined as being Covid-19 negative.

125. To provide further context in relation to the MRI bed position on 24th March 2020 the hospital configuration was as follows:

    i. Receiving/Assessment Unit – 93 beds were identified for the receiving/assessment pathway, which was for patients who required admission, but their Covid-19 status had not been defined as the hospital was awaiting swab results. Of the 93 beds 22 were closed to facilitate social distancing or due to IPC and there were 3 empty beds all of which were on the Acute Cardiac Coronary Care Unit.

    ii. Non-Respiratory Beds (green) – 569 beds of which 220 were ring fenced

specialty beds, 55 were shielded elective beds and the hospital had 64 beds closed due to IPC requirements. There were 26 empty beds with the majority of these being on the elective and specialty areas (25).

iii. Respiratory beds (blue) – 93 beds were identified for the respiratory pathway, of which 17 were closed due to other IPC issues than Covid-19. There were 20 empty beds within this bed capacity.

126. For the Critical Care Unit (combined cardiac and general units) 43 of the 52 beds (77%) were occupied at midnight on the 17th March 2020 a week later the 24th March 2020 28 of the 52 beds (50% were occupied) which was the result of a significant increase in capacity for patients requiring critical care intervention due to Covid-19 infection.

127. The oversight and planning to manage the critical care bed base was coordinated at a MFT level to meet individual hospitals as well, Trust and Greater Manchester needs as part of the GM Critical Care Network. MFT is part of the Greater Manchester Critical Care Network along with Bolton NHS Foundation Trust, East Cheshire NHS Trust, Northern Care Alliance Group, Stockport NHS Foundation Trust, Tameside & Glossop Integrated Care NHS Foundation Trust, The Christie NHS Foundation Trust, and Wrightington, Wigan & Leigh NHS Foundation Trust. A staged Escalation Plan was devised for each MFT hospital site including the Oxford Road Critical Care based within the MRI. The stages of the plan started with the baseline position at the start of the relevant period moving through how capacity was increased in line with the escalation plan as demand increased over the relevant period.

128. For the MRI Critical Care at the start of the relevant period the bed base consisted of 52 beds, 20 general ICU (level 3) beds including 7 side rooms, 20 general HDU (level 2) beds including 2 side rooms and a 3 bedded bay and a 12 bed Cardiac Surgery Unit (CSU) comprising 8 ICU (level 3) beds, including 2 side rooms and 4 HDU (level 2) beds.

129. Side rooms in critical care areas were designated for the triage of admissions, and patients were then transferred to an appropriate Covid-19 or non-Covid-19 bed area following confirmation of their infection status as a result of Covid-19 screening results.

130. For MRI, the first area outside of the existing critical care footprint to be utilised as a critical care area was Ward 14, which became a non-Covid-19 critical care area providing an additional 20 beds. This area subsequently became a Covid-19 critical care area as the Covid-19 numbers increased. The next area of escalation was into the second-floor theatre complex, which was also a designated Covid-19 area providing an additional 6-

8 beds, followed by Paediatric Intensive Care Unit (PICU) at The Royal Manchester Childrens Hospital (part of the MFT Group which provided an additional 4-6 beds. Escalation into PICU was supported by the PICU nursing teams with a senior adult critical care nurse allocated to oversee care.

131. At the peak of the pandemic in April 2020 there were 100 Critical care beds at MRI, an increase of 48 beds above the MFT commissioned levels.

132. In line with the Critical Care Escalation plan, MFT wide Critical Care Bed Management meetings were instigated at 08.00 hours and 10.00 hours. The 08.00 hours meeting was to ensure the data submitted on internal and national sitreps was accurate. This enabled the clinical team at the MRI and on each hospital site to review and address capacity issues in each area.

133. The plan outlined specific triggers in terms of bed capacity which then resulted in the implementation of the next stage of the plan. For example, when an area was at 85% capacity, discussions would take place regarding what action would need to happen in the event of further admission/s to that site. Preparations would be made for transfer to another site within MFT and the receiving unit would be identified at the 10.00 hours meeting. The responsible clinician on the site declaring 85% capacity would review patients and identify those appropriate and safe to transfer across the city.

134. The plan also outlined the actions to be taken if all critical care sites were at 85% capacity. In this situation discussions would take place to decide which area was most at risk to rise to 92% and a plan to alleviate that would be implemented. Factors that would influence decision making would include whether the demand was for Covid-19 or non-Covid-19 capacity, the influx of Covid-19 patients to the hospital sites, information in the current GM modelling data provided through the GM Hospital Cell and usual factors such as known potential referrals for admission to critical care.

135. When a critical care area was at 92% or 100% capacity the same discussions as above would take place and actions agreed relating to which unit within MFT the patient (or patients) would be transferred to decompress the unit. A private ambulance service was commissioned in case it was required to expedite patient transfer.

136. Due to the number of critical care beds on the MRI site and across the MFT group of hospitals, our flexibility and willingness to adapt our escalation plans, the MRI and MFT Critical Care Units were always able to decompress and support units across the group and where appropriate across GM.

137. Some critical care transfers to hospitals outside of MFT did take place for repatriation purposes to enable patients to be cared for in their local provider and release capacity within the MFT Critical Care services.

138. The Adult Critical Care Service Clinical Director advised they did not receive any concerns from clinicians about the impact of operating at increased capacity on patient safety at any time.

139. As previously noted, requests to transfer in and out of the critical care units from one hospital to another were managed by GM Covid-19 Gold Command. MRI critical care units and MFT units were importers of patients from elsewhere within the GM Network and beyond. Patient transfers from MFT units to other hospitals within the GM Network and beyond were for the purposes of repatriation back to the referring hospital following care and treatment.

140. Critical care patient transfers also took place from MFT unit to MFT unit of non-Covid-19 as well as Covid-19 patients when this was necessary to decompress a particular hospital site/unit to enable them to continue to function. The table below shows the number of transfers to units from other MFT units during the "relevant period".

| Transfers between MFT sites | |
|---|---|
| Receiving Unit | Number of Transfers between MFT units from 01.03.2020 to 28.06.2022 |
| ACCU MRI | 126 |
| CICU MRI | 99 |
| AICU WYTH | 120 |
| CTCCU WYTH | 127 |
| NMGH | 9 |
| MFT Total | 481 |

141. During the relevant period 179 patients were transferred from MFT adult critical care units to other non-MFT hospital units (132 patients were transferred to other hospital units within the GM Critical Care Network and 47 to other hospital units outside of the GM Network). These were all repatriations. Of these, 51 were from the MRI units (45 to units within the GM Network and 6 to units outside of the GM Network).

142. During the relevant period, 260 patients were transferred to MFT units from a different non-MFT hospital (145 patients were from hospitals within the GM Network and 115 from

outside the GM Network). Of these, 64 were from hospitals within the Greater Manchester Network to the MRI Critical care beds, and 7 from outside of the Network.

143. Within critical care there was a key focus on ensuring adequate equipment was available to support the needs of patients. The increased requirement for critical care to manage a larger than usual number of patients, in an increased bed base with critical illness, raised several challenges regarding equipment, medical gases and medication. Some of these issues were highlighted nationally at the time.

144. For the MFT Critical Care Services, the provision of sufficient mechanical ventilators for invasive ventilation was a major concern at the start of the relevant period as the purchase of additional ventilators was not possible due to the increase in demand nationally and internationally.

145. The only additional ICU level ventilators that we were able to source, and received, were via a GM Critical Care Network managed response, in liaison with NHS England. Unfortunately, these were found to be unfit for purpose as they were out of date, had been in storage for 15 years and parts such as filters etc. were no longer available for the specific type of ventilator.

146. Some transport ventilators were purchased by the Trust and used when needed as bedside ventilators. Additional requirements were met by using anaesthetic machines from Theatres which were used in those escalation units supported by staff experienced in the use of these ventilators. Finally, when some of the PICU space was used in escalation (10 beds), the PICU ventilators were used to support the ventilation of adult patients.

147. Whilst there was concern about equipment providing non-invasive ventilation, these machines were more available and purchased by the Group through the Trust Procurement Team in April 2020. These were used in the level 2 (High Dependency) areas identified in the escalation plan.

148. Medical gas supply and in particular oxygen, was a significant concern at the start of the relevant period, which meant that MFT established a monitoring process to provide insight into the usage of oxygen within each hospital/site. Additional critical care capacity and use of high-flow oxygen delivery systems had the potential to stretch hospital oxygen delivery systems to capacity.

149. This was highlighted nationally by two alerts issued from NHS England. These alerts

requested the Trust Estates and Pharmacy Departments to take steps to optimise oxygen supply infrastructure. These actions were overseen by the Group and addressed at both a Group and Hospital level.

150. Oxygen usage and monitoring results were reported daily to the MFT Strategic Group, and then regionally and nationally weekly. This enabled oversight and the agreement of interventions where supply might affect clinical care. An example of this reporting process from the meeting held 5th April 2020, which was an update provided to the Group by the MFT Director of Estates and Facilities detailed that additional oxygen capacity had been built by the supplier to allow an increase in the oxygen flow rate on the Oxford Road Campus from 3600 litres/per minute to 4600 litres/per minute. The oxygen usage monitoring graph from this date is provided at JS11 / INQ000475230, with the red line indicating that usage is approaching maximum capacity and the blue line indicating usage daily during the period reported.

151. I recall that whilst there were initial concerns about oxygen supply for the MRI, during the relevant period there were no instances where supply for the hospital became a concern.

152. There was a national recognition that the supply of anaesthetic drugs, opioids and other sedatives, renal replacement fluids, steroids and Covid-19 treatments would be challenged. Several national alerts and actions were taken to help mitigate this including national guidance on specific commissioning arrangements with detailed criteria for use of Covid-19 treatments.

153. Ensuring adequate and consistent medication was a huge challenge for the pharmacy teams, and this was managed at a Regional and Group level with guidance to individual hospital sites, including the MRI. There was daily monitoring of critical medicines undertaken to identify stock challenges and the need to re-order (within any allocations) or to advise clinical teams when alternative treatments were needed.

154. I am advised by Critical Care Services, which includes anaesthetic services, that there were specific challenges in the use of immunoglobulin replacement therapy, midazolam and propofol (as sedating agents) and neuromuscular blockers. Guidelines were developed by clinicians and pharmacists across the hospital sites, agreed at Group level through the CAG, to mitigate the impact of this. An example of this was the development of 1st, 2nd, 3rd line options by palliative care teams working for the community, acute hospital sites and the Nightingale units for patients requiring palliation of symptoms.

155. The MRI did not use the private healthcare sector to increase staffing capacity or for the

supply of medical equipment. We did, however, use the private sector for the provision of non-Covid-19 related care.

156. Specifically, for the MRI, we continued cardiac and colorectal surgery using private healthcare facilities. Through the Greater Manchester Command and Control structure, the MRI was designated as one of a few sites to carry out cancer work, consolidating head and neck cancer at the MRI.

157. The MRI Colorectal team transferred from November 2020 to a private hospital provider enabling the continued delivery of cancer colorectal surgery within a protected environment. This meant that the delivery of this service was not impacted on as the demand for Covid-19 bed capacity increased during the relevant period.

158. The hospital ceased renal transplant surgery in line with national guidance in March 2020. The Renal Transplant surgeons and specialist nursing team rapidly established a renal transplant patient hot line to enable this group of patients to access expert advice, care, and reassurance whilst the programme of transplantation was suspended.

159. Following the first wave of Covid-19 the hospital reviewed the ward configuration which enabled the recommencement of renal transplant surgery in a dedicated renal transplant ward, with patient and staff screening protocols agreed through the MFT IPC Expert Group, MFT Clinical Advisory Group and approved through the MFT Strategic Group in July 2020.

160. The first renal transplant was successfully undertaken in July 2020 and the service continued to expand capacity to support recovery of this key speciality service within the hospital. By February 2021 the renal transplant service had undertaken the most transplants in the country since the pandemic commenced.

161. The provision of renal replacement therapy, often referred to as renal dialysis, both in ward and critical areas posed logistical issues from an infection prevention and control perspective, but there were no issues in terms of being able to provide renal replacement for any patient that required it.

162. For the patients looked after in critical care areas, the service used the Paediatric Intensive Care Unit, (located in the Royal Manchester Childrens Hospital) renal replacement machines that were not being used during the relevant period. These machines were the same make as the ones used in the adult areas and therefore staff were familiar and able to safely use these machines to provide renal replacement therapy

for patients within critical care. In total 19 renal replacement machines were available for use from the Royal Manchester Childrens Hospital.

163. A specific approach was also required for the provision of renal dialysis to the cohort of renal patients which the hospital provides this therapy for (circa 600 individuals). The MRI is a hub provider for the renal dialysis providing care to this group of patients across an Acute Dialysis Unit on the MRI site and 5 satellite units.

164. Renal dialysis therapy is an outpatient's procedure which requires a patient to attend three times a week for a period of 4-6 hours to allow dialysis to take place. Patients attend alternate days either on a morning or afternoon session.

165. The hospital had to consider how we would continue renal dialysis therapy taking in to account that some of the patients attending may be Covid-19 positive and require isolation from other patients attending the service. Each of the dialysis units have side room areas which enables the isolation of patients to prevent infection or protect a specific patient clinical need. Each unit has between 2-4 side rooms which was sufficient to manage the requirements of the service before the significant increase in patients due to Covid-19 who required isolation facilities.

166. The service recognised that due to the pandemic there would be an increase in patients who required to attend to continue their dialysis therapy who might be Covid-19 and therefore need isolation from the other patients. To meet this increasing demand the service developed within the MRI Covid-19 escalation plan process from May 2020 to enable the safe delivery of the service to our patients. This involved the MRI Renal Dialysis Unit moving to managing non Covid-19 patients Monday, Wednesday, and Friday with Covid-19 patients Tuesday, Thursday, and Saturday. This approach required significant staffing resources to ensure that patients were allocated to the correct sessions as the individual incidence of which patients were Covid-19 positive and needed isolating for a minimum of a 14-day period was ever changing.

167. Alongside this, during specifically wave 1 of the pandemic (March 2020-June 2020) there was an increase in demand for renal dialysis for those patients admitted with Covid-19. This required the in-patient renal dialysis service provision to increase, which meant that staff with dialysis experience were redeployed from across MFT to support this expansion. To meet this demand the hospital had to identify additional areas where dialysis therapy could be undertaken. Dialysis therapy requires a specific water outlet, which is supplied by water that has undergone a specific treatment process before it is

used in the dialysis process. Within the hospital these dialysis water outlet points are predominantly within a specific area (Acute Kidney Unit) and patients requiring dialysis are transferred to this area to receive their dialysis and then returned to their in-patient bed on the ward where they are receiving care.

168. For any in patient who was Covid-19 positive and required renal dialysis it was necessary to establish an area on one of the designated Covid-19 wards where the dialysis water outlets were located to provide this function, keeping the Acute Kidney Unit area for the use of non-Covid-19 in patients who required dialysis.

169. This required additional dialysis nursing staff as the team were providing staff for two areas rather than one area. In response the hospital used the escalation process through the MFT Strategic Group to request mutual aid in terms of renal dialysis skilled nursing staff which resulted in the redeployment of between 8-10 nursing staff to the service for the relevant period.

**Infection Prevention and Control**

170. MFT followed national Covid-19 and infection control guidance throughout the pandemic ensuring this was disseminated and implemented throughout the organisation.

171. The MFT Group structure enabled quick and effective access to infection prevention and control (IPC) expertise 24 hours a day 7 days a week, which supported the hospital to provide care to patients and staff aligned to the guidance.

172. The Group Infection Control Team and Associate Medical Director Infection Prevention, led by the MFT Chief Nurse established an MFT IPC Expert Group which met daily to evaluate and agree how the implementation of national guidance would be managed across the Trust. The group also responded to hospital/site queries enabling rapid resolution and response to any issues or concerns within the hospital. The daily review of guidance was key to ensuring that the Trust could be responsive to changes in guidance which were often issued late in an evening for immediate implementation.

173. The daily MFT Strategic Group provided a mechanism for escalation and access to expert advice, in addition to the on call and robust out of hours arrangements provided by the Group Infection Control Team members.

174. The MFT IPC Expert Group reviewed changes to policies or practice consulting and engaging with senior clinical leads through the Clinical Advisory Group, led by the MFT Group Medical Director or the Directors of Nursing Group led by the Chief Nurse and

were ratified through the daily MFT Response and Recovery meeting structure.

175. This was supported by enhanced senior on call arrangements by the MFT IPC team and senior nursing team within the MRI that provided 7-day expert advice and guidance for staff to enable prompt and timely decision making in relation to IPC and clinical pathways.

176. As a hospital we utilised our established communication processes (described within the Impact on Staff Section), to ensure that the cascade of any changes in guidance and therefore practice. This included briefings of staff through our leadership structures and walk rounds to areas to ensure that effective communication was received by staff providing the care to our patients.

177. Understandably guidance changed during the pandemic as we gained more knowledge about the virus and how best to manage it. On occasions this happened rapidly, and guidance was issued with little warning late on a Friday afternoon.

178. Despite the established MFT and Hospital communication structures, this posed logistical difficulties at a Group and Hospital level to ensure appropriate changes to practice were made and disseminated. For example, receiving revised guidance late on a Friday evening which required review to understand the practical application across the Trust often meant staff who had already worked a full day remained late at work to interpret guidance into simple messages which could then be cascaded across the Trust for dissemination within the hospitals/managed clinical services.

179. An example of how this structure supported the MRI, relates to the MRI Haematology Service. In terms of national guidance at the start of the pandemic there was a lack of clarity in relation to PPE face mask type to ensure the protection of this vulnerable group of patients. The Public Health England guidance indicated that standard surgical face masks were recommended as FFP3 masks were only recommended for use where Aerosol Generating Procedures were being undertaken. FFP3 masks are a type of respiratory protection which offers the wearer the greatest protection from breathing in air that might contain Covid-19 virus particles. Aerosol Generating Procedures increase the volume of virus particles in the air and hence when staff were undertaking these types of procedures the requirement was for them to wear FFP3 masks. Examples of Aerosol Generating Procedures include cardio-pulmonary resuscitation, endoscopy investigation, (where a fibre optic tube is passed through an individual's mouth to view such areas as the stomach or lung), and intubation procedures in theatre (i.e. where patients are being anesthetised) and the anaesthetist inserts a breathing tube to support

their breathing whilst they are sedated.

180. A surgical face mask blocks large particle droplets, splashes, sprays, or splatter that may contain the Covid-19 virus to stop the virus reach an individual's mouth or nose. If the virus reaches an individual's nose or mouth, there is a risk of transmission of the virus.

181. The haematology clinical team raised concerns that they felt that staff working within the Haematology Unit should routinely wear FFP3 masks all the time. The team identified the vulnerability and clinical requirements of the patient group (most were immunosuppressed and therefore a significantly higher risk of infection, and as a result were often significantly unwell should they contract Covid-19). They also raised that other Haematology Units had reviewed the guidance and gone beyond the guidance by implementing the use of FFP3 face masks for all staff to reduce further the risk of transmission of Covid-19 to this group of patients.

182. Utilising the MFT IPC Expert Group, meetings were held with the Haematology Clinical Team, MRI Director of Nursing, and myself to review evidence and explore the concerns the team had raised. The outcome from this process was the agreement that staff working on the Haematology Unit should wear FFP3 face masks and alongside this routine staff testing was introduced in line with the MFT guidance from November 2020.

183. Protecting our patients from the transmission of Covid-19 was key and the Trust implemented national guidance on the screening of patients from the start of the relevant period.

184. All patients attending ED who were identified for admission were all screened for Covid-19 using either the Polymerase Chain Test (PCR) testing method or a rapid testing process. Screening of patients involved taking a nasal and throat swab using a specific testing kit which was provided to all clinical areas by the MFT Laboratory services. All samples were sent for processing in the laboratory facilities based on the Oxford Road Campus. Turnaround times for results were often variable based on demand, with laboratory processing taking place 24 hours a day to meet demand. Rapid testing results were available within 4-6 hours, with the aim for PCR results to be available within 24 hours.

185. The hospital had limited suppliers of the rapid testing swabs due to national supply challenges and I recall during the relevant period that the hospital had access to approximately 30 rapid tests which had to be utilised across several areas, including ED. Clinical prioritization of patients who were rapidly screened was determined through the

CAG meeting process and was amended dependent on patient risk. For example, within the MRI when we recommenced our renal transplant programme in July 2020 these patients had to be prioritised for rapid screening. This uses matched donor organs and there is a time critical period when transplantation can occur (ideally within 12 hours of harvesting) and therefore routine PCR screening turnaround times could not provide results for patients within the required timescale. This meant that the number of rapid testing swabs available to ED was reduced, resulting in PCR screening being used to determine a patients Covid-19 status.

186. I recall that the MFT laboratories acted as the regional testing centre on the Oxford Road Campus, which appeared to cause significant demand on these services often resulting in admission testing results taking up to 48 hours to be available. Until swab results were available patients were admitted to a receiving/assessment ward area, where social distancing was in place to minimize the risk of Covid-19 transmission. As soon as swab results were available transfer to patients to an appropriate ward area was facilitated.

187. The delays in the availability of Covid-19 swab results caused operational challenges resulting bottlenecks in the receiving/assessment areas. When peaks of admissions from ED occurred, the hospital struggled to identify capacity on the receiving/assessment units for these undifferentiated patients, with patients waiting longer periods of time in ED.

188. To address this challenge, the MRI participated in an MFT pilot during the relevant period of near patient testing for Covid-19 in ED to enable rapid identification of Covid-19 status. Unfortunately, concerns about the test's reliability and difficulties with recording the result meant this technology could not be used in practice to reduce the need to test through the laboratory pathway.

189. Another element to the approach to reducing transmission of Covid-19 was to configure areas of the hospital estate to allow the separation of Covid-19 positive or suspected patients from patients who did not have Covid-19 symptoms or a positive swab result.

190. Within the MRI ED estate to meet these IPC requirements the ED department and receiving/assessment areas were required to have dedicated streamed pathways, estate, and workforce to support respiratory and non-respiratory patients. For example, wards within the hospital were defined as Covid-19 positive areas, or non-Covid-19 areas. For the ED this estates configuration meant that there was duplication of clinical areas for minors, majors and resuscitation and assessment areas, resulting in an

increased workforce requirement.

191. As a hospital reducing the risk of Covid-19 transmission required regular implementation of new guidance issued nationally, as knowledge and evidence about Covid-19 progressed over the relevant period. At the start of the relevant period (March 2020) the use of surgical face masks by staff and patients was implemented in specific areas. This included receiving/assessment areas where a patients Covid-19 status was unknown until admission swab results were available and areas such as ED waiting rooms.

192. In areas where patients were known to be Covid-19 positive or had respiratory symptoms such as cough and temperature PPE was used (gowns, FFP3 face masks, gloves, and face visors).

193. To support staff and enable MFT to launder staff uniforms staff moved from specific professional uniforms to theatre scrubs. MRI staff changing facilities were created in all clinical areas by repurposing offices and storages areas to enable staff to change into scrubs at work and then change out of these at the end of a shift. MFT provided laundering facilities for scrubs within each area receiving stocks of clean scrubs daily. As a hospital I recall that donations of scrubs were received by MFT to help meet the significant increase in demand for these which resulted in staff having scrubs in various colours rather than the traditional green and blue which is usually seen within the hospital.

194. As the relevant period progressed implementation of the use of face masks in all ward areas took place from May 2020, this included any visitors who were able to visit the area in line with the MFT Visiting Policy at the time.

195. During May 2020 as the incidence of Covid-19 infection continued to rise and across MFT outbreaks of Covid-19 infections were seen in staff groups the hospital implemented to use of surgical face masks in all areas, including administration and other non-clinical areas. Where staff were in areas with other staff, they were required to wear a face mask and when they were unable to wear a face mask (whilst eating or drinking) they were required to socially distance by at least 2 meters. The MRI Director of HR and MRI Director of Operations visited all administration and non-clinical areas over a 48-hour period in May 2020 to brief staff, implement signage which detailed room occupancy numbers to ensure social distancing and support plans to enable staff to work from home to reduce staff numbers on the hospital site.

196. I recall that implementation of social distancing in staff break areas required careful and

imaginative solutions. Most of the break rooms used by staff within clinical areas were too small to support social distancing for more than two staff at a time. It was obviously important to ensure staff had facilities to take breaks but also it was recognised that when staff took breaks, they would be removing face masks to eat and drink. The hospital used alternate rooms such as seminar and meeting rooms (which were not being used as meetings had been moved to be done virtually) to provide additional space as staff rest areas.

197. Within the MRI leadership team office environment, which are mostly single offices, we did not wear face masks when alone in the individual offices but would wear them to leave offices to use facilities such as the kitchen or toilets. I recall that it very quickly became a habit when leaving your office to put on a face mask which was available from hand sanitising and mask stations located at all entrances and exits of clinical areas and non-clinical entrances, and exits within the hospital.

198. In April 2020, MFT rapidly implemented the use of virtual meetings and communication tools which supported staff working from home to stay in touch with colleagues, but I recall that some staff still found working from home isolating and reported feeling cut off from the business of the hospital. MRI managers were supported to implement keep in touch sessions with staff who were working from home, for example holding regular team meetings using videoconferencing equipment.

199. FIT testing is a test which is undertaken with individual staff members to verify which respiratory protection (FFP3 mask) is both comfortable and provides the wearer with the expected protection from Aerosol Generated Particulates, which is the means of transmission of the Covid-19 virus. This process was undertaken by MRI staff who received additional training for FIT testing. The process involves the member of staff trying various face masks which are then tested using a FIT testing device to ensure an effective seal around the face is achieved to prevent the entry of aerosol particles behind the mask. Given the various facial features and how different individual faces are, this process can often require individuals to try several masks before a mask type can be confirmed as suitable for the individual.

200. As the supply of the types of Respiratory Protective Equipment (RPE), an example of which is FFP3 masks, varied regularly by manufacturer staff often underwent numerous FIT testing sessions. For example, if FFP3 masks were supplied by manufacturer A and staff had passed FIT testing on this mask, if the manufacture changed and FFP3 mask came from manufacturer B then the member of staff had to attend to repeat FIT testing

on the mask supplied by manufacturer B. This was due to individual manufacturers recognising that even masks identified for same purpose (ie FFP3 masks) they were unable/unwilling to guarantee the protection an individual mask provided unless FIT testing was completed on the specific mask.

201. I recall staff feeding back about the challenges of working when wearing full PPE. Full PPE involved staff using PPE such as FFP3 masks, gowns, gloves and face visors. Staff reported that when wearing full PPE for 8-12-hour shifts, they were often exhausted, due to the restrictive nature of the equipment and that staff became very warm when wearing it and working in enclosed clinical areas. During wave 1 the weather was unseasonably warm, which further impacted on staff comfort.

202. To ensure protection FFP3 masks had to fit tight to the face often causing indentations to the face when removed at the end of a shift and some staff developed facial sores where the mask had caused pressure. The hospital sought advice on suitable moistening face creams that staff could use to reduce the risk of skin damage.

203. In November 2020, the MFT Covid-19 All Staff & Asymptomatic Adult In Patient Testing and Screening Guidelines were issued. These guidelines provided hospitals/site with clarification in terms of patient and staff testing (which commenced in December 2020) and were aligned to national guidance, being updated as any national guidance changed.

204. This document set out the standard operating procedures and pathways in place for the testing of asymptomatic adult patients and all staff for Covid-19 at MFT. The overarching purpose of the guidelines was to protect patients and staff from Covid-19 infection, informed by the available evidence and Public Health England guidance which was initially the *Covid-19: investigation and initial clinical management of possible cases. Public Health England. Dec 2020* and subsequently guidance such as *Covid-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations. Public Health England. January 2021.*

205. Patient testing was undertaken using a risk-based approach to identify patients with infection. Patients were divided into several groups including 'symptomatic', 'asymptomatic, 'emergency admission' and 'elective admission' group. The document identified the specific testing required for each group of patients enabling patients to be placed in an appropriate ward environment based on the estate configuration described the section above related to bed capacity.

206. This document also outlined the principles of staff testing within MFT. The document

identified that regular testing of asymptomatic staff was important to reduce the risk of hospital acquired Covid-19 infection. It is recognised that some areas of the hospital may be of higher priority than others in terms of protecting vulnerable patients. Within the MRI examples of this were the haematology and renal patient cohorts.

207. MFT had access to several modalities of testing, for example lateral flow devices (LFD) and laboratory-based PCR testing. These tests varied in their ability detect infection (i.e. their sensitivity) but also have advantages and disadvantages in terms of accessibility and ease of use. The testing offered to staff varied depending on the prevalence of Covid-19 in the community and the availability of testing equipment.

208. Measures to prevent nosocomial infections were a key feature in the pandemic's management and resulted in frequent changes to the hospital estate and ward configuration. The hospital has estate of varying age and configuration. Within the Hospital we created different areas to look after patients whose Covid status was unknown, those who were known to have Covid-19 and those who did not or had recovered from Covid-19.

209. As noted previously, an example was how the ED was divided into respiratory and non-respiratory areas for all levels of acuity. A streaming tool to direct patients to the most appropriate pathway was put in place to identify patients more likely to be infected with Covid-19. In addition, we installed a marquee outside ED to extend ED waiting areas to support social distancing.

210. The number of separate areas within ED, sometimes with a particular staffing skill mix requirement (for example the resuscitation areas in ED), which increased from one area to two from March 2020 to allow the separation of respiratory and non-respiratory patients did mean more staff were required to look after patients. This required an increase in ED staffing resources to enable staff to be dedicated to separate areas and reduce staff movement between the respiratory and non-respiratory pathways in ED. This ensured that the ED maintained ratio of staff to patient care needs during relevant period. For example, the medical workforce on duty each day shift increased from 2-3 consultants each shift to 4-5 staff.

211. New roles were created to help with this for example ‘Runners’ in critical care/ED and family liaison officers on the wards with the MRI. The ‘Runners’ roles were key in supporting staff to be able to wear full PPE and have individuals outside of the isolation area to provide equipment or specific interventions reducing the need for staff to remove

and replace PPE.

212. Due to the need to be able to isolate patients until their Covid-19 status was known, the hospital worked with the IPC Expert Group to understand how we could admit specialty patients to their specialty ward (i.e. stroke and vascular) to receive appropriate specialty care rather thaen transfer these patients through the receiving/assessment unit model which was used for ED patient admissions. The MFT purchased in June 2020 single patient disposal isolation facility equipment which could be temporarily installed in ward areas. For illustrative purpose an example of this type of facility is provided in JS12 / **INQ000475231**

213. Within the MRI we installed these facilities in our stroke and vascular specialty ward areas to provide additional isolation room capacity. Patients transferred to these isolation facilities in the ward areas whose Covid-19 status was unknown, and once the patients Covid-19 status was known patients were transferred either into the bed base on the specialty ward or if the patient was Covid-19 positive they were transferred to a Covid-19 ward.

214. Whilst these temporary isolation facilities supported safe delivery of care to patients, I recall that patients and staff reported that they did not like using or being cared for in these facilities.

215. The MRI also relocated services, for example in April 2020 the Stroke Unit to Manchester Ward a separate facility on Oxford Road Campus which enabled the continued provision of stroke rehabilitation and support to the hyper acute unit at Salford.

216. Within the MRI, the Director of Nursing or Deputy Director chaired daily infection control review meetings to ensure appropriate mitigating actions were in place in all areas where nosocomial outbreaks had been reported. Examples of actions taken include closing beds/bays within a ward area where a positive Covid-19 result had been identified for a patient due to the routine screening being undertaken for patients. This often resulted in lost bed capacity within the hospital resulting in specific challenges for the MRI during wave 2 of the relevant period.

217. Within the MRI Endoscopy Service activity had been reduced to undertaking emergency procedures only, due to the aerosol generating nature of endoscopic procedures which required downtime within procedure rooms between cases to enable the ventilation system to purify the air and reduce any risk to subsequent patients.

218. The endoscopy team trialled portable air filtration devices, supported by Group Estates colleagues, which could be in procedure rooms to increase the air exchange cycles and therefore enable the service to increase patient activity from July 2020, but this activity remained reduced due to the aerosol generating nature of endoscopic procedures.

219. These systems have been installed within the MRI Ear, Nose and Throat outpatients service where similar restrictions on patient capacity existed because diagnostic procedures were defined as Aerosol Generating Procedures.

220. As a hospital the overall estates (large patient bays within several wards) and the burden of Covid-19 infection amongst patients and staff made the management and reduction of nosocomial outbreaks challenging. The hospital focused on assurance in relation to PPE wearing compliance and hand hygiene practice as a means of mitigation for this issue. The model of social distancing implemented in the receiving/assessment units described in the section above related to bed capacity was also a practical example of actions the hospital took to reduce this risk to patients.

221. In terms of hospital outbreaks the hospital implemented, in line with group IPC support, patient and staff screening processes to enable some mitigation of PPE guidance and enhance cleaning to enable some mitigation of Covid-19 transmission risk. The high transmissible nature of Covid 19 unfortunately meant that hospital transmission occurred especially where patents or staff were asymptomatic.

222. I am aware that the MRI Director of Nursing in May of 2020 implemented a daily (7 days a week) IPC review meeting with the IPC team. This meeting reviewed all hospital acquired cases to provide assurance relating to IPC practice in the areas affected and enabled a rapid response to mitigate the risk of further transmission. Patients exposed to Covid-19 were isolated in line with guidance to ensure that transmission risk was mitigated during the incubation period.

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

223. MFT has a centralised model which supports the procurement and management of stock across all hospitals/sites. This enabled hospitals/sites to receive consistent supply and provided a mechanism for quick responses to be made to stock requirements within clinical areas.

224. MFT made and received mutual aid deliveries to support gaps in PPE stock from across the Northwest. For example, Liverpool University Hospitals, Northwest Ambulance Service and Northern Care Alliance.

225. I am advised by the MFT Director of Procurement that in March 2020 MFT established a dedicated space for the storage and distribution of PPE stock, which enabled daily stock takes to be undertaken to support daily reporting to the Strategic Command Group.

226. MFT established from April 2020 a dedicated email Covid19.Stock@mft.nhs.uk for any PPE stock requests to support internally across MFT and support with GM mutual aid. All clinical teams had access to this email address which enabled the prompt identification of stock requests 24 hours a day 7 days a week.

227. The process for ordering and supply/distribution of PPE was managed at a group level through the procurement team. Deliveries to the clinical areas in the MRI were made 7 days a week by the Group Material Management Team meaning that clinical staff had access to PPE on an on-going basis.

228. This model enabled the MRI to maintain appropriate supplies of consumables and specifically PPE and RPE equipment during the relevant period.

229. The Trust Genesis procurement system helped the Trust and hospital to monitor expiry dates, unfortunately we did receive a lot of stock which was out of date by the time it entered the Trust.

230. The MFT Procurement Team from June 2020, when the National Foundry process was established by NHS Supply Chain, used the "Foundry system" to order all PPE lines. The Foundry system was established by NHS England during the relevant period to support the monitoring of PPE stock within hospitals daily and coordinate the issuing of stock to healthcare providers. The principle of the system was to ensure that stock was provided to an organisation based on their stock levels and usage rather than their organisational size and as a consequence, potentially holding large volumes of stock and other organisations experiencing supply issues. The Foundry process used a 'Push' model which meant that NHS England used the data provided by organisations to anticipate and predict the number of patients and therefore PPE usage to priorities the issue of PPE to organisations.

231. The foundry system, I am advised, enabled the Trust to consolidate the ordering processes and reduced the previous 'competitive' nature of ordering as providers found themselves in prior to this. The Procurement Team advise me that prior to the creation of the national Foundry process suppliers were being contacted by individual Trusts which resulted in significant work for the team as suppliers were overwhelmed with calls and requests for PPE.

232. To support the Foundry process, the MFT procurement team were able to monitor daily Trust use of PPE, as the Trust has an electronic procurement system, for each PPE line, which enabled the team to predict future usage and therefore proactively place orders through the National Foundry for supplies.

233. This transparent oversight of stock levels provided the live count of products which enabled stock stored off site to be actively moved to relevant hospitals as well as ensure that daily stock levels could be upload to the National Foundry. Where the Trust identified any requirement for additional stock for any reason this could be requested via the Foundry portal and would arrive 48 hours later.

234. In the event of urgent items being required by MFT due to the risk of any stock being unavailable, our regional contact at NHS Supplies was available and would try to source nationally using the portal to see what stock had been sent to other trusts that could be re-distributed and vice-versa if we had anything that other trusts could use.

235. I understand from the Director of Procurement that MFT made many requests via the National Foundry portal mainly for FFP3 masks, body bags, thumb loop gowns and FIT testing solutions/kits.

236. For most of the time the Foundry system worked well however there were occasions where the system incorrectly predicted our requirements leaving us with far less PPE than we required to meet out predicted demand. As a result, the MFT procurement team placed urgent follow up orders through the Regional NHS Supplies Team to obtain the required supply.

237. There were many recalls of various types of PPE, so it was not uncommon to lose large volumes of stock overnight leaving you requiring urgent replenishment. An example of a circumstance where an emergency request was made was when a recall on a FFP3 masks occurred in February 2021, resulting in large percentage of the remaining FFP3 masks being removed from the MFT stock. This resulted in a risk to the resilience of the supply for the predicted usage over the subsequent days, although in practice MFT did not have any specific instances where supply of FFP3 masks could not meet demand.

238. Initially in the early part of the relevant period, the Trust was limited to 3M 1863 / 1873V masks due to national shortages of FFP3 masks. There were instances where FFP3 masks which were supplied had amended expiry dates with labels that had been stuck over the top of original expiry dates. The MFT procurement highlighted this issue with NHS Supply Chain who advised that 'some products may appear to have out of

date/expired dates or have been relabelled'. NHS Supply Chain advised that these products had undergone stringent tests which demonstrated that they were safe for use.

239. Another example of PPE received that were unsuitable was when we received large quantities of PPE gowns that had been sent from China via the foundry 'Push' model. The gowns were not splash resistant and had to be recalled by all trusts as they were not fit for purpose, but there were few other gowns available.

240. The IPC Expert Group undertook several reviews of possible solutions to address the specific issue of PPE gown supply, including consideration of using washable gowns, but this solution was not required as supply through the Foundry process slowly improved.

241. FIT testing solutions and kits were part of the national shortage for around 6 months from March 2020, these were managed at a national level via the Foundry system. The Trust managed to obtain small supplies directly with suppliers until May 2020 when the government required us not to partake in any local purchasing of these products due to the national shortage.

242. Within the Hospital we had staff who we struggled to gain FIT testing compliance. This could be overcome on occasions by using a different make of FFP3 mask. Staff in this position were particularly impacted when specific makes of mask became difficult to source and a change was required.

243. Staff who mostly encountered this problem were those with facial hair often linked to religious beliefs. I was involved in discussions with colleagues and faith leaders within MRI to explore and resolve the issue as faith leaders were able to reassure staff members that decisions, they might make in these circumstances did not go against their overall faith and beliefs. An alternative device in this circumstance could have been a using a RPE hoods. These are a type of RPE which are designed to protect the wearer's head, neck and face for exposure of hazardous chemicals, gases and other harmful airborne particles such as Covid-19 virus. Unfortunately, the supply of these hoods was difficult, which resulted in some staff being redeployed to non-Covid-19 areas, where FFP3 masks were not required.

244. Within the Hospital, departments had FIT test registers prior to the Pandemic where appropriate but a regular and accelerated schedule of FIT testing across the whole hospital was put in place in February 2020 and continued throughout the relevant period.

245. A hospital register was kept of staff who had received the FIT, including the type of mask

that they had been passed to use. This supported the allocation of staff to the most appropriate clinical areas for them.

246. Most staff were FIT tested on several occasions as PPE supplies changed, due to changes at a national level to supply providers. To ensure that FIT testing was responsive the hospital had in place provision to FIT test at short notice if required when masks changed and or staff changed.

247. The type and make of PPE changed throughout the pandemic, within the hospital whilst the levels of stock at times were low, the hospital did not experience a shortage of suitable equipment that impacted on staff or patient safety and wellbeing. The changes did however continue to cause anxiety and logistical issues with staff needing to be reFIT tested for different FFP3 masks.

248. There was a specific challenge with the supply of RPE for Aerosol Generating Procedures especially for theatre procedures. An IPC expert group worked on behalf of the Trust to develop a solution to this and in some instances, staff were issued with a personal RPE system.

249. Whilst the provision of adequate and suitable PPE caused considerable concern amongst staff at the start of the relevant period, I am not aware of any incidents of inadequate supply impacting on staff or patient safety.

250. The issue of level of PPE worn, particularly regarding face masks became less of a problem as the supply became more assured and outcomes improved.

251. In the earlier stages of the relevant period, the level of PPE was effectively set at a level specific level with no scope for wearing enhanced protection above any national guidance even if this was felt necessary by staff. This was particularly relevant to the use of FFP3 masks when individual staff either did not agree with the national guidance or had personal anxieties that a higher level of protection than was specified was required.

252. The hospital used the MFT Staff Risk assessment process to support compassionate, evidence-based discussions with staff to help to mitigate what was a fear of the unknown for these individuals.

253. Risk assessments were completed for all staff working within the MRI in line with the MFT policy to understand the individual risk to staff and implement the appropriate mitigation to manage this risk for each member of staff. This process allowed vulnerable staff to be identified. Mitigation for staff included staff with high-risk profiles working from

home, or staff who had a low risk profile could be allocated to work in covid isolation ward areas.

254. Overall, the risk assessment process was perceived as being helpful and supportive by staff. The risk assessment guidance and the tool was communicated to all staff, describing the approach being taken to risk assessment, reassuring them as to the nature of the assessment being undertaken and the support available to them prior to the assessment being undertaken.

**Changes to Visiting**

255. Following National guidance issued by NHSE in March 2020 (Visiting Healthcare Inpatient Setting During The Covid-19 Pandemic, NHS England) MFT developed an MFT Interim Visiting Policy – Version 1 (March 2020) in keeping with National requirements. This policy was approved on 17th March 2020 through the MFT Strategic Group, for immediate implementation across hospitals/sites.

256. The policy aimed to protect patients and staff by reducing the risk of transmission of Covid-19 and provided clarity to staff and visitors regarding restrictions on visiting Trust premises during the Covid-19 outbreak. For patients this policy was implemented across all the sites within the Group including the MRI. This meant for the MRI that visiting ceased in all areas of the hospital except for when a patient was receiving end of life care, or a family member was key to the patients care delivery (i.e. a patient with a learning disability). In this instance, where this could be safely supported one immediate family member was permitted to visit.

257. Within the wards where suspected or confirmed Covid-19 cases were being treated, and patients where clinically stable visiting was suspended, and contact with families for these patients was through telephone or videoconferencing facilities on portable electronic devices.

258. If the patient had a learning disability or cognitive impairment (i.e., Dementia) visiting was restricted to one hour per day by one named individual who was required to wear PPE (plastic apron, gloves, and surgical face mask).

259. If a patient was receiving end of life care, the senior clinician and Ward Manager assessed the individual needs of the patient and family agreeing named visitors, with only one of the named visitors permitted at any one time.

260. For non-Covid-19 patients, visiting was restricted to one visitor per patient, no children

were allowed to visit, with visiting times restricted to one-hour per day and arranged by the ward team to ensure that numbers of visitors on the area at any one time was kept to a minimum. Visitors were asked when the visiting time was agreed with the ward team to not visit if they had any symptoms of illness and strict hand washing was required upon entering and leaving the ward areas.

261. The visiting policy was regularly reviewed by MFT to ensure it reflected national guidance in relation to visiting or reflected periods of national lockdown in place. Any changes to the Visiting Policy were communicated through the MRI command and control structures to ensure implementation within the clinical areas took place. An example of changes to the policy relates to the times of national lockdown during the relevant period when visiting was not possible for any family members due to the national lockdown guidance.

262. As a hospital, feedback from our staff showed that the visiting restrictions negatively impacted on patients and staff, affecting both physical and mental health. An example of this is a story recounted by one of the MRI Corporate Nursing Team who was redeployed to Critical Care for the relevant period. This individual recounted and shared her story as a blog in the MRI 'Mark this Time' publication that the hospital developed to mark one year after the start of the pandemic.

263. The nurse recounts caring for a patient critically ill within critical care who was being treated for Covid-19. He had exceeding low oxygen saturation levels despite treatment and his overall organ function was failing meaning he was predicted to die. She had met the man when he was awake, and he had told her about his children and that being a dad was his greatest achievement. The nurse recounts how she held his hand as his daughter was crying on the phone saying her final goodbyes to her father as medical teams switched off his life support machines. Her lasting memory of this difficult situation is that the patient did not die alone as he died with love, care and undivided attention of this nurse.

264. The hospital actively focused on ensuring that there was support for families and patients to maintain contact with each other by utilised administration and nursing staff in roles as Family Liaison Officers. This work was coordinated by the MRI Palliative Care Team who provided specific training and support to these staff in communication skills via telephone and using videoconferencing facilities with patients and relatives.

265. The hospital received over 30 electronic devices which were distributed to ward to enable videoconferencing between patient and families, but often these devices were in use and

staff used personal devices to support patients who did not have their own equipment to make video calls to family members.

266. The MRI Family Liaison function also facilitated 'Letter to Loved Ones' which enable patients and family members to send in pictures and letters via a dedicated email address which team members then distributed to the patients.

267. The MRI Palliative Care Team utilised their knowledge in advanced communication skills to support and train staff who were often undertaking difficult discussions with families via the telephone. The team provided resources and guidance as well as supporting staff though individual and team debriefing as this lack of face-to-face contact with families had significant impact on staff. Staff shared that the inability to talk to family members face to face meant that it was more challenging to develop a supportive relationship with the individual as physical contact and seeing facial expressions is a vital part of human nature.

268. There were some specific and practical issues around the discharge and rehabilitation process that were highlighted by Allied Health Care professionals as not being able to undertake home visits with patients made some elements of discharge planning difficult. For example, for some patients arranging a safe discharge includes undertaking a home visit with the patient to their home to understand how they mobilise or function at home. This allows Allied Health Professionals to understand the patient needs and where necessary arrange equipment or support for the patient in their own to be available on discharge. Staff adapted processes using questioning skills and if possible, family members to film the home environment but these techniques were not as beneficial as going to the home with the patient on a home visit.

269. As part of the MRI reflective processes undertaken during the relevant period, the invaluable contribution that the presence of patient relatives provides to our patient's recovery was clear, and it was recognised that family and friend visiting patients holds health care professionals to account for the care they are providing.

270. From an MRI perspective it is difficult to say how effective the guidance was in reducing the risk of infection between patients and staff and measurement of the harm caused is difficult to quantify.

271. Many of the admitted patients came from households where many had already been infected and recovering and as such did not pose a risk to themselves or others. One of the MRI consultants recounted a story at the MRI Learning Conversations in May 2020

of caring for a BAME family where three sons and a mother were admitted with Covid-19 over the 2-week period, with sadly 3 of these individuals dying. The impact of these multiple death often in families was immense for our staff and was even more distressing for the consultant who comes from a BAME background.

272. Patients with learning disability or a cognitive impairment and communication difficulties were disproportionately affected as the supportive measures put in place could not overcome the lack of presence of relative.

273. MFT removed all visiting restrictions in July 2022, and the MRI returned to providing visiting for our patients to meet their individual needs.

**Patient Care Pathways**

274. All Outpatient and Elective activity between 26th March – 30th June 2020 was suspended pending further consideration and planning as to how elective theatre and outpatients' appointments could be delivered safely.

275. From an outpatient's point of view, a MFT Group Wide Outpatient Recovery Programme, chaired by the MFT Director of Corporate Resilience, was established with an aim to ensure that a consistent approach was adopted across the Group for resuming and managing outpatient activity moving forward.

276. Patient's outpatients' appointments were changed to be undertaken via telephone or videoconferencing from April 2020 except for patients who required a specific clinical investigation at their outpatient review (e.g., blood test to titrate medication doses), such as patients receiving anti coagulation therapy. The MRI established a clear principle in May 2020 that as part of the recovery of activity 80% of outpatient activity would be delivered via telephone or videoconferencing technology.

277. Patients and staff initially found the change to virtual appointments difficult as these require specific skills in questioning which were different to those used when undertaking face to face appointments. The hospital changed the content of letters to patients about this appointment to ask them to do practical things before the appointment like writing down questions and ensuring that they had the currently medication list available to discuss with the doctor.

278. During the relevant period, scheduling and management of surgical patients changed, with the most notable amendments being implemented during the wave 2 of the pandemic (September 2020) when the hospital was managing an increase in Covid-19

cases alongside the recommencement of elective surgical activity.

279. As a result of theatre nursing staff redeployment to support increased critical care demand and the utilisation of theatre recovery to support critical care expansion, the available theatre capacity to support MRI surgical patients was significantly reduced.

280. The MRI rapidly implemented a Bookable Theatres process (theatre time available to be booked by any speciality, rather than theatres being designated to a particular speciality) from April 2020, which enabled access to theatre capacity for urgent surgical procedures in addition to the provision of the established emergency theatre pathways.

281. To support the bookable theatre tables utilisation the MRI established a surgical prioritisation process led by one of the MRI Associate Medical Directors supported by the MRI Director of Operations. This process enabled the prioritisation of surgical patients aligned to the theatre capacity and urgency of clinical need. The patient prioritisation was supported by the evolving guidance from the Federation of Surgical Speciality Associations (FSSA).

282. The MRI Surgical Prioritisation process was undertaken twice a week and was a collaborative review process including surgical, anaesthetic, and critical care consultants to understand the capacity in theatres, anaesthetic provision, and critical care capacity, if this was required in the post operative period for a patient.

283. Manchester Elective Surgical Hub (MESH) was developed at MFT level which built on the MRI surgical prioritisation process commencing in July 2020 an MFT wide surgical prioritisation process, led by the MFT Medical Director. The primary role of the MESH was to ensure equity and consistency to the allocation of reduced theatre capacity across MFT aligned to evolving FSSA guidance. Any delays in surgical treatment which could not be accommodated within the MFT capacity could be escalated to the GM Gold Command to explore mutual aid. However, this was not necessary during the relevant period.

284. In common with the other hospitals in MFT, MRI continued with the hospital based surgical prioritisation process twice a week to inform the weekly MFT MESH process.

285. Cardiac surgery provision was led by Wythenshawe hospital as the lead site within the MFT Group model for cardiac surgery. I am aware that provision for cardiac surgery during the relevant period involved the utilisation of the private sector and collaborative working with Liverpool Heart and Chest Hospital.

286. Angiography and Angioplasty procedures continued on the MRI site, with appropriate pathways recognising that these patients were undifferentiated in terms of their Covid-19 status.

287. The MRI continued colorectal cancer surgery during the relevant period (as outlined in the section describing our approach to bed capacity) as this service transferred during the relevant period to the private sector.

288. MRI continued to provide specialist support for hip replacement that required input from highly specialist teams such as renal and haematology.

289. The majority of surgical cases undergoing surgical procedures during the relevant period through the MRI theatres were hepatobiliary, head and neck cancer and life and limb threatening vascular procedures such as aortic aneurysm cases.

290. During the first wave of the pandemic ambulance handover times were not affected as the patient attendances at ED reduced. In subsequent waves despite the change in streaming and ED estate, the increased patient attendance as well as the complexities of managing the Pandemic. Alongside resuming elective activity meant that hospital bed capacity demands increased. This resulted in a busier and fuller ED, which may have affected handover times within the ED. I have been unable to source any reliable data from both internal and external sources.

291. During the relevant period the MRI adapted their Triage and Streaming tool used to undertake the initial assessment of any patient presenting to the ED to prioritise the patients care requirements in line with the Manchester Triage Tool. This included the adoption across MFT and the MRI with Northwest Ambulance Service the 'Fit to Sit' process within our triage. For a patient arriving by ambulance the triage assessment was undertaken which determined whether the patient's care needs and therefore the pathway of care within ED.

292. Several pathways of care were developed between the hospitals in MFT at the onset of the relevant period. This helped clinicians to make decision which where possible were evidence based and helped support decision making and care of patients. This guideline evolved over the course of the relevant period as more evidence became available and experience was gained by clinicians. An example of such a guideline used within the MRI in July 2020 is provided in JS13 / INQ000475232.

293. Patient care and decision making was supported further by the development of a daily

specific Covid-19 multi-disciplinary team meeting (MDT). This was initially established in the MRI during April 2020, but quickly became a Trust wide meeting. This meeting started when 3-4 medical staff came together to discuss specific patient treatment plans for patients who had Covid-19. This meeting evolved into the Covid-19 MDT daily meeting which gave medical staff treating Covid-19 patients access to virologists, respiratory physicians, critical care, and other clinical specialty medical staff. As well as providing mutual support it helped plan patient treatment and care and brought together knowledge and insight to learn and develop treatment pathways.

294. In addition, the Covid-19 MDT was a forum where decisions about escalation of care to a Critical Care Unit could be discussed. This enabled clinicians to share information, discuss treatment and patient safety issues and reduced variability by improving the standardisation of care. This forum was particularly key as clinical staff especially in wave 1 were encountering clinical treatment challenges for patients which had not been experience before and the evidence in relation to the most effective treatments for Covid-19 was evolving. This collaborative discussion and decision-making in terms of how a patient's care might be managed enabled clinicians to feel supported.

295. As a hospital we worked in partnership with the MFT Research and Innovation team participating in national platform trials programmes, such as RECOVERY. A platform trial is defined as a randomised, adaptive trial, to assess multiple interventions, which may evolve through the addition or discontinuation of treatment arms according to review of outcome data.

296. RECOVERY was an international clinical trial identifying treatments that may be beneficial for people hospitalised with pneumonia. RECOVERY started in the UK in early 2020 as the Randomised Evaluation of COVID-19 Therapy, a clinical trial testing treatments for people admitted to hospital with Covid-19 pneumonia. Since then, the programme has identified four life-saving treatments for Covid-19 and demonstrated that several other commonly used treatments were not effective.

297. Within the MRI the hospital recognised the need to ensure that the number of Covid-19 patients recruited to the trial was maximised, as this enables to trial to develop the evidence base for patient treatment. The hospital therefore identified a specific workforce resource including medical and nursing staff whose role was to visit patients who could be included in the trial and discuss the trial with a view to gaining their consent to be included in trial. I am aware that this approach meant that the hospital made a

significant contribution to the recruitment of patients from MFT and therefore I am proud of the contribution that MRI made to the development of the evidence base.

298. The criteria for using oxygen or ventilatory support did not change during the relevant period. I am not aware of any instances where care or patient outcomes was determined by the availability of oxygen, drugs, or the availability of a critical care bed. I am also not aware of any concerns raised by staff during the relevant period that this was the case. The Covid-19 MDT and the cross-Group collaborative Critical Care Escalation Plan (both previously described) were crucial factors in enabling this.

299. I am aware that that the MFT Strategic Group received and approved the MFT Ethics Committee a 'Covid-19 Pandemic: ethical framework for clinical decision making in MFT hospitals', at JS16 / INQ000475235. That document draws upon the 'Clinical Frailty Scale' (JS17 / INQ000475236); the Faculty of Intensive Care Medicine: 'Decision Making for Critical Care in the context of Covid-19 Background to the NICE Guidance' (JS18 / **INQ000475237**); an MRC Centre for Global Infectious Disease Analysis, J-IDEA; Department of Infectious Disease Epidemiology, Imperial College London paper entitled: 'Impact of non-pharmaceutical interventions (NPIs) to reduce COVID19 mortality and healthcare demand' (JS19 / **INQ000475238**); NICE: 'COVID-19 rapid guideline: critical care in adults' (JS20 / **INQ000228380**); and NICE: 'Covid-19 rapid guideline: critical care in adults' (JS21 / **INQ000475240**). The framework provided key principles for clinical teams to utilise to guide decision making ensuring that there would be consistency and transparency in decision making in relation to patient care and treatment. The framework recognised the national context at the time and the prime focus to ensure the best utilisation of resources to deliver the greatest benefit to the greatest number of people. The framework also recognised that the position needed to be dynamic as the pandemic progressed balancing supply and demand in terms of resources against the need to increase bed capacity, as well as recognising the potential for demand to exceed capacity as had been seen in other countries.

300. MRI did declare a "major critical internal incident" on 24th June 2021 but changed the language removing the phrase "major critical" later in the day to make clear this was an internal incident. We did not at any point declare a "major incident" this is a phrase which has a very specific meaning.

301. I am unable to comment on how this became a matter of interest to the media nor am I aware of how this became a media report or the source suggesting that this was the case. This was an internal communication only and did not require external notification

or support as a Major Incident would.

302. On the 28th June 2021 an addendum to the MRI Operational Site Policy was produced to clarify the definitions around incidents and invoking arrangements to reflect this change in language.

303. There was a rapid report produced on 24th June 2021 to highlight adverse ED performance on 23rd June 2021. The report highlighted staff absence in the ED area coupled with successive days of high attendance as factors in the adverse ED performance unnecessary on the 4-hour national standard on the 23rd June 2021 which stood at 42%.

304. No patients were turned away during the period in question, and there is no record of ambulance diverts.

305. During the relevant period, as was our usual practice where appropriate, patients deemed unsuitable for invasive ventilation were admitted to critical care for trial of continuous positive airways pressure (CPAP)/Non-invasive ventilation (NIV) and nasal high flow oxygen for patients infected with Covid-19. These therapies were not delivered in a non-critical care ward areas at MRI. If not already in place, for these patients a respect form (limitations of treatment) and generally a 'Do not attempt cardiopulmonary resuscitation (DNACPR) would be implemented following appropriate conversation with the clinical team, patient, and patient's family/care network.

306. The MRI has used the ReSPECT process and documentation with limitations of care described and DNACPR status of the patient defined as a part of routine practice for several years. This did not change during the relevant period and is considered as a part of routine care for all patients.

307. Clinical staff as part of mandatory training undertake resuscitation training during which the ReSPECT form and process is discussed.

308. During the relevant period, MRI was using a paper-based patient record and the ReSPECT form containing the DNACPR notice was also paper based.

309. On the Critical Care Unit, patients with Covid-19 who had been determined as not being appropriate for invasive intubation but were being admitted for CPAP/NIV would generally have a ReSPECT form (limitations of treatment) and a DNACPR placed following appropriate conversation with the ward team, patient, and patient's family/care network. Also, if patients were deteriorating significantly, and it was felt unlikely that they

would survive, once invasive ventilation had been commenced, a DNACPR would be placed, again following the same principles of discussion.

310. The Clinical Director for Critical Care has advised me that they were not aware of any concerns being raised that patients from a particular background were being discriminated against in terms of referral and access to hospital or critical care or having inappropriate DNACPR placed. In fact, the MRI as a Hospital and Critical Care Unit, because of their inner-city location, treated and cared for many patients from ethnic minority backgrounds. Our outcomes generally were good when compared nationally as shown in the data provided in JS14 / INQ000475233.

311. I am also not aware of any concerns about patients arriving at the MRI or during their hospital stay with an inappropriate DNACPR notice. There was close communication and oversight between the ED, ward based medical teams and critical care teams in terms of triage and treatment to ensure patients received the correct management plans.

312. The hospital was aware that the absence of visitors and family members meant that communication with patients where English was not their first language was more difficult. To help with this we had access to telephone interpreting services and if these were unable to support time critical discussions the hospital was able to identify a member of staff who could fulfil this role. The hospital has staff from over 60 different nationalities which enabled staff to support patients whose first language was not always English.

313. The use of face masks in patients with impaired hearing patients was a particular challenge as these patients often supported their communication needs by lip reading. The hospital worked with MFT IPC and procurement colleagues over several months (May-July 2020) to source masks with transparent fronts which would enable patients to still see the persons speaking lips and therefore lip read to understand what was being communicated. We explored this issue several times over the relevant period but were unable to identify a suitable product which complied with IPC requirements and the needs of this patient group.

314. The hospital worked with staff when such patients were being provided with care to review how best to ensure effective communication, and based on a risk assessment process this occasionally meant staff removing face masks to ensure effective communication and understanding was achieved. This would only be undertaken where the Covid-19 status of the patient was known through the planned patient screening

processes that were in place.

**Impact on our Workforce**

315. As a hospital we have a well-developed managerial and leadership team with a clear structure for decision making and communication from Ward to Board level. This really came into its own during Covid-19 as we were able to distribute messages and briefings out quickly and efficiently to our staff across and down the MRI.

316. The MRI very quickly introduced informal 'huddles' or 'quick catch ups' for colleagues to get together. We introduced a new communication and engagement framework with the following purpose: 'Following the significant change COVID-19 has caused, accurate and meaningful communication is more important than ever if we are going to support staff through perhaps the most complex change of their lives both personally and professionally'.

317. The MRI communications plan was developed to support the leaders within the hospital to cascade the key messages as we 'learn to live with Covid-19' and reset our plans under an Annual Plan refresh JS15 / INQ000475234.

318. The hospital introduced 'Well-Being Wednesdays' at the start of the pandemic specifically to focus time and energy into listening to and supporting our staff. These sessions evolved into 'Motivational Mondays' where we started the week (on Microsoft Teams for 15-20 minutes) with a positive story, or 'TED talk' led by a member of the senior leadership teams across the MRI. We launched our commitment to 'Belonging' in October 2021, to enhance our approach to Equality, Diversity, and Inclusion and at that time our weekly meetings evolved again into 'Celebrating Diversity and Difference' where staff from all levels come along to tell their stories of how we support them in their roles at the MRI. This has included sessions on neurodiversity and dealing with the impact of Long Covid and is regularly attended by 50-60 members of staff. I honestly believe that had we not encouraged staff to share their experiences during Covid-19 at a personal level, our culture would not have evolved sufficiently enough to allow people to be so open and honest. It was - and is - very humbling - these sessions continue up to the present day and remain as inspirational as ever.

319. The introduction of 'wellbeing rooms' across the MRI was an early programme of work the hospital undertook at the very start of the pandemic and completed by May 2020. This was mostly led locally by teams wanting to do their very best for their staff, initially providing resources themselves. This dedicated area (often a staff restroom) was within

each ward where staff could take time away. Rooms were equipped with resources often provided through the generous donations received by the Trust and centrally coordinated by MFT Charities to ensure donations were both appropriate and safe. I know these gifts were very popular and staff were very appreciative. I do remember we were overwhelmed by the generosity of local people and organisations, which caused a coordinated effort to make sure gifts were shared out responsibly and equally. I recall the excitement and gratefulness from staff when these donations arrived, especially when hot food was provided. Staff reported that they felt supported with these tokens of recognition often making tough shifts at work feel slightly better.

320. Local initiatives were put in place by the MRI teams to take well-being directly to the wards and departments. For example, 'Time for Tea' trolley visits to areas, which gave the opportunity not only for ward staff to have a cup of tea, but to ask them how they were feeling and to listen to their experiences. Appropriate 'walkarounds' were in place, recognising the IPC requirements in clinical areas, from the MRI Executive and CSU leadership teams to both support staff and to hear what more could be done.

321. The MRI theatre staff redeployed to critical care in wave 1 reported on their return to theatres in summer 2020 that they had found working in this setting difficult especially being part of the team due to the intense workload during the first wave with critical care. The Critical Care Education Team and Clinical Services Unit Leadership Team worked with the staff to develop further support and training, before the second wave which included regular meetings for each member of staff with a senior nurse from within theatres, and the theatres senior nursing team visiting staff in the Critical Care areas. These further interventions received positive feedback with theatre staff stating they felt part of the Critical Care Team, whilst not losing contact with their substantive place of work.

322. At the end of May 2020, the MRI hosted a series of 'Learning Conversations' with colleagues from across the hospital to gather insight and feedback on the response to the Covid-19 pandemic while also considering the direction of travel for us in the future. As a hospital we wanted to learn from the period of change and transformation taking place as staff genuinely felt liberated to do thing differently for patients. These learning conversations were sessions held in a large lecture theatre in person (some things just simply do not lend themselves to teams) so staff could be socially distanced. Staff shared both their personal stories and learning of how to improve things for patients from Wave 1. At the time, as a hospital there was a perception that we felt we were 'over it' and looking ahead to make the learning sustainable. The sessions enabled staff to recognise

the impact of the previous 3 months about themselves, alongside agreeing what might help in any potential future surges in Covid-19 patients. Following the sessions, the MRI developed an updated Covid-19 Escalation Plan to reconfigure the ward locations which was implemented across the MRI in September 2020.

323. In March 2021, the MRI collected staff experiences and charted a timeline of the 1st year of the pandemic. This was published in a booklet 'Mark this Time **JS1 INQ000416875** MRI Mark This Time Brochure Print Version Final Review 10 June.pdf], and included a dedicated poem penned by the Palliative Care Poets. The MRI held a listening event to mark the anniversary of the first lockdown where staff shared their stories which were very moving. A commemorative badge was given to staff with a thank you card in recognition of the contribution that they had made. A programme of events took place over a two-week period which was greatly appreciated and had led to an annual festival of belonging each year since.

324. Many doctors who do not usually see general medical ward patients stepped up to run Covid-19 wards with leadership and support provided by our colleagues from respiratory medicine or care of the elderly. I am aware that support was offered through a 'buddy' and local forums to all of our staff, as often working in unfamiliar areas or clinical settings can for some people be difficult, especially during the relevant period when we were managing a situation with which no one was truly familiar. MRI staff were offered our 'Employee Assist Programme' through the MFT Employee Health and Well-being service for any formal support.

325. The Associate Medical Directors in my team at the MRI held regular meetings in the junior doctor's mess to keep the juniors updated about developments with Covid-19 and within the hospital. These were very well attended, and I think well received by the juniors. I think that communication with all staff was a vital element of the MRI response during the relevant period.

326. At the start of the relevant period, I recall that there was significant anxiety about the unknown. Staff had heard of experiences from China and some areas of Europe and had numerous questions and concerns which I recall at times the MRI leadership team felt unable to address. The approach the hospital took throughout the relevant period was to undertake daily briefings and the established communication processes within the hospital were in place to listen and acknowledge concerns using MFT Strategic Group and other resources to work with staff to resolve concerns and answer questions.

327. As a hospital we put in place several measures to support staff recovering from long term absence including the 'Lime Arts' programme, where staff could access arts and crafts e.g., screen printing, pottery and other activities in a dedicated arts studio which was a safe and supportive environment.

328. Reasonable adjustments were put in place to enable staff to safely return to work, e.g., flexible working and adjusted workloads, and staff were supported to build their confidence to return to work after shielding through support from MFT Employee Health and Well-being and local flexibility in roles following a phased return. Decisions in terms of staff return to work were informed by the MFT Risk Assessment process which both staff and managers found a supportive tool to inform discussion and reach agreements for individual staff.

329. In December 2021, the MFT Employee Health and Well Being service secured £150,000 of charitable funding to provide staff who are suffering from symptoms of Long-Covid with easy/rapid access to relevant treatments or signposting to self-management advice for their symptoms.

330. The funding awarded to the programme was divided to support resourcing a multi-disciplinary team required to provide the service. This included administrative support and commissioning services from the GM Long-Covid team. In addition, part of the funding was used to create resources which were shared with staff after they receive a positive Covid-19 test result, bringing together documentation and resources for signposting to suitable support groups/self-help information.

331. I recall staff whose risk assessment profile indicated that they should shield and work from home approaching managers to express a wish to return to work as they felt that they should be contributing to providing care for patients and supporting colleagues. This was often a difficult situation as staff in this position found being 'forced to stay at home' very distressing. Working with managers and the individual members of staff solutions were identified which ensured the member of staff understood the risk of returning to work balanced against the distress that remaining at home was causing.

332. Understandingly there were staff who expressed anxiety about working in clinical areas and the risk that this may pose to them individually, these concerns were resolved by supportive conversations with colleagues and managers brining in IPC expertise to support as required. I have included specific examples throughout the statement.

333. The MRI as a hospital did not undertake local Equality Impact Assessments (EIA) but

followed the MFT Group wide EIA. An EIA is an evidence-based approach to support organisations to ensure that policies, practices and processes are fair and do not present barriers to participation of disadvantage any protected groups. For example, a Trust wide EIA had been carried out while implementing national IPC directive during Covid-19. This included the Trust Equality Diversity and Inclusion Lead collating issues raised by the operational staff and discussing these with the Trust IPC lead to ensure a consistent and equitable approach was adopted while ensuring effective IPC protocols were in place. An example of this within the MRI is described earlier in the statement where I worked with local faith leaders to address concerns raised by a group of staff.

334. From an MRI point of view, I am not aware of any specific issues which were not able to be resolved which resulted in an unequal impact on our staff. I was involved in discussions such as outlined in my statement related to staff with beards due to religious beliefs and the challenge this caused in terms of appropriate FIT testing outcomes.

335. The Trust interacted with national decision-making bodies using the GM Cell and Provider Federation Board to connect regionally and nationally with the system and where possible influence changes and solutions. As a hospital we did not have direct interaction with national bodies or decision makers, with the Trust Strategic Group structure supporting the dissemination of information and any feedback from hospitals to these bodies. The hospital used established communication processes described in the statement such as daily huddles or Associate Medical Director forum with junior doctors to provide the two-way communication and feedback.

**Recommendations**

336. National pandemic preparations need to be updated and maintained to ensure that they are always current to the evidence base, to avoid the plethora of guidance that was often received late at night and at weekends for Trusts to implement immediately.

337. A recognition within any guidelines that organisations responsible for implementation will have to risk assess the requirements of the guideline to enable implementation within services. There needs to be a recognition that guidelines may have to be implemented in different ways within organisations and services, as such factors as workforce resource or the physical infrastructure of buildings may not always be optimal for implementation.

338. Alignment of National, Regulatory and Professional bodies and Societies on guidance and policy is a key factor. There were times during the relevant period when the guidance from each of these different bodies conflicted with the national guidance issued by NHS

England or Public Health England, which caused anxiety and at times difficulty in their implementation.

339. Any guidance produced, especially where this requires immediate implementation, needs to be concise, clear, and as simple as possible and be published and distributed well. Where national guidance does not yet exist, national support to agree and implement local guidance in the interim is an important factor.

340. Recognition that working as a Group of Hospitals or Providers with a collaborative approach in an integrated system such as exists in GM has real benefits. Attention needs to be paid to the form and function of healthcare systems to encourage this way of working and culture. The collaborative approach at all levels enables mutual aid which benefits both patients and the workforce to deliver care and remain resilient to challenges.

341. As a part of preparation for a further pandemic ensuring sufficient stocks of PPE, medicines, and equipment, as well as ensuring hospitals have an estate fit for purpose with workforce models to enable quick response. This would help in the delivery of healthcare during normal times as well as in a Pandemic.

342. Recognising when guidance may have had a negative impact on patients, families, and our staff such as the visiting guidance. Whilst the intention of this guidance to ensure the protection of patients was the priority the impact of family members not being able to visit their loved ones will I feel be felt for several years.

343. The importance of paying attention to the workforce wellbeing, ensuring that there is sufficient management and leadership capability in all professional groups. Having a key focus on culture, ensuring that this is compassionate, and time is taken to value, listen to and learn from staff. Ensuring senior leaders within organisations are visible and engaging with staff to listen is vital to always developing the right culture.

344. Recognising the impact on mental health and wellbeing is and always should be part of usual practice for staff, patients, and families. Equipping staff to recognise and support the mental health needs of staff, patients and families is a key factor.

345. Ensuring attention is paid to providing an infrastructure for research and platform trials to provide the best evidence for treating and care for patients in a new and evolving situation such as in a Pandemic.

346. The continued development of new ways of working with in the NHS enabled by digital

technology and flexible working. This needs the provision of sufficient informatic hardware and software with appropriate support to staff to use this equipment to enhance care. As well as the acceptance of different models of working including flexible hours and working from home where appropriate and possible.

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 in its truth.

Signed: **Personal Data**

Full Name: Jonathan Christian Gerard Simpson

Dated: 09/05/2024