Witness Name: Dr Magda Smith
Statement No: 1
Exhibits: 19
Dated: TBC following signature

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR MAGDA SMITH

---

1. I, Dr Magda Smith, make this statement in response to the UK Covid-19 Inquiry's ("the Inquiry") request to King George Hospital (KGH) of Barking, Havering, and Redbridge University Hospital NHS Trust (BHRUT) for evidence in relation to Module 3 of the Inquiry's work.

2. I am currently the Deputy Group Chief Medical Officer at Barts Health NHS Trust and have been in this role since April 2022, on secondment from BHRUT. I am a Consultant Physician and Gastroenterologist registered with the General Medical Council and my qualifications are MB MD FRCP. Before this role, I worked at BHRUT between December 1996 and April 2022 during which time I undertook a number of senior clinical management roles at the Trust. At the time of the relevant period subject to this Rule 9 request, I was the Chief Medical Officer at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and was in this role between January 2019 and March 2022.

3. Together with the Chief Nurse and Chief Operating Officer we formed the “Gold command” as part of the response to the pandemic. I chaired the clinical reference group which met weekly or twice weekly, and comprised clinical leaders from all disciplines advising on clinical matters. As a member of the executive team and the Trust Board, I shared responsibility for decisions made as part of the pandemic response. I was also a member of the North East London Clinical Advisory Group.

4. I understand the Inquiry’s overall aim is to identify and understand the challenges faced by the hospital, but also how they impacted on our staff and our patients. I, on behalf of the Trust, welcome the opportunity to assist the Inquiry`s review.

5. This statement is drafted on the basis of my memory, various documents relevant to the period subject to this Rule 9 request, and I have also received input from colleagues in leadership with the relevant expertise.

Introduction

6. Barking, Havering, and Redbridge University Hospital NHS Trust (BHRUT) operates King George Hospital in Ilford and Queen's Hospital in Romford, Essex. During the pandemic, the Trust operated as two hospitals with a body of executive directors overseeing the Trust. Much of the decision-making was undertaken as a Trust and therefore, most responses within this statement are from a Trust perspective, rather than from the individual hospital's perspective.

7. The Trust managed the pandemic with a major incident command structure in place: Gold, Silver, and Bronze. During the Covid-19 pandemic, the command structure set the 'Battle Rhythm' in terms of the approach to managing incidents.

8. At the top of the command structure was Gold, which comprised of the Chief Nurse, the Chief Medical Officer, and the Chief Operating Officer. Gold command made strategic decisions and reported directly to the Trust Executive Committee. Gold command was supported by Silver and Bronze on each hospital site. The Silver Command is the hospital's Operational group responsible for the practical aspects of managing the hospital. It carried out instructions from Gold with the support of Bronze command, escalating to Gold where necessary.

9. BHRUT offers District General Hospital (DGH) services to the three local authorities across the London Boroughs of Barking and Dagenham, Havering and Redbridge.

King George Hospital

10. King George Hospital (KGH) is one of the District General Hospitals for the London Boroughs of Barking and Dagenham Havering and Redbridge; across East and Northeast London. The population for Barking & Dagenham is 218,534, 262,100 for Havering, and 309,836 for Redbridge; totaling 790,470 (Census 2021). The Trust also provides tertiary, specialist care to some areas in Southwest Essex. This population is served by both Queen's and KGH

11. Below is an outline of the patient population the Trust hospitals serve; the respective geographical areas covered by the Trust; and the demographic characteristics of the patient

population. The data has been obtained from the *Office for National Statistics*; from *Trust for London.Org*; and from *NHS North East London*.

Barking and Dagenham

12. The population of Barking and Dagenham increased by 17.7%, between 2011 and 2021 (census 2021) with the population of Barking and Dagenham experiencing the third-largest percentage increase in England. This borough was among the top 10% most densely populated English local authority areas at the last census.

13. The Office for National Statistics (ONS) confirms the age groups of the usual residents of Barking and Dagenham as in the following percentage range:

    i. 0 – 15 years: 26.1%
    ii. 16 – 64 years: 65.2%
    iii. 65 & above: 8.7%

14. Barking and Dagenham, has an ethnically diverse population. The ethnic groups of the usual residents are as follows:

    i. White 44.9%
    ii. Asian, Asian British or Asian Welsh: 25.9%
    iii. Black, Black British, Black Welsh, Caribbean or African 21.4%
    iv. Mixed or Multiple ethnic groups 4.3%
    v. Other ethnic groups 3.6%

15. With respect to the socio-economic picture of Barking and Dagenham (B&D), the organisation 'Trust for London' has produced some key indicator rankings.

    a. In 2021/22, 29% of people in the borough lived in households with an income of less than 60% the UK median after housing costs have been subtracted. This was around the same as the average London Borough.
    b. 42% of children in the borough lived in households with an income of less than 60% the UK median after housing costs have been subtracted in 2021/22. This was worse than the average London Borough.
    c. 24.6% of residents were estimated to be earning below the Living Wage in 2023. This was worse than the average London Borough.

Havering

16. The population of Havering increased by 10.5% between 2011 and 2021. This area was the second least densely populated local authority area across London.

17. The Office for National Statistics (ONS) confirms that the age groups of the usual residents of Havering is in the following percentage range:

    i. 0 – 15 years: 20%
    ii. 16 – 64 years: 62.4%
    iii. 65 & above: 17.6%

18. Havering has an ethnically diverse population. According to the ONS, in 2021 the ethnic groups of the usual residents is in the following percentage range:

    i. White 75.3%
    ii. Asian, Asian British or Asian Welsh: 10.7%
    iii. Black, Black British, Black Welsh, Caribbean or African 8.2%
    iv. Mixed or Multiple ethnic groups 3.7%
    v. Other ethnic groups 2%

19. With respect to the socio-economic picture of Havering, 'Trust for London' has produced some key indicator rankings. Among its key findings were:

    a. In 2021/22, 16% of people in the borough lived in households with an income of less than 60% the UK median after housing costs have been subtracted. This was better than the average London Borough.
    b. 28% of children in the borough lived in households with an income of less than 60% the UK median after housing costs have been subtracted in 2021/22. This was around the same as the average London Borough.
    c. 16.2% of residents were estimated to be earning below the Living Wage in 2023. This was around the same as the average London Borough.

Redbridge

20. The population of Redbridge increased by 11.2% between 2011 and 2021 (census 2021). This area was among the top 10% most densely populated English local authority areas at the last census.

21. The age groups of the usual residents of Redbridge were in the following percentage range (ONS):

    i. 0 – 15 years: 22%
    ii. 16 – 64 years: 65.8%
    iii. 65 & above: 12.2%

22. Redbridge, has an ethnically diverse population and the ethnic groups of the usual residents is in the following percentage range (ONS):

    i. Asian, Asian British or Asian Welsh: 47.3%
    ii. White 34.8%
    iii. Black, Black British, Black Welsh, Caribbean or African 8.4%
    iv. Other ethnic groups 5.4%
    v. Mixed or Multiple ethnic groups 4.1%

23. With respect to the socio-economic picture of Redbridge, 'Trust for London' has produced some key indicator rankings. Among its key findings were:

    a. In 2021/22, 27% of people in the borough lived in households with an income of less than 60% the UK median after housing costs have been subtracted.
    b. 32% of children in the borough lived in households with an income of less than 60% the UK median after housing costs have been subtracted in 2021/22.
    c. 19.6% of residents were estimated to be earning below the Living Wage in 2023.

24. KGH provides some services to patients from Southwest Essex and has an elective surgical hub. It has 320 general & acute inpatient beds, plus a further 13 critical care beds. Inpatient care is delivered across 14 wards and there is a day-case unit for same-day elective procedures. During the pandemic we increased our Critical Care capacity to 37 beds across 3 units.

25. The hospital currently provides the following clinical services to its patient population:

    a. Cardiac services including an angiogram suite
    b. Rheumatology
    c. Frailty services (including an ambulance receiving unit)
    d. Diagnostics for the following clinical services: Imaging, Endoscopy, Breast Screening, Respiratory, Urology, Cardiology, Pathology
    e. Antenatal services

f. Urgent and Emergency care including for Paediatrics
g. Paediatrics care including Paediatric surgery
h. Endocrine
i. Respiratory
j. Gastroenterology
k. Critical Care
l. Elective surgical hub
m. Redbridge renal unit (Barts Health)
n. Outpatient services (including a Fracture clinic and Audiology services)
o. Stroke rehabilitation services
p. Opthalmology

26. The current workforce at KGH (January 2024) comprises of 1019.44 Whole Time Equivalent (WTE) staff, with 1082 members of staff employed overall. At the beginning of the pandemic in March 2020, WTE was 872.52 with 945 members of staff employed overall. It is important to point out that the workforce number will be significantly larger than presented here because the data does not capture staff who work across both hospital sites.

Staffing the hospital during the pandemic

27. At the onset of the pandemic, shortages were far reaching across all staff groups. Sickness levels increased to a significant degree and some staff had to shield; there was also a reduction of available temporary staffing. The most significant area of staff shortage experienced was in nursing staff within the Intensive Therapy Unit. The pre-pandemic vacancy rate for Intensive Therapy Nurses was already at 19%; therefore, ensuring safe staffing levels was challenging with a combination of absences, a 50% reduction in the availability of agency staff to provide support, and a slight decrease in Bank staff supply.

28. Staff shortages were prominent within Respiratory Medicine, Critical Care and the Emergency Department. The issue was initially managed by the existing staff, within these services, taking on extra shifts to ensure safe staffing levels wherever possible. Those who could work from home did, as the ability to work from home reduced staff shortages in non-patient facing roles. Due to the age profile of our consultants, there were a number across all specialties who had to shield, and this impacted on capacity.

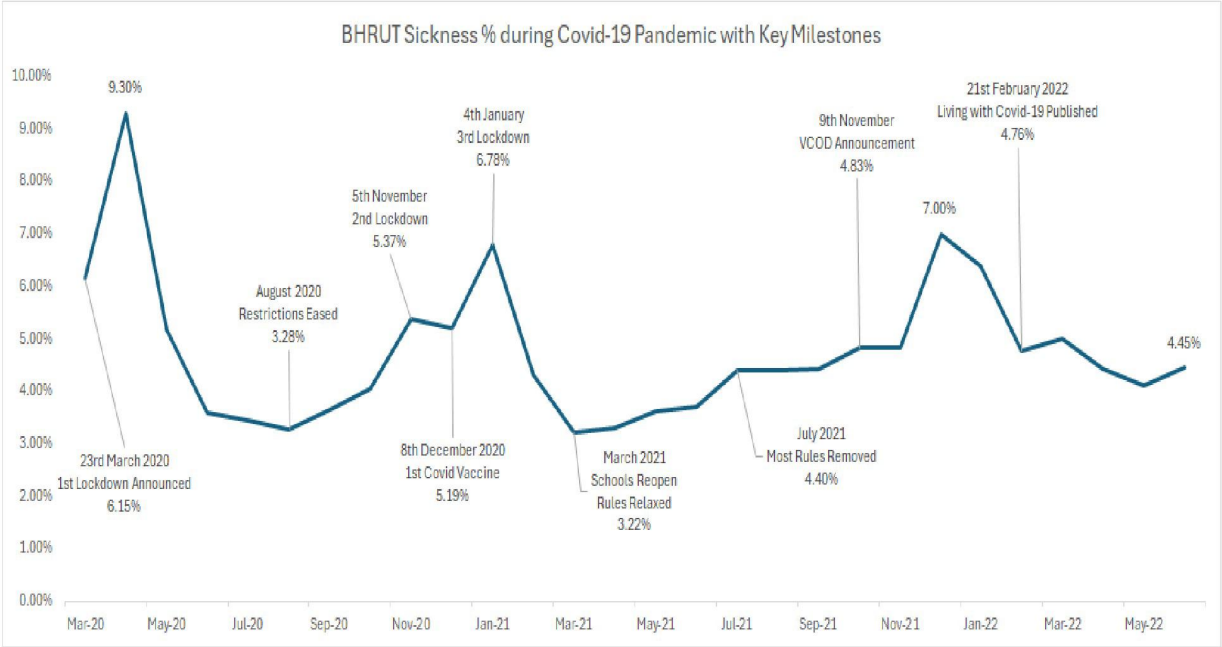

Figure 1

29. Figure 1 above, exhibited as **MS/11** **INQ000477345** shows staff absences across the Trust during the relevant period. There were high levels of absences at the initial stage of the pandemic with spikes again when Covid-19 levels rose across the population. This stabilised when vaccination and lateral flow tests were made available.

30. Through the period in question, staffing levels started to improve as the pandemic went on, particularly with the introduction of the vaccination programme in December 2020. However, staff levels were always impacted by the various Covid-19 'waves' and by the isolation requirements for NHS staff whenever they tested positive or whenever exposure to the virus was detected.

31. The overall pre-pandemic vacancy level was 10% across the Trust, and there was little fluctuation in levels at the start of the pandemic. There was a reduction in staff mobility during the pandemic and the Trust's retention was maintained. Staff mobility across the NHS did not restart until September 2021. This is indicated in Figure 2 below, exhibited as **MS/12** **INQ000477346**

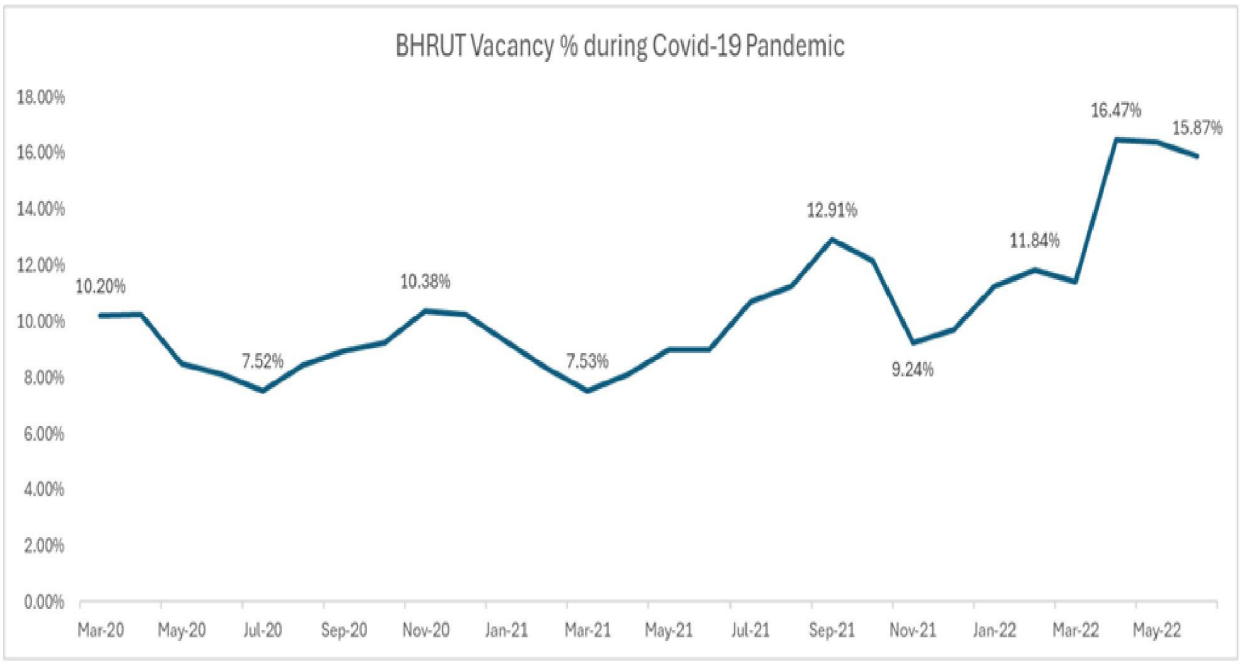

Figure 2

32. During this period staff leavers were tracked, and this is shown in the data in Figure 2 above. Figure 3 below, exhibited as **MS/13** **INQ000477347** identifies the patterns of leaving staff. There is nothing significant until March 2022 where there were a number of midwives who left due to the planned introduction of VCOD. There was also a number of retirement issues due to post-covid-19 pension changes.

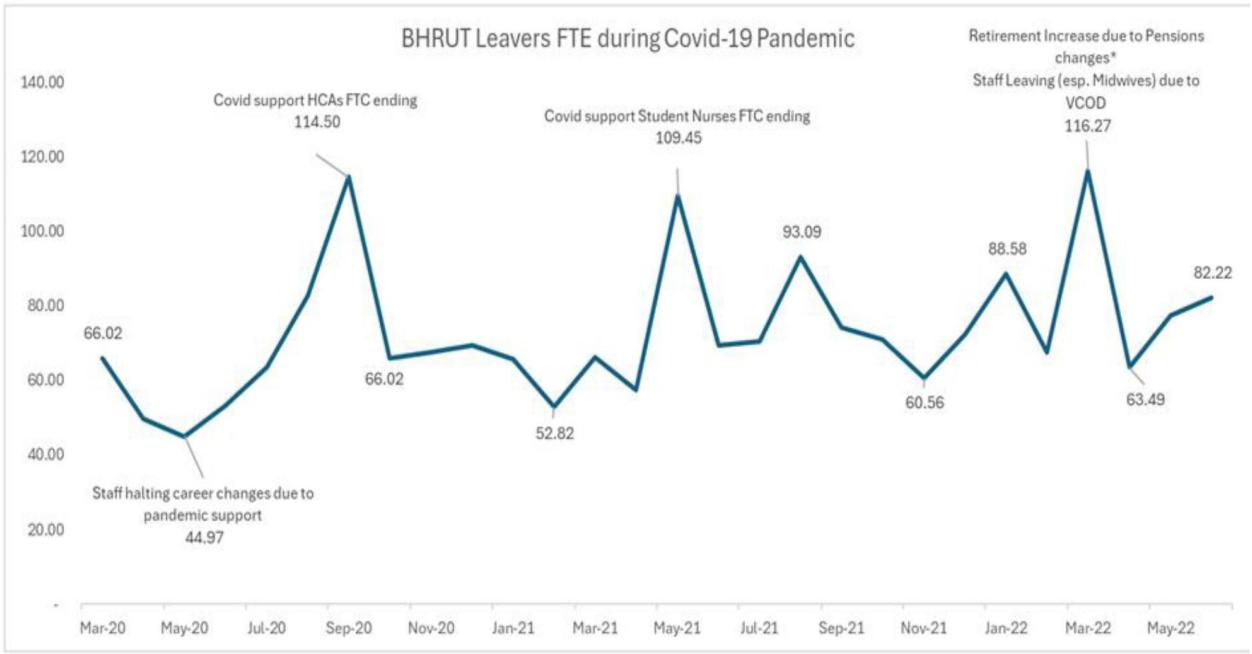

Figure 3

33. Staff shortages at the hospital were caused by many factors including increased sickness levels, staff having to isolate, staff shielding, and a reduction in temporary staffing availability. The redeployment of staff initially increased staffing capacity within acute areas such as critical care, but it did not support other areas and staff shortages remained.

34. A detailed daily absence report was created reporting on all the above. This report tracked all types of absence data, those who were self-isolating and/or shielding, and those staff who had tested covid-19 positive. There were also social factors which impacted workplace capacity; these included the lockdown, new covid-19 variants, self-isolation due to family members being either symptomatic or covid-19 positive, caring responsibilities, school closures and the reduction in the availability of wrap-around care, and spikes in covid-19 positive cases.

35. In April 2020 PCR testing became available. As expected, the initial process was logistically challenging when test centres opened as they were mainly accessible by car only. The Trust undertook a process in contacting all staff who had reported covid-19 symptoms and asking them to get tested, with a focus on junior doctors; however, as this required access to a car, it was challenging. The Trust therefore established a team that would drive to individuals homes to undertake tests if they were unable to access a drive-through centre or did not have a car. As additional walk-in centres were introduced, testing became more accessible.

36. The introduction of PCR testing, along with other external factors, had a dramatic impact on staff availability. Symptomatic staff, as well as those who had been in contact with covid-19 positive individuals, were able to get tested. As time went on, these members of staff did not have to self-isolate if they did not test positive themselves.

37. Lateral Flow Tests (LFT) were introduced at BHRUT in November 2020. Again, this had a positive impact on sickness absence levels prior to the UK-wide spike in covid-19 cases leading to the lockdown in January 2021. We consider that, but for the new variant of covid-19 leading to the Spike in December 2020, the introduction of LFTs would have had an overall positive impact on workforce capacity.

38. The covid-19 antibody testing commenced in June 2020 but did not have much of an impact on staff availability. There were instructions from NHS England to carry out antibody testing on staff, and this was done over a period of 48 hours as per instruction. This did not have an impact on available work force capacity and did not inform ways of working.

39. Other than nursing, there was limited increased staff resources from the introduction of temporary registers for Doctors, Nurses, Midwives and Pharmacists. Very few retired staff returned to front line work, with issues around health and shielding being a factor. However more 'return to work' staff were hired and did participate in the Trust's vaccination hub once this was established. These included retired staff members who provided the backbone of this service.

40. The main benefit of the temporary register was the ability to recruit student nurses earlier into roles. Annually, we introduced 60 student nurses into the organisation and they were able to start approximately 6 months earlier. Another provision of great benefit was the relaxation of the NHS Employers Employment Check requirements; this enabled virtual employment checks to be undertaken and a quicker hiring process.

41. Additionally, Health Education England deferred the medical rotation of doctors and pulled some GP trainees back into the main acute workforce. Together with the earlier start for medical students in the supporting workforce, this action had a small impact on increasing capacity in the medical workforce.

42. Touching on the constraints to increasing staffing, there were roles which were exceedingly difficult to recruit into, an example was the specialist medical roles. There was reduced staff mobility across the NHS and overseas medical recruitment, which the Trust relies upon, was diminished greatly during the period in question. Additionally, a number of agency staff who had undertaken regular shifts withdrew from work during key periods of the pandemic. Generally, there was no available pool of clinical staff to help support an increase in staffing capacity.

43. The Trust made an executive decision to actively continue with recruitment efforts for all roles. Prior to the pandemic the Trust had commenced an international recruitment programme for nursing staff, it was agreed that whenever restrictions were lifted, international recruits would be onboarded.

44. Specific roles were advertised for recruitment, and we undertook local campaigns to recruit healthcare assistants (HCA); these were very successful. A similar campaign was offered for temporary workers to increase our Bank Capacity. As a result of these efforts, there were positive increases in staff numbers – as evidenced in Figure 4 below, exhibit **MS/14** **INQ000477348**

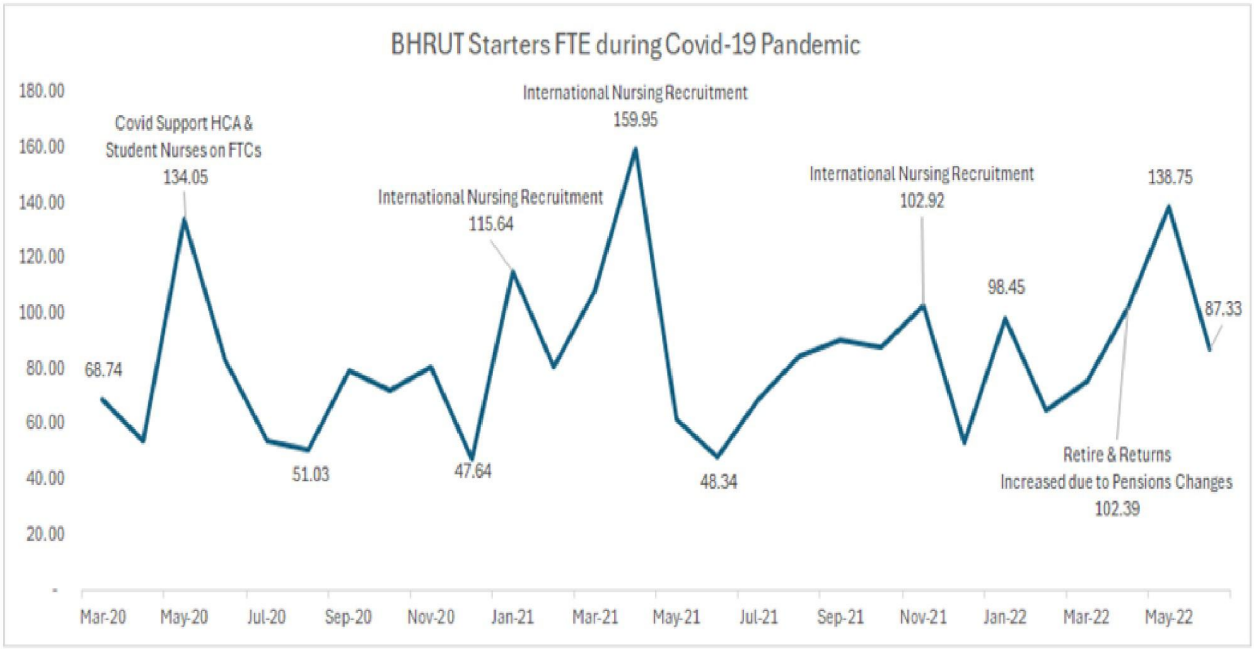

Figure 4

45. A key aspect of our efforts to alleviate staffing shortages was the introduction of two centralised Workforce Hubs for both medical and nursing staff. At the onset of covid-19, with a view to dealing with consultant and junior doctor absences, as well as the increased demand in key areas such as ITU and medical wards, new staff rotas were created for both consultants and junior doctors. This centralised approach enabled the creation and management of rosters across the more impacted clinical Divisions working on a daily basis. This was to ensure available staff resources were best utilised.

46. The Hubs consisted of a Clinical and Operational lead, supported by Human Resources (HR) staff, HR Business Partners, Workforce Information, rostering and temporary staffing management. Rosters were agreed with medical staff and there was helpful temporary guidance on working hours introduced with the support of the British Medical Association (BMA).

The Redeployment of staff

47. Redeployment was one of the most impactful resources available to us as a Trust in responding to staff shortages in key areas during the pandemic. The medical hub focused on the redeployment of medical resources within the clinical areas less impacted by covid-19 and

this led to the creation of the covid-19 Rota which enabled consultants and juniors from all specialties to support the rota 24 hours a day.

48. The Nursing Hub was initially created to implement Safe Care, which was a system which would enable live reporting of available nurse capacity on wards. During the pandemic, its principal aim was to support nurse capacity in the ITU via resource-management; this included absence management, rostering support and the redeployment process. The Hub led and supported the redeployment process for nursing staff which included the reviewing of health risk assessments, competency reviews, and identifying educational support when required. The hub was also the liaison between the providing ward and the receiving ward, ensuring that staff who were required back to their substantive roles were able to return.

49. An Administrative and Clerical (A&C) redeployment bureau at the Trust was also established during the pandemic period. Its purpose was to identify corporate staff and other A&C staff who may be able to provide support in clinical and other key areas where there was greater need. There were volunteers from our finance team supporting areas such as laundry, the provision of PPE, and other clinical support services.

50. The management of bank rates was important to recruit new bank staff, but also to attract existing staff to undertake additional shifts. Enhanced bank rates were agreed for medical and nursing staff and reviewed weekly. Enhanced agency rates were also in place to alleviate staff shortages.

51. The introduction of a Memorandum of Understanding (MOU) was agreed across London to allow the transfer of staff from one Trust to another - with very minimal processing. Although useful, as most Trusts needed all the support they could get from existing staff, it did not prove to be effective. Overall, there was little transfer of staff between NHS Trusts within North East London.

52. The changes to the NHS Employers recruitment checklist were extremely helpful to the Trust's recruitment process as it helped to reduce the time it took to hire staff, and moved Corporate Induction to an online process.

53. Wellbeing initiatives were introduced at the hospital and across the Trust to support staff during the period of the first national lockdown in March 2020. We started by creating temporary wellbeing spaces including hubs, wobble rooms and rest rooms for staff to relax and recharge. These rooms had snacks, drinks, activities (colouring, puzzles), information on where to get

help, and access to some of our support services such as meditation and coaching. Later on, we introduced the provision of hotel accommodation, to allow staff to stay temporarily near to hospital, and free parking. Another was the introduction of staff risk assessments in late March 2020; this was following on from the awareness of a potential unequal impact of covid-19 on staff members from the BAME community which I elaborate on further in my statement, as well as recognised issues of fit testing for PPE. In response to this a "BAME covid-19 Working Group" was established and chaired by the Director of Workforce, with the aim of ensuring issues or concerns regarding diversity were raised and appropriately addressed.

54. The redeployment of staff was crucial to Trust efforts in ensuring resourcing was effectively managed. As previously identified, this process was managed centrally via the two Workforce Hubs. Skills assessments were undertaken and if any gaps were identified training would be provided to upskill staff; particularly for the purpose of working in the ITU and ED. These were areas where an increase in staff capacity was necessary to cope with the demand, and where a specialist course was developed.

55. In clinical areas like the Critical Care Unit and the ED, the redeployment of staff did have a positive impact on capacity. On 9 April 2020, the ITU reported a Critical Care trained nurse-to-patient ratio of 1:3.6 (approximately 1:4 - one Critical Care trained Nurse to four Patients) which vastly differs from the typical ratio of one ITU nurse to a patient. It is noteworthy that these ITU nurses, who sometimes found themselves caring for more than one patient, could only execute their role under these conditions with the support of nurses and clinicians redeployed from other clinical areas across the hospital.

56. Whilst all staff were risk assessed ahead of redeployment, this was not voluntary, and the overall process was not popular among staff. Lessons were quickly learned, and improvement processes put in place. For example, keeping in touch sessions were introduced to ensure staff were regularly contacted by their substantive manager. Induction processes were introduced to ensure staff felt welcome and safe when redeployed, as well as regular check-ins with the HR Business Partners. The staff risk assessments were central to these discussions.

57. Concerns had been raised that more BAME staff were being redeployed, resulting in a sense of unfairness. In response to these concerns, an analysis was undertaken in June 2020 and a report was presented to the Trust Executive Committee, and the People and Culture Committee. The review findings indicated that this was not the case. It found that there indeed

was a higher volume of BAME staff working on wards; however, this was due to the fact that a higher number of BAME were undertaking additional bank shifts on these wards during this period.

58. Redeployment had an impact on staff morale. However, measures were in place to ensure staff were risk assessed and safe; and that improved communication and support was provided to redeployed staff. Fit testing was also crucial to ensuring staff felt protected and supported in safely carrying out their roles.

59. As previously touched on, due to widespread staff shortages across the NEL and the region, there was very little redeployment to other hospitals outside of the Trust but redeployment within the Trust was undertaken. One member of our staff was redeployed to a Nightingale hospital but redeployment there was limited because staff were required at their bases, which also had challenges with staffing capacity.

Long Covid

60. The Trust currently has limitations on the medical conditions it can record on its Employee Service Records (ESR) and, at the moment, Long Covid is not one of the conditions noted in the system. However, a number of staff have reported symptoms of Long Covid, and support has been provided by Occupational Health.

61. Some members of staff had long periods of sickness absence, and there were those returning to work who reported that it took more time to return to full health. On occasion, lengthier periods of return-to-work phases were offered. However, this information was not collated in a specific way. Now that we have a better understanding of the disease, we should have ensured that staff suffering from Long Covid were centrally managed and reviewed. This is a learning for the Trust.

62. Several interventions have been offered by the Trust to support staff who may have this condition. The Trust was one of the first to set up a Long Covid clinic with the opportunity to refer staff. This was implemented by the Respiratory Medicine service. Another intervention, which was psychologically focused and used for supporting staff to help manage longer term conditions, was a referral to colleagues at the Northeast London Mental Health NHS Trust.

Staff deaths at King George Hospital

63. KGH recorded the death of two members of staff due to Covid-19. One held the role of a Radiology Support Worker and whilst he had not been at work for some time before contracting the virus, his death was still felt greatly by colleagues. A bank nurse, who also worked in the community, sadly died after working a shift at the hospital.

64. All staff deaths are devastating to colleagues but, more so, during the Covid-19 pandemic because it brought the impact of the disease uncomfortably close to home. The impact of the deaths of these members of staff was felt across the Trust. Staff were already aware and coping with the devastating impact that Covid-19 was having on those who had become infected; however, they needed to be able to express shared grief at the loss of a staff member. In one instance, this was demonstrated by an agreement for the family to provide a celebration of the individual at the hospital (within the boundaries of Covid-19 restrictions in place). In addition, the Chaplaincy was available to provide colleagues of the deceased with guidance, counselling and support. There were also wellbeing resources available to colleagues: for example, the 'Let's Talk' call/virtual call service; Psychology Support Service; and arrangements for compassionate conversations.

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

65. The VCOD programme was divisive. The process took up a considerable amount of resources and time; much of this involving the provision of information and support to staff so that they could make an informed choice on taking up the vaccination. We monitored uptake and undertook risk assessments for those who remained unvaccinated with a view to considering whether roles could be undertaken elsewhere or off site. Advising staff that they may be dismissed for not taking the vaccine was unhelpful and counterproductive during this period.

66. There were members of staff who believed the vaccine programme was important, but there was a number who had strong differing views. As a result, the Trust's Chief Executive Officer (CEO) and HR team met with members of this group to listen to their concerns. BHRUT was one of the few Trusts where a group of staff held protests/demonstrations against the VCOD policy and the Trust is grateful to its Trade Union colleagues who were extremely helpful in dealing with these incidents and liaising with staff. Additional webinars were held with all staff led by clinical leaders of all backgrounds who tried to support staff in their decision making.

This was done with the knowledge of many differing opinions circulating in social media, and in the mainstream media, regarding vaccination.

67. Before and during the VCOD period, weekly reports were provided on the uptake of the vaccination. By January 2022, the final position for the entire Trust workforce was that 93.7% of staff had taken the first dose; 89.3% had taken the second dose; and 68.4% had taken the booster dose. Although we have no way of definitively confirming why there was a significant reduction in the percentage number of staff taking the booster (3rd dose), we can certainly speculate that one reason would be the push back against the VCOD policy. Other reasons would be vaccine fatigue and vaccine hesitancy, which was becoming more prevalent at the time.

68. Assessments were continuously undertaken on the impact of VCOD. Areas of low vaccine uptake were assessed and, in common with a number of other Trusts, the uptake for the midwives was identified as a significant issue. There was low uptake in this area and discussions took place within the Clinical Commissioning Group (CCG), now Integrated care boards (ICB), with planning to mitigate against this risk. The government reversed implementation of the VCOD regulation before the Trust could fully access its possible impact on staff capacity.

69. Following guidance from NHS England, a Trust wide VCOD policy was introduced to implement governmental guidance on mandatory Covid-19 vaccination for staff. Whilst there was an uptake in vaccinations towards the end of the national VCOD deadline, the Trust accepted it would never achieve 100% compliance. The view by senior leadership at Trust level, was that VCOD impacted the morale of some staff and relations between senior leaders and some clinical teams. The concept that staff may be at risk of losing their jobs was not a proposal supported by the majority of leaders at the Trust.

70. The pandemic proved to be a very challenging period for the Trust's Workforce. However, this was mitigated in so far as we were able, by the hard work, dedication and by the 'over and above' approach our staff took during this period. The Trust was fortunate to have embarked on international recruitment for nursing staff, recruitment campaigns were mobilised, and staff capacity was managed as best as possible to ensure adequate clinical cover.

Bed Capacity at the Hospital

71. In order to address this section with a level of accuracy and completeness, I have largely relied upon input from the hospital's Head of Nursing for Theatres, Critical Care and Anaesthetics; who was present for much of the period of the pandemic.

General and Acute (G&A) bed capacity in the early stages of the pandemic:

72. When the Trust received the discharge policy of 17 March 2020, a stakeholders meeting was convened shortly after on 23 March 2020. In attendance were representatives from Havering, Redbridge, Barking and Dagenham Local authorities; the Clinical Commissioning Group (CCG); the North East London Foundation Trust (NELFT) Palliative care and BHRUT. The aim of the meeting was to decide on how to respond to and embed the policy.

73. Several discharge pathways were evaluated to enable discharges sooner into the community. Pathway 1 was for discharge home with support; Pathway 2 was for inpatient rehabilitation; and Pathway 3 was for discharge to a care home. These pathways were reviewed and redesigned with the Trust stakeholders, and it resulted in the hospital being able to move patients, who had experienced delayed discharges due to funding streams, into community settings without prejudice.

74. Daily system calls were established to discuss patients who did not meet the criteria to remain in an acute bed. The financial support that came with the discharge policy enabled the hospital to discharge patients promptly with no funding decisions having to be made in hospital. This was the main benefit to the discharge guidance which enabled patients, that were being delayed in hospital due to funding decisions, to be discharged.

75. On 17 March 2020, there were 56 available G&A beds available at KGH. At the end of the week ending 20 March 2020, following the release of the discharge policy, there were 100 available G&A beds available. At the end of the week ending 27 March 2020, there were 86 available G&A beds.

76. Prior to the release and implementation of the discharge policy. in the week commencing 24 February 2020, the Trust held an exercise called 'Perfect Week' at KGH. The exercise was also undertaken at Queen's Hospital on 9 March 2020. Perfect week exercises were conducted in response to post-winter pressures with the aim of freeing up bed capacity and working with hospital stakeholders to discharge patients back into the community. They were a regular event

to manage bed pressures. As a result of the Perfect Week exercise at KGH, the hospital had 59 empty G&A beds in the week ending Friday 28 February 2020. The paper presented to the Trust Board, ahead of implementing the 'Perfect Week' exercise, is exhibited to this statement as **MS/01 [INQ000417071]**.

ITU Bed Capacity in the early stages of the pandemic:

77. In the early days of the pandemic, the collation of data on bed occupancy and patient acuity in the ITU was imprecise. In the ITU, the earliest record of bed occupancy was on 19 March 2020. On this date there were 3 confirmed Covid-positive patients, 2 of whom required mechanical ventilation. There were 2 other patients unconfirmed as Covid-positive, 1 of whom was ventilated. The tables below show the progression of admissions and uplift in ITU beds at KGH in response to the demand of the Covid-19 pandemic. Table 1 is exhibited as **MS/15** **INQ000477352** and Table 2 as **MS/16** **INQ000477353**

First Wave	19/03/2020	23/03/2020	25/03/2020	27/03/2020	31/03/2020	02/04/2020
Total No of beds	9	11	15 (Recovery opened)	15 (Recovery closed, 7 beds on standby)	29, (Clover ITU opened)	29
Total No of patients	5	9	10	12	14	17
No of confirmed Covid +ve	3	2	2	3	3	5
No of Level 3 patients	3	9	9	11	11	14
No of empty beds	4	2	4	3	15	12

Table 1

First Wave	04/04/2020	07/04/2020	14/04/2020	30/04/2020	01/05/2020	01/06/2020
Total No of beds	29	29	29	25 (Recovery 4 beds on standby)	25	22
Total No of patients	21	24	26	18	20	10
No of confirmed Covid +ve	11	9	11	17	16	6
No of Level 3 patients	16	20	21	13	14	7
No of empty beds	8	5	3	7	5	12

Table 2

78. From table 1 above, we can see that on 19 March 2020, which was shortly after the discharge policy implemented on 17 March, there were a total of 9 Critical Care beds with 4 empty beds. By 31 March 2020, just under 2 weeks after the policy was implemented and with the hospital having converted one of its general wards (Clover) to a Critical Care ward, there were a total of 29 Critical Care beds with 15 empty beds. Rather than reducing, the numbers of patients admitted in Critical Care increased within the 2-week timescale from the implementation of the policy.

79. From the above, we can deduce that the discharge policy did not have a measurable impact on increasing Critical Care bed capacity, as it did for the G&A beds. This is because the hospital responded to the increase in demand, caused by rising Covid-19 patients, by creating additional capacity. Therefore, any Critical Care capacity created by implementing the discharge policy would be difficult to assess.

80. Prior to the discharge policy coming into place, there was a reduction in elective work at the hospital and this created some additional Critical Care bed capacity.

81. We have reviewed the newspaper article of 20 November 2020 with the headline: *King George Hospital nearing maximum 'comfortable' capacity*. The article reports that "*Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), which runs both hospitals, is "60 beds short of… target occupancy", even after opening 43 beds at King George"*. It also reports that a "*CCG spokesperson explained that "target occupancy" means the "comfortable (bed) occupancy to best enable flow through the hospital*".

82. It is notable that the article references Critical Care beds in the opening paragraph, and then G&A beds later on in the article. Therefore, it is unclear whether it seeks to report on **all** hospital beds including G&A, or just Critical Care beds. If we proceed on the presumption that this was with respect to Critical Care beds, we are unable to substantiate the information reported by the article. We note that the article reports 43 beds at KGH; however, table 3 below (**MS/17 INQ000477354** will show that in the period before and after November 2020, there were never up to that number of Critical Care beds at the hospital. On 1 November 2020, the total number of Critical Care beds at KGH was 20, with 11 empty Critical Care beds.

Second Wave	01/10/2020	01/11/2020	01/12/2020	01/01/2021	05/01/2021	06/01/2021	07/01/2021 (Jasmine ITU opened)
Total No of beds	19	20	21	24	27	27	36
Total No of patients	12	9	14	23	25	26	31
No of confirmed Covid +ve	5	7	8	23	24	25	31
No of Level 3 patients	1	4	4	14	17	20	20
No of empty beds	7	11	7	1	2	1	5

Table 3

83. The phrase 'comfortable bed occupancy' is not recognised terminology used at the Trust. The article reports a CCG spokesperson explaining this as being comfortable (bed) occupancy to best enable flow through the hospital. However, we are familiar with the term 'Effective Occupancy' and I will refer to this term in addressing the contents of the article. Effective Occupancy, from the perspective of Critical Care, is to run the service at 85% occupancy with good patient flow in line with demand. It demonstrates the ability of Critical Care to continue to provide a safe ongoing service where it can readily admit patients at the point of need and without delay.

84. During the pandemic, as the hospital saw an exponential rise in cases requiring critical care, the focus was on creating sufficient capacity to meet this demand. The Critical Care service had an identified number of beds which were expected to uplift the Northeast London Critical Care Network. The service had to maintain admitting capacity to meet the high demand. This was achieved by opening additional critical care beds in a second unit and managing patients requiring non-invasive ventilation on the respiratory ward.

85. At the peak of demand, the Critical Care service had a total of 36 beds, with the maximum occupancy recorded as 32 beds in January 2021. Whilst there were significant pressures in ensuring that there was always admitting capacity, with regards to the bed occupancy being comfortable, or being at Effective Occupancy, this was not the reality because of the extreme challenges faced in terms of high demand for ITU beds. Although more ITU beds were created

to meet demand, ITU care was being delivered in repurposed areas not designed as critical care facilities with a stretched medical and nursing workforce. The resulting situation was not one that could be termed 'comfortable' in any regard.

86. If we are to go by our description of the term Effective Occupancy, which is to run the service at 85% occupancy, then I do consider that the threshold was reached and exceeded several times including at some of the points depicted in the tables above. In April 2020, there were days when occupancy exceeded 85%, same as in January 2021. It is important to reiterate that whilst KGH maintained the ability to continue to admit patients and provide organ support to those requiring this support, the peak periods of each wave saw the service face challenges to 'comfortably' providing an ongoing service. Bed occupancy was always high, and capacity was challenged.

87. In early November 2020, the service was not in state of surge and there was sufficient admitting capacity. The hospital still had the additional beds created during wave 1 and was running two units to meet the needs of Covid-19 and non-Covid-19 patients. There was always regional support provided by the North-East London Sustainability and Transformation Plan (NEL STP); as well as Northeast London Critical Care Network. Daily meetings were set up to discuss the situation report (SitRep) in each hospital, identify where support was needed, and where this could be sourced. At the height of the pandemic the frequency of these meetings was raised to three times a day. A WhatsApp group was also created to facilitate ongoing communications and requests between sites. Support for sourcing additional equipment and consumables was provided at a national level.

88. All decisions pertaining to the increase in Critical Care capacity were made at Service and Trust level. There were obstacles and practical difficulties encountered in securing sufficient Critical Care capacity; predominantly from managing large numbers of acutely and profoundly sick critical care-requiring patients in repurposed areas not designed to function as critical care facilities. Particularly difficult to navigate in these repurposed spaces were challenges posed by the use of piped medical gases, sufficient power supply, adequate space and equipment.

89. In addressing all the difficulties faced in increasing Critical Care bed capacity, there was collaborative working across the Trust (with Queen's Hospital), with the NEL STP, and with the Critical Care Network. These were all key sources of support throughout the pandemic.

90. Additional equipment was supplied through the national supply chain with new ventilators being provided. These required rapid training of staff to enable their use. In the early stages, anaesthetic equipment was used from the operating theatres in order to provide additional ventilatory support.

91. On 11 November 2020, the Trust made the decision to temporarily suspend the hospital's overnight Paediatric service from 16 November 2020. . This was mainly due to the difficulty in providing a safe level of Paediatric medical staffing, and also to support the hospital's emergency department. This was planned in collaboration with the emergency department and Paediatric teams and approved internally by the Trust's Clinical Reference Group. Prior to the closure, there were meetings involving the Trust CEO, the CMO, the local Councilors (Redbridge Health Oversight committee) and subject to a review from London Clinical Senate of the plans. The North Thames Paediatric Network was also fully informed of all developments, especially in view of potential increased attendances at other Children's ED.

92. There were several factors which contributed to the decision to temporarily suspend the overnight service:

a. Whilst recruitment to the specialty had aways been challenging, the situation had become exacerbated by the loss of Paediatric medical staff due to pregnancy or serious underlying health issues which necessitated their shielding from the virus.
b. A large percentage of staff within the Paediatric service were absent due to illness or isolating.
c. Due to the staffing shortages across both hospital sites, the Trust needed to consolidate with a view to having an adequate number of staff to provide robust in-patient care at Queen's Hospital.
d. There was a need to provide cover for Tropical Lagoon ward at Queen's Hospital, which is a 30-bedded inpatient children's ward with a co-located children's high dependency unit.
e. Consideration was also given to the fact that the number of paediatric attendances to the Children's ED at KGH during this period was much less than the attendances to Queen's Hospital, during the day and overnight.
f. An additional factor was that there had been no children's ward at KGH since March 2020 when it had been taken over by the adult team to be used as adult Critical Care.
g. A final factor was that a large section of the Children's ED at KGH had been taken over as an adult area by necessity. Therefore, the Children's ED was in a smaller area which made facilities for children quite confined.

93. The closure enabled the hospital to redeploy staff. During the day there was a paediatric registrar at KGH but at night the paediatric team were redeployed to Queen's Hospital. There was a paediatric consultant on call who was available to come in if there was an unexpected emergency presentation to KGH. There were robust measures put in place to manage the very sick children who might be brought to KGH emergency department who had ensured all shifts had competent staff to manage emergencies 24 hours a day. This was tested by the clinical teams prior to the closure.

94. The process, with all its risks and mitigation, was scrutinized by the London Clinical Senate which was satisfied that all mitigations were appropriate. Care of children attending KGH requiring transfer was tracked on a daily basis.

95. The Trust made a commitment to reopening the department at night as soon as it was safe to do so. Subject to the on-going impact of the pandemic, the plan was to reopen by April 2021; however, it was reopened in June 2021.

96. As the numbers of patients being admitted to critical care rose, contingency plans for increasing the Critical Care capacity were implemented. Initially, the critical care bed base within the unit was uplifted by placing beds between existing bed spaces; thereby creating an additional 3 beds. The first area to surge outside of the Critical Care unit footprint was into theatre recovery; however, due to the exponential rise in admissions, it was clear this would not be sufficient. Therefore, Clover ward, which was formerly a paediatric ward, was identified as a suitable area to repurpose for critical care; providing an additional 14 to 18 beds. In addition, the respiratory wards increased capacity for non-invasive ventilation for sick Covid-19 patients who did not require other organ support or intubation.

97. In order to meet ongoing demand during the height of the second wave, a further 9 beds were created in another ward area. The ability to continue to provide an ongoing service able to admit patients at the point of need was kept under constant review. Concerns around capacity were escalated internally and to the NEL STP as they occurred.

98. All Critical Care clinicians had concerns around the ability to manage patients safely during the pandemic, and the potential of Critical Care operating beyond target capacity of 85% - up to 100% capacity. Whilst preparedness had been underway, no one could have predicted the rapidity of the increased demand, nor the volume of acutely and profoundly sick patients who

would require multi organ support. Whilst we never reached full capacity, as set out above in tables 1, 2 & 3, we did on occasion come incredibly close.

99. Although there were concerns about Critical Care capacity, this was not the sole source of concern. Clinicians were equally concerned about the potential impact to patient safety due to stretched medical and nursing workforce. A workforce which was delivering critical care outside of purpose-built critical care facilities, all while trying to ensure sufficient equipment and supplies were readily available.

100. As part of a standard practice for managing capacity issues during the pandemic, the hospital had cause to carry out non-clinical transfers to neighbouring units with the ability to receive additional patients. These non-clinical transfers were of the most stable patients who would be moved to other critical care units with the aim of creating capacity to care for patients who were less stable.

101. These transfers happened in certain situations. There were periods where there would be patients being reviewed in the ED and on the wards; if it appeared that they would require Critical Care admission which could then result in a breach in capacity, plans would be put in place to transfer the more stable patients with a view to allowing for pending admissions. Additionally, during discussions at the network surge meetings, there would be occasions when KGH would be identified as being under pressure even though it had some remaining capacity. It would then be determined that the hospital would benefit from mutual aid from a unit that had the ability to support.

102. The hospital is part of Northeast London Critical Care Network. Going by transfer data from April 2020:

    a. 126 patients from KGH were transferred out of hospital; of which 114 were transfers to other NEL hospitals.
    b. 15 patients were transferred to KGH Critical Care from a different hospital during the relevant period; 11 were transfers from NEL hospitals.

103. For the duration of the pandemic, Critical Care experienced significant challenges due to factors including care delivery in clinical areas which were not designed for critical care; the loss of good visibility or 'line of sight'; a significant reduction in staff to patient ratio; and the size of the Critical Care unit. There were particular challenges faced in working in the repurposed areas which were not optimal for infection prevention and control practices.

104. There was no way to predict the demand for additional organ support required due to Covid-19 and the high demand for respiratory support, characterised by high oxygen requirements. Patients required cardiac and renal support for prolonged periods, as well as sedation and paralysis at the most acute stages of the illness. This resulted in the use of consumables on a massive scale, which in turn resulted in shortages.

105. During the first wave, as with many other hospitals across the country, anaesthetic machines were utilised in the critical care units. Their use was supported by Operating Department Practitioners (ODP) due to the lack of familiarity of using these machines by staff in Critical Care. Additional ventilators and Non-Invasive Ventilation (NIV) machines were provided centrally through the National Equipment Allocation Panel and training was made available to staff unfamiliar with the new equipment.

106. Additional oxygen supply was obtained using cylinders and by utilising condensers to give additional ports for connecting equipment in the Critical Care areas outside the original unit.

107. Renal replacement therapy was extremely challenging due to the high number of patients requiring this treatment. There were ongoing issues with the availability of the machines, consumables and filter fluids. A twice weekly sitrep on dialysis fluid stock holding, consumables including filter sets, and effluent bags was made to NHS London Procurement Partnership.

108. To manage the demand for renal therapy, there was a prioritisation of treatments and intermittent filtration, which was in line with guidance provided by NHSE/I in their letter of 17 April 2020. At Queen's Hospital, renal therapy points were installed in the General High Dependency Unit and with the support of the Renal dialysis team, staff were trained in hemodiafiltration. Patients from KGH requiring ongoing renal support were then transferred at a clinically-appropriate times to receive haemodialysis and relieve the burden on Continuous Veno-Venous Hemofiltration (CVVH) resources at KGH.

109. The clinical engineering team played a key role in providing infusion pumps and feeding pumps obtained from their stores and other areas of the hospital not requiring them. They were also on hand to meet repair and servicing needs.

110. The critical care pharmacy team maintained drug stock levels by closely monitoring the usage and availability of drugs. When there was a likelihood of a drug shortage, alternative treatments were explored and sourced within the guidelines on prescribing, administration, and monitoring. The critical care pharmacy team worked with regional procurement partners to

ensure the hospital needs were met and the medicines supply chain was maintained. National policies and directives related to medicines supply were also adhered to.

111. Stock levels were constantly uplifted in preparation for increased usage, and close collaboration with the Trust's procurement team supported ongoing monitoring. Twice weekly stock counts were submitted centrally as per NHSE/I's request. Redeployed staff who were unable to deliver direct clinical care were tasked with monitoring the stock levels and ensuring timely re-ordering, working closely with the supply and procurement teams. Where we identified shortfalls, which needed to be resolved quicker than could be addressed through daily deliveries, they would be sourced from QH or other units in the NEL critical care network.

112. With the supply of most of our stock coming from the NHS Supply Chain, and with some specialist stock and consumables being ordered by the procurement team, the issue of shortage of stock and consumables was raised by the Procurement team daily in conference calls to the highest levels in London and NHS England. It is important to note that every NHS Trust on these calls was reporting back with the same issues, and manufacturers tried their best to keep up with demand.

113. I have relied upon the input of the Trust's Deputy Chief Operating Officer for Elective care during the pandemic, to address the use of the private healthcare sector to deliver care to Trust patients. The information here is not specific to KGH but also to Queen's Hospital; this is because any arrangement made pertained to the Trust as a whole.

114. The Trust used private sector 'insourcing' providers to provide additional staff to support our elective recovery. There was an NHSE-funded arrangement with Medinet, engaged to provide surgery teams (Anaesthetists, Scrub Nurses, ODPs) and full endoscopy teams. The provider also supplied Consultants for Ophthalmology outpatient clinics. All of this was conducted under the NHSE-funded inner London contract framework from January to March 2021. The Trust made use of other insourcing providers during our Covid recovery; these were through local contracts.

115. In the immediate response to the first Covid-19 wave in March 2020, the Trust sought to segregate its treatment of Covid-19 and non-Covid conditions by transferring its non-elective treatment to the private sector. For the treatment of trauma patients, we relied upon Independent Sector Treatment Centres (ISTCs).

116. Throughout the three Covid-19 waves, the Trust made use of the private sector to undertake diagnostics; principally for cancer patients. Our records indicate that we began using independent sector hospitals during wave 1, from April 2020, to diagnose and treat our cancer patients. By July 2020, this included a range of diagnosis and treatment at a number of private healthcare providers.

117. The Trust also made use of the private sector to provide outpatient appointments and treatments (e.g. infusions) for non-cancer patients. In the period from April to July 2020, we relied upon a number of private healthcare providers to treat these patients. Arrangements were in place as part of the use of the private sector for elective surgery, and care was provided by a number of private healthcare providers.

118. As part of the Trust's plan in response to the phase 3 letter from Simon Stevens on 31 July 2020, we continued to make use of the independent sector provision. The Trust established regular theatre sessions at our local providers to undertake surgery for cancer and non-cancer patients. From this point through to early 2021, our use of private healthcare was largely confined to a few providers; with a small number of paediatric, neurosurgery and colorectal cases taking place at another few providers.

Guidance on Infection Prevention and Control (IPC)

119. The Trust's IPC team was involved in every facet of delivering care across the Trust hospitals. This was crucial due to the nature of the presenting situation where the hospital was dealing with a virulent virus and no precedent to rely on. The IPC had the critical task of reviewing frequent guidance, interpreting them, ensuring the modification of guidance to fit a clinical area where necessary, and involving all stakeholders to ensure implementation. All of these were done at pace.

120. The Trust followed all national guidance on IPC as they were issued. At the onset of the pandemic in February 2020 guidance was issued by Public Health England on the 'Management of a suspected case of 2019-nCoV acute respiratory disease'. In March 2020, there was more detailed official guidance jointly issued by DHSC, PHE and a host of other health agencies; this was 'Guidance for infection prevention and control in healthcare settings - Adapted from Pandemic Influenza: Guidance for Infection prevention and control in healthcare settings 2020' The Trust adopted this and also implemented the Pan London

Guidance on the principles of infection prevention and control which was published in May 2020 and approved through the London Clinical Advisory Group (CAG).

121. In May 2020, NHSE/I issued an Infection Prevention and Control Board Assurance Framework (IPC BAF) for acute Trusts to use in assessing themselves with regards to best practice. Also, for Trusts to use as a tool to monitor actions required to ensure continuous improvement. The Trust reviewed all 10 Sections of the IPC BAF with its 63 key lines of Inquiry, and completed a self-assessment which was reported through to the Trust Board on 27 May 2020. The Trust's self-assessment for the Infection Prevention and Control Board Assurance Framework is exhibited as **MS/02 [INQ000417072]**.

Disseminating and Implementing IPC Guidance

122. All IPC guidance was discussed at a daily Silver Command meeting. These daily meetings were attended by representatives from each Division, including service leads in Operations, Nursing, Medicine, Allied Health Professionals (AHPs) and Scientific services. During the peaks of each wave, a 'Tactical' battle rhythm was the approach as it ensured greater coordination of events and improved communication channels. Escalations were made to Gold Command where required.

123. Following the discussion of the IPC guidance at the daily Silver Command meeting, with instructions to the attendees to commence dissemination to staff, a central cascade was sent via email from Silver Command with information and instructions for implementation across the Trust. A daily update was then disseminated to all staff via email and made available on the Trust intranet. Exhibited, as **MS/03 [INQ000417073] and MS/04 [INQ000417074]**, are some of the daily updates made to all Trust staff. There was a dedicated Covid-19 area on the home page of the Trust intranet for access to all communications and the latest guidance on all aspects of care provision touching on the pandemic.

124. Other means of disseminating IPC guidance was face to face on the wards, and by department-based training sessions delivered by the IPC team to support the implementation of specific guidance. For example, in relation to PPE donning and doffing, and with fit testing for FFP3 masks. The IPC team also developed PPE donning and doffing videos for staff training; these could be accessed via the Trust intranet.

125. The frequency of the issue of new guidance was difficult to keep up with, in addition to the constant updates to guidance. A major factor as to why the Trust did not develop its own internal policies or IPC guidance documents was due to the risk of them becoming out of date and requiring frequent updates. The IPC team provided clarity on the issued or revised guidance; ensured areas had the most up to date information available to them; and provided daily support to staff in implementing guidance.

126. As new updates and guidance were received, they were reviewed and discussed at the daily Silver Command meetings. Links to the guidance would then be published on the Trust intranet, cascaded via the communication team and via email from Silver Command. Guidance in the form of flow charts and decision tools were printed and distributed, by the IPC team, to the key clinical areas.

127. The main challenges encountered were in the ability to promptly respond to, and implement IPC guidance, with little notice. For example, a QR code for Track and Trace check was sent to the Trust on Friday 18 September 2020, for launch on 24 September 2020. These codes were put in place for scanning on to the NHS app for the purpose of tracking and tracing individuals who may have been in close proximity with someone who tested positive; these individuals would then be required to isolate under the governmental guidelines in place at the time. The short timescale in the receipt of the QR code meant that the trust had only 3 working days to prepare for implementation. Managing these tight timescales, by an already stretched workforce, was very challenging.

128. There were also challenges encountered in disseminating IPC guidance on Lateral Flow Device (LFD) testing. A standard operating procedure (SOP) for LFD testing for emergency department patient pathways was issued on the afternoon of Thursday 24 December 2020, in advance of a 4-day bank holiday weekend. Implementation was delayed because processes had to be put in place to ensure patients were managed on the correct pathway. Specifically, to ensure symptomatic patients with a negative LFD test were isolated until more sensitive and accurate PCR results were received. A system also had to be established to ensure the recording and documentation of the LFD test. To address these matters, the Trust disseminated information to staff through the usual processes including via internal communications, the intranet, emails from Silver Command to senior hospital leads for dissemination to staff, bed meetings and other command meetings. Throughout the pandemic,

the Trust's Infection Prevention and Control Group continued to meet virtually for the review of any guidance changes and discussions on implementation.

129. The guidance was straightforward but their practical roll out was often complex, time-consuming and required implementation at a fast pace. Implementing guidance at such short notice was incredibly challenging, but even more so on a bank holiday weekend over the Christmas period with a workforce already facing staff shortages as a result of the pandemic. Whilst it is acknowledged that guidance did need to be updated and implemented swiftly, it would have been more achievable to successfully roll out with more notice and consideration given to reduced staffing. With a swiftly changing workforce due to isolation, sickness, redeployment and shift patterns, it was difficult for staff to remain up to date.

130. At the onset of the pandemic, the logistics of screening patients coming into the hospital with symptoms, or those who met the criteria for testing, was incredibly challenging. A public information poster had been published advising on actions to take if a person had travelled from China in the prior 14 days, and had symptoms; the advice was to call 111. At the time, there was no testing in a community setting and people were sent to hospital for testing. It was difficult to keep these patients separate from others, implement testing areas, and manage Covid-positive patients. This procedure had to be implemented at pace, but it required planning and changes to the environment to enable it to happen including the need to establish testing pods outside the emergency department for those needing testing.

131. Another major challenge faced in implementing IPC guidance was the process of fit testing staff for the use of respiratory protective equipment. There were a limited number of staff trained to undertake fit testing within the organization and, initially, this resulted in an increased demand on the hospital's IPC resource to carry out fit tests. Testing was initially delivered to areas based on the risk. These were high risk areas such as critical care unit, respiratory wards and the emergency department. The situation evolved rapidly, and fit testing was required across all clinical areas; therefore, additional staff were trained to carry out fit tests.

132. One of the more critical challenges to the implementation of IPC guidance was the shortage of PPE equipment including FFP3 masks, gowns, visors, scrubs and body bags for the mortuary. These were all in short supply. To address the issue of shortages, the IPC team worked closely with the Trust`s Procurement team to ensure that each area had sufficient stock levels according to need and usage. Issues with supply were escalated internally via the Silver

and Gold command structure; then on to the regional and national levels due to the high risk associated with short supply of these necessary materials.

133. Another early constraint to implementing IPC guidance was the availability of side rooms for isolation. There was a limited number of side rooms and negative pressure isolation rooms on the KGH site with 6 bedded bays without doors. This was resolved through the implementation of Covid-19 and non-Covid-19 pathways which allowed wards to be allocated for patients with or without Covid-19 symptoms. Ultimately, the cohorting of Covid positive patients had to be done at a ward level due to the estate constraints.

134. Implementing the guidance on visiting policy was also incredibly challenging on a practical and also on a moral level, because of the impact that visiting restrictions had on our patients and loved ones. In line with the national visiting guidance issued throughout the pandemic, where visitors were permitted to visit, we had to ensure they had the correct PPE and information to protect them from exposure to Covid-19. There were instances where family members, who had travelled from high-risk countries and should have been isolating, would instead attend the hospital to visit loved ones. This was very difficult to manage because government guidance was clear in the expectation that they should be isolating due to the risk of being infected. We also had instances where patients, who did not have Covid-19, were dying and wanted to be with a family member. Prior to the lock-down, in these instances we made use of an 'off the ward' room (Dennis's Den) where we could move patients as this allowed a family member to be with the patient while not risking exposure to other patients. In the early days we had many occasions where family members arrived at the hospital to be with their dying relatives, and we had to turn them away; this was incredibly difficult for staff.

135. The Trust developed the dedicated elective non-Covid surgical hub with a dedicated non-Covid inpatient ward and clinical areas including a non-Covid critical care unit. The Emergency department also had separate pathways. The decision to continue elective care provision at KGH was taken because of the hospital layout. KGH was more easily segregated into Covid and non-Covid areas than Queen Hospital would have been. The hospital was colour-zoned based on the following admission pathways:

    a. Green for low-risk cases: which were non- Covid patients for elective procedure.
    b. Yellow for medium risk cases: these were patients presenting to the ED, who would then be tested before being designated as Covid or non-Covid after which they would be admitted either in the green or blue zone.

c. Blue for high-risk cases: these were patients admitted with Covid-19 symptoms or confirmed by testing.

136. It was initially difficult to cohort or group patients in bays because there were no doors to separate them from the adjoining areas. However, the design and layout of the estate at the hospital enabled good segregation of Covid and non-Covid pathways (high, medium and low risk). The hospital sectioned off and locked down areas with separate entrances and exits accessible for patients and staff; as well as for visitors when visiting.

137. Due to the zoning of the hospital and restriction of patients in zones according to their Covid status, staff movement from Covid to non-Covid areas was also restricted. Therefore, staff members who worked in the green zone could not work in other zones; similarly, staff from the blue and yellow zones could not work in the green zone. The new layout, to safely manage patient pathways, impacted on staffing numbers because it required a change in the staffing cohort. This caused some issues, not only with the staffing levels, but also with the rest areas and shared offices which also needed to be designated as covid or non- Covid.

138. There were 45 side rooms across all specialty wards which were utilised for isolation. When there was an increase in the prevalence of the virus, and side rooms were full, the wards were then designated as Covid or non-Covid; this was when an entire ward would be utilised to treat patients presenting with symptoms or with suspected or confirmed Covid-19. Patients were risk-assessed for side room use within this situation if they had another known infection that we would need to control its transmission; or did not have confirmed covid-19, but were suspected to have covid-19 based on their symptoms. This was to try to reduce the transmission risk if they did not have Covid-19.

139. The hospital relies on natural and mechanical ventilation within all wards. The majority of the estate depends upon natural ventilation. Mechanical ventilation was managed through the ventilation system in the building which provides both the supply and the extraction of air. There are also negative pressure isolation rooms in some of the wards. A negative pressure isolation room is used for the isolation of high-risk infectious patients. The air pressure inside the room is lower than the air pressure outside the room; this means that when the door is opened, potentially contaminated air or other dangerous pathogens from inside the room will not flow outside into non-contaminated areas. Ward ventilation was reviewed as part of the infection control process by the estates team.

Testing as an IPC measure

140. Asymptomatic staff testing commenced on 11 November 2020, initially for staff working within cancer services and with full implementation the week commencing 16 November 2020. Asymptomatic patient testing (PCR) commenced for non-elective admissions from 27 April 2020.

141. Symptomatic patient testing commenced in February 2020, in line with national guidelines. All guidance was followed as issued in relation to testing with and without travel history.

142. Lack of diagnostic testing capacity was commonplace in 2020. In May 2020 the hospital reported a risk, on the Trust's Risk Register, of a lack of capacity for required SARS-CoV-2 testing. The impact of this risk was listed as "*difficulties in admitting, discharging, moving patients, and an increase in infection levels*". The Trust's Pathology services registered another risk associated with the reliability and adequacy of the supply of reagents.

143. In response, the Trust sourced additional molecular platforms in agreement with the NEL Testing Lead and NHSE/I. However, there were significant delays in delivery dates and supplier commitment. As a result, the Trust was not able to mitigate in-house testing internally to meet demand. This resulted in having to rely on external laboratories and the procurement of multiple platforms from a range of suppliers.

144. Although this cannot be quantified, the lack of rapid Covid-19 testing to identify Covid positive patients within the first 24 hours of admission would have had consequences. A review found that testing turnaround times, were up to 72 hours and more depending upon demand; this was because the testing was being carried out off site. A hospital risk highlighted an impact from the lack of capacity for testing as follows: "*the trust needs to test approximately 400 tests per day but can only get reagents and supplies for around 150*".

145. Prior to the implementation of asymptomatic testing, there was no prioritisation for testing other than for symptomatic patients and keyworkers. Staff and patient testing were carried out in accordance with national guidance, and we were compliant with national guidance.

146. For the duration of the pandemic, all testing was done in line with national and Pan London guidance. The hospital policy on testing did not differ from the guidance. The Trust adhered to updates in guidance whenever this happened throughout the pandemic period, until the current testing guidance issued in August 2023.

147. With respect to asymptomatic testing, from November 2020 LFD tests were available for asymptomatic staff to test themselves at home twice a week with results available before coming into work. For patients, those admitted via the emergency department were to be tested on admission, then a single retest was to be performed at days 3, 5 and 7 post-admission. Elective patient testing was to be undertaken within 72 hours of a planned admission and, after admission, tests to be undertaken at days 3, 5 and 7 post-admission.

Nosocomial infections

148. The hospital did experience nosocomial outbreaks. In the period of 2020 to 2021, outbreaks of Covid-19 were managed in line with national guidance created by the NHS England and NHS Improvement (NHSEI) – '*Reporting and responding to hospital onset Covid-19 cases'*. All outbreaks were reported to Public Health England by the IPC team, and regular outbreak meetings were put in place. Measures were taken in the Trust to minimise the risk of transmission of Covid-19.

149. Following a rise in hospital onset probable and definite cases of Covid-19 during October and November 2020, the Trust sought external advice and support from PHE and NHS England and Improvement (NHSE/I) to identify anything that could be contributing to nosocomial transmission that had not already been identified. In November 2020, an IPC Safety Support team review was undertaken of both hospital sites by a team of subject matter experts from NHSE/I, as well as the Clinical Support Unit and Clinical Commissioning Group. A further review was undertaken in December 2020 due to escalating community Covid-19 prevalence and the increasing number of admissions as a result. A key finding of the review highlighted a lack of rapid Covid-19 testing in place for the Trust to identify Covid-19 positive patients within the first 24 hours of admission; this was because testing turnaround times at the time were up to 72 hours depending upon demand, due to testing being off site. Post-pandemic, the Trust undertook a looking back exercise in relation to nosocomial outbreaks from a learning perspective.

150. In the period of 2021 to 2022, all outbreaks of Covid-19 and cases of nosocomial infections were managed in line with national guidance. All outbreaks were reported to the UK Health Security Agency (UKHSA) by the Trust's IPC Team, and regular outbreak meetings were held to monitor the situation. All sporadic cases were managed through bed and bay closures, utilising the Pan London decision making tool for managing Covid-19.

The Procurement of PPE

151. The hospital took practical steps, which were crucial to our ability to obtain and maintain a sufficient quantity of PPE, to protect our healthcare workers and provide safe care to our patients.

152. We constantly conducted thorough inventory checks to determine the quantity of PPE in stock against the estimated required quantity. We researched and identified reliable suppliers of PPE. This involved ensuring the quality of their products, based on the current Infection Control Guidance at the time, and their ability to meet our demand. Orders were placed using Regulation 32 of The Public Contracts Regulation (PCR) 15 which allowed us to go directly to suppliers in extreme emergency requirements such as during a pandemic. We negotiated prices, delivery timelines, and ensured that the products complied with the requisite standards in place at the time.

153. We closely monitored the delivery of the ordered PPE to ensure it arrived within the expected timescale. We inspected the quality of the received items to ensure they met the required standards based on guidance and, when they failed to meet the required standard, they were quarantined. Delivery timelines consisted of quick turnaround times for small quantities, but larger orders had a longer lead time varying from 5 days to 2 weeks depending on product and availability. In some instances, for a quicker turnaround, collection from the suppliers was required and carried out.

154. We reached out to our community and local businesses for donations of PPE. This included organising donation drives and establishing partnerships with organisations willing to support our hospital. Support was mainly seen from schools that provided us with goggles, as well as charities and local businesses that donated non-surgical gowns and scrubs.

155. We collaborated with other organisations in the region to share information, resources, and strategies for obtaining and managing PPE. This helped us to collectively address any shortages and ensure a more equitable distribution of PPE. This was particularly impactful across the North East London network.

156. The Trust hired a warehouse to enable storage of all PPE and we supported other Trusts within the North East London with facilities to safely store PPE.

157. The steps we took did not change significantly during the relevant period; however, reduction and reliance on suppliers changed due to the introduction of the NHSE Central Hub for push stock. The NHSE Central Hub provided additional support to gain PPE but, up until June 2021, its impact was limited as items such as face masks were not available in the quantities required from the Central hubs; the Trust continued to use suppliers. Post-June 2021, PPE was available in the quantities required and therefore purchases directly with suppliers was minimized.

158. In terms of quality, we experienced similar issues to purchasing directly from suppliers whereby you would find that a small percentage (less than 1%) may have defects or arrive in damaged boxes; however, this is a normal occurrence which happens with direct suppliers under normal conditions. In relation to delivery timelines from NHSE/ Central Hub push stock, this could be around 2 days depending on stock availability. We had particular challenges in receiving FFP3 masks which had significant delays from the central hub and from direct suppliers.

159. PPE procurement was one of the most challenging aspects faced by healthcare providers during the pandemic, particularly in the early days. In those early days, a shortage of PPE quickly presented itself and we went to great lengths to ensure there was provision for the continued protection of patients and staff. There were a lot of innovative practices we engaged in to ensure a supply of PPE; some successful and some not so much. An example of a successful innovation, at a time when we were running low, was in the creation of laminated face visors by colleagues in the Trust's Finance and Improvement teams who were working from home during the first lockdown. They created these visors with simple materials like elastic, laminate sheets and acetate – and they were utilized by staff in the ITU.

160. There were other attempts to create substitutes: for example, attempts were made to replicate the solution for fit testing when stock ran out; a member of staff attempted making a mask out of a snorkel – but it was not used as its proposed usage was not approved by the IPC team, the Trust CMO, and Health and Safety. There was a proposal to wash and re-use gowns. None of these were signed off by the Trust's IPC team.

161. The Trust used the Emergency Request System to request PPE and RPE on two occasions. The first time was in order to obtain Fit Test Solution in June 2021 and this was effective; the second time was to obtain FFP3 masks in July 2021. We found this to be not so effective as we only received 50% of the quantity required and some had to be quarantined.

162. Whenever a decision was made to quarantine any item(s) this would have been because they did not meet standards based on the guidance at the time. This could have been related to IPC guidance, supplier defects or product re-calls directly from suppliers, or via the NHSE Central Hub.

163. We had to quarantine the following items received via the NHSE Central Hub.
    a. Honeywell FFP3 items, in November 2021
    b. Bluetree IIR Face Masks, in October 2021. This presented problems due the vast quantity they quarantined which was around 90% of our stock holding.
    c. Hunan IIR Face Masks (Easy Mask), in June 2022. Similar to above, but this was around 50% of held stock.
    d. Drager FFP3 (X-plore), in July 2021
    e. PFF Healthcare Aprons, in June 2021

164. The delivery of unsuitable PPE and RPE was significantly problematic and resulted in recalling much-needed stock from the hospital. When this happened, urgent communications were sent out Trust-wide to all staff and a notification sent to the relevant departments to ensure all substandard stock was returned. Logistics staff had a section in the main storage facility for holding quarantined items with clear notices on location boards that they were not to be used. Quarantined items were collected from the hospitals and taken to the storage location. All stock was kept at the warehouse site even though this should have been collected regionally which resulted in the Trust having to dispose of stock.

PPE Fit testing

165. The Trust policy was to ensure that only those staff who passed a fit test, and had access to the appropriate face mask, would be able to undertake any "high risk" procedures. The Trust initially provided fit testing with trained fit testers using the Qualitative fit test methodology. This involves using a substance with a bittersweet taste which, if when the mask is worn correctly and affords appropriate fit and therefore protection, the person being tested cannot taste the substance. This test cannot be used with powered respirators and so staff could not be tested on this.

166. In May 2020, the Trust's Health and Safety Steering Group (HSSG) was approached to support the IPC team to deliver Fit Testing for Respiratory Protective Equipment. Health and Safety

was provided with a summary of the number of fit tests undertaken in recent weeks. The summary showed that only a small number of staff were able to undergo fit testing each week; this was because the fit testing was being carried out by the IPC team which did not have adequate resources to complete more numbers. Also, there was a large percentage of staff who did not pass, meaning that they would not be fully protected when using a mask. As a result, funding approval was given to enable Quantitative Fit Testing which would also enable fit testing on powered respirators.

167. In the meantime, NHSE arranged for PHE to provide fit testing and this resource was taken up by the Trust. The Trust also procured a Quantitative fit testing kit and subsequently deployed this to increase fit testing ability across its hospitals.

168. A further update to the HSSG was provided on Fit Testing on 22 July 2020 with a detailed summary of fit tests carried out. This reported that of 394 staff who had undergone fit tests, the overall "Pass" rate had been 65%. 35% of the staff who had been fit-tested could not achieve a suitable face fit and required a different solution to protect them whilst at work; or were advised not to work in high-risk areas.

169. An external company started providing the Fit Testing service in mid-2020 with more successful outcomes.

The impact of PPE and RPE shortages

170. On the whole, the Trust's Procurement team, with hard work and dedication, did a remarkable job of maintaining stock levels of entry level PPE. There was some challenge, prior to stock arrival, with some specialist equipment, like the FFP3 mask; however, the Trust never completely ran out of PPE, although there were certainly occasions when it came close. We were always able to manage what we had until supply was replenished.

171. Staff who failed fit testing certainly would have experienced anxiety. For these members of staff, other protective measures were explored and provided including respiratory hoods, half masks with filters attached to them, etc. Where staff failed fit testing, it was recognized that their safety would be compromised without adequate protection and consideration was given to where they could work safely; this often resulted in their redeployment to working in non-Covid areas, in line with the advice from the Trust's IPC team.

172. We recognise that staff were extremely anxious about the level of protection being provided throughout the pandemic and particularly in the early phases. We were asking staff to work in an environment of a novel virus with international reports of its virulence and with a lack of virus specific treatment in the first phases. At all times we followed national guidance and providing support was very challenging for the IPC team and clinical leadership in the Trust.

Hospital visits during the pandemic

173. Following the issuing of the NHSE Visiting Guidance dated 16 March 2020, BHRUT created its own local guidelines which aligned with national guidance. This was implemented in the hospital and Trust on 26 March 2020. A rota of staff was created to work with the hospital security team and the wards, to ensure that each named visitor was identified and signed in and out at each visit.

174. The updated visiting policy was provided to the public via the Trust website and also within notices placed outside the hospital premises. Below is the policy that was issued on the Trust website:

Visitor restrictions

Visiting at both Queen's and King George hospitals is suspended until further notice, to help us protect our patients and staff.

The exceptional circumstances where one visitor – an immediate family member or carer – will be permitted, are listed below:

- *You are the birthing partner accompanying a woman in labour*
- *You are a parent or appropriate adult visiting your child*
- *You are supporting someone with a mental health issue such as dementia, a learning disability or autism.*

Two visitors – immediate family members and/or carers – will be permitted, is listed below:

- *The patient you wish to visit is receiving end-of-life care*

Our ward managers will ensure all patients have a named relative and allocate a time for people to call to keep in touch on a daily basis. Please remember not to come to our hospital if you have a cough, cold, flu-like symptoms or any infectious illness like diarrhoea and vomiting.

We appreciate how important it is to be able to stay in touch with your relatives, so we've launched our 'Thinking of you' service, so that you can send them a letter and some photos. We will continue to monitor the situation.

Exhibited as **MS/05 [INQ000417075]** is a printout of the webpage for family and friends to send a '*Thinking of You*' message to loved ones in hospital.

175. From April 2020, the hospital applied some discretion in relation to visiting; mainly for those patients with learning disabilities, mental health issues, and those receiving end of life care. In March 2020, the directive from the Medical Director was that if wards had an end-of-life patient, they were allowed more than one visitor, and this was disseminated across the wards by May 2020. The Trust increased the number of visitors for babies in the neonatal Intensive Care Unit (NICU), permitted visitors for mental health patients and those receiving end of life care visitors increased to 2 persons. In August 2020, visitors were allowed to visit patients on the stroke unit. The end-of-life care visiting policy was reviewed in September 2020 and allowed for a change from "last days of life" to "last week of life".

176. Given the visiting restrictions in place, we understood that ensuring communication between patients and their loved ones was imperative. The hospital received a number of iPads donated by patients' families and businesses, these were uploaded with Skype software to enable video calls and each ward arranged a time with families to video call their loved ones. The wards set up a system of daily calls to relatives to provide updates on patients. 'Thinking of You' letters were also initiated for relatives to write messages and include photographs for their loved ones.

177. The Visiting Policy allowed visits from persons supporting patients with a mental health issue such as dementia, a learning disability or autism. We relied on online interpreters to facilitate communication with patients with limited English.

178. The Trust's Visitors Policy was revised to reflect national guidance. The national guidance of March 2020 was first 'reviewed' or 'modified' in May 2020, with the permitting of visits for mental health patients, and allowing 2 visitors for NICU babies. In November 2020, there was formal revision of the Trust's Visitors policy.

The effect of visiting restrictions

179. Although restricting visiting was met with both disappointment and frustration (as well as distress for some) from patients' friends and relatives, enforcing it was necessary at a time of uncertainty and anxiety. The national guidance was workable once the information had been disseminated to all teams/areas via the hospital's Silver Command. Social media and the internet were utilised by the Communications Team to share this information with members of the public.

180. To provide a factual perspective of the effect of visiting restrictions, I have drawn upon the input and personal experience of the hospital's Lead Chaplain, who was one of the key members of staff working within the patient-facing roles during the critical periods of the pandemic. With his permission I am exhibiting his personal reflection, in July 2020, as **MS/06 [INQ000417076]**.

181. The Trust Chaplaincy played a significant role at the hospital during the pandemic. The team members became the link between the hospital and the families of patients in hospital. They relied on the use of mobile phones and iPads to facilitate meetings where families could say goodbye to their loved ones. They also sat with staff members when they were breaking bad news to families, as this was not an action most staff were experienced in at such a frequent rate.

182. The Chaplaincy team has always provided pastoral care and not just religious care but support to our patients, their families and our staff. However, very early on in the pandemic, the team knew they had to be on the ward providing hands-on assistance to patients and staff members alike. End of life care and staff support became the focus of the work of the Chaplaincy.

183. Our lead chaplain considers that the policy to restrict visitors might have saved lives because less people were exposed to Covid-19 patients in hospital; however, he is emphatic that the visiting restrictions had a negative impact on patient experience, as well as the experiences of their loved ones. When the team spoke with families after the death of a loved one, it was clear that they required support and that they had lasting guilt for not being present for their loved ones in their final moments.

184. As part of their daily duties, the team would obtain the list of deceased patients on the day after their death. They would then telephone family members to inform them of the mortuary

location of their loved ones. It was usually during the course of these conversations that family members would express immense guilt for not being there with their loved one when they passed on. They wanted to be on the ward, holding the hands of their loved ones and providing some measure of comfort.

185. With respect to staff support, the Chaplaincy carried out training on the ward, went to handovers in the morning with the Trust CEO and Chief Nurse, and supported staff as they did their job. The Chaplaincy had a task with getting staff to understand that they had to do things differently in relation to their emotional wellbeing. This was a novel situation where staff rarely had the chance to leave work-related trauma behind after a day's job, as many could not go home but had to stay in hotels to protect their family. This isolated staff from loved ones at an anxious and frightening time. The lead Chaplain recalls an occasion when, in passing a senior staff member from the Emergency Department, he asked how they were and they burst into tears.

186. Ensuring the availability of adequate staff support was essential and the Trust did its best to focus on staff wellbeing, particularly after the first wave with the benefit of the learning from it. The Chaplaincy had trained volunteers who would ring up staff members to offer support, and staff would visit the team for counselling. Group sessions were held on the wards and the team ensured support was available from the CEO down to the hospital porters.

187. The lead Chaplain states that a review of data collated by the Chaplaincy puts things in perspective with respect to the post-pandemic increase in the level of staff support provided by the team. He reports that in 2019 it was recorded that 750 members of staff required support sessions for reasons including work-related trauma. However, from the first year of the pandemic the number was over 3000 contacts, and this remains the same after the pandemic. The review has found that the number of staff requiring Chaplaincy support is almost as high as the number of patients and relatives who require support from the team.

188. For an objective overview, we have also undertaken a review of a number of complaints and concerns received during the period from March 2020 to March 2021. We found that between March 2020 to March 2021 KGH received 18 formal complaints with concerns relating to visiting restrictions. There were 5 Patient Advice & Liaison Service (PALS) records relating to visiting restrictions during the same period.

189. The Visitor's Policy was regularly reviewed to ensure that it met national guidelines, whilst cases were considered on an individual basis. It will be important to evaluate the impact of

national guidance at a national level for future guidance. However, there can be no doubt that the severe visiting restrictions caused distress for patients and their families with a loss of trust in staff caring for patients in some instances as families could not be 'on hand' when a family member was extremely ill. There was also increased pressure on medical and nursing staff as additional communication with families took significant time although teams tried to ensure this was in a planned manner.

190. However, the need for strict infection control precautions, social distancing and isolation of patients meant that visiting restriction was necessary, at least in the first wave before testing was more widely available. We quicky learnt how to provide support and some comfort to patients and their families with the introduction of virtual calls and letter communications, which did make a difference.

The treatment of non- Covid conditions

191. In the first wave of the pandemic all elective procedures at the hospital were suspended. Urgent treatment and procedures were moved into the private sector often supported by our own staff where possible. This was a Trust decision and in line with national policy. There was a rapid move to virtual clinics where possible. In line with national guidance for diagnostics and with the loss of endoscopy capacity in particular, changes were made to diagnostic pathways with increased use of imaging in line with national guidance. Clinicians worked with national guidance to revise treatment plans for patients, for example with cancer. There was also a requirement to inform patients who were immunosuppressed and at high risk of the need to shield and take additional precautions. This was initially very challenging as specialties did not hold registries of patients in high-risk groups and it required manual review of clinical records.

192. As the pandemic progressed, the hospital was divided into two zones. One zone/area was converted into an elective surgical hub which was a self-contained area with its own Critical Care, theatres, wards, pre-op assessment areas. This area was designated to admit elective patients who had completed home Covid tests and had been isolating before being admitted into the hospital for their elective surgery.

193. The other zone/area was designated for non-elective cases. It also had its own Critical Care and wards including Respiratory, Care of the Elderly (COE) or Geriatric Medicine, and other medical wards. This zone received urgent and emergency acute surgical cases including acute

urology, acute abdomen, colorectal surgery such as GI bleeds; essentially, conditions which were non-elective. These urgent surgical patients would then be stabilized and once the beds were available, they would be transferred to a surgical assessment unit or directly to the theatres at Queen's Hospital.

Cardiology Services

194. For Cardiology, the procedure lists for the Cardiac catheter laboratories (for the implant of pacemakers and for undertaking coronary angiograms) were suspended on 25 March 2020. Follow up Pacemaker appointments were deferred but some of the more urgent patients, including those requiring closer monitoring, had their appointments retained. The service was restarted on 21 April 2020 with a maximum of 3 patients per day who required negative Covid tests prior to the procedure. These were usually same day cases with some in-patient cases, but they were not limited to emergency cases. Complex cardiac procedures were restarted in August 2020.

195. Routine cardiology clinic appointments were initially stopped, and then restarted via telephone and gradually returned to face to face. Cardiology diagnostic tests for outpatients (echocardiography) were initially suspended but restarted with longer slots to allow for Covid cleaning / safety procedures to be followed. Inpatient diagnostic services were maintained throughout.

196. The Cardiology service encountered challenges, much the same as other clinical services across the hospital. There were different categories of challenges encountered:

Zoning Challenges:

A lot of clinical activities were moved to accommodate rules on zoning the hospital into red, yellow and green. Sometimes to a different location, sometimes to a different site, sometimes to private hospital spaces.

Social-distancing Challenges:

Clinic rooms, waiting room spaces, clinic profiles all had to be amended to accommodate social distancing rules. This resulted in reduced capacity as appointment slots were lengthened and the number of chairs in the waiting rooms reduced.

The capacity for carrying out respiratory tests, which can result in patient rapid breathing and coughing, was severely reduced as there were no rooms which met the required air change standard.

The administrative teams worked 1 day a week from home, in rotation, because rules on distancing meant office space was insufficient.

Lockdown Challenges

Lock downs resulted in the rescheduling or cancellation of appointments, which in turn resulted in longer wait times and lists.

The admin teams were fatigued as many had to work overtime to ensure patient pathways were appropriately managed.

197. Innovative Practices in Cardiology

a. Video and telephone consultations were introduced to continue Cardiology patient care and reduce wait times for care.
b. A new pathway was introduced (ATLAS) to allow patients who were admitted with acute coronary syndrome, and deemed to be lower risk, to be discharged and monitored daily via an app until they were able to attend Barts Hospital for a coronary angiogram.
c. There was more frequent use of remote monitoring devices for pacemaker users.
d. A new courier-based service was used for the management of Cardiac Holter monitors to reduce the footfall in the Hospital; patients, therefore, did not have to physically attend the hospital to have cardiac Holter monitors fitted.

Hip replacement Surgery

198. Elective joint replacement surgery was not a clinical service offered at KGH prior to the pandemic.

Colorectal Cancer

199. During the first wave of Covid-19 in March 2020, the last elective colorectal cancer procedure was undertaken on 20 March 2020 at Queen's Hospital. Operating at Queen's and KGH had been suspended at this time and we were considering options to safely operate on colorectal cancer patients. After negotiations and discussions with the private healthcare sector, the colorectal team was able to operate at the Princess Grace Hospital with the first surgery lists on 6 May 2020 and the last list being on 24 June 2020.

200. In the meantime, a Pan London discussions network for Covid-19 was set up and a decision to have 2-week wait referral forms for all suspected cancer patients and 'Faster Diagnostic Standard' (FDS) triaging was set up. One Consultant who was shielding carried out the triaging

of all the colorectal referrals. The multidisciplinary team MDT reviews across NEL was not cancelled but continued weekly with the team focused on the cancer cases and attending MDT virtually. We also had regular and frequent Pan North East and Central London Colorectal Meetings for the prioritization of operations. Virtual outpatient clinics were set up.

201. With the onset of the second Covid pandemic wave at the end of December 2020, surgery was undertaken at the London Independent Hospital in January 2021 up until the end of March 2021.

202. After the first wave all elective colorectal patients were operated on at the green elective hub. The first surgical list was in July 2020 and operations continuing until December 2020. Aftercare of patients with stoma was undertaken with the support of Clinical Nurse Specialists (CNS) from the Royal London Hospital. There was also support available from dieticians and physiotherapists. The last theatre list was at the end of March 2021.

203. Challenges faced by the Colorectal Service:
    a. There was reduced clinic capacity, including for endoscopy procedures and diagnostics. However, telephone clinics and ad hoc clinics for cancer diagnosis were arranged to ensure continuity of care.
    b. Adapting to working in a new environment was a challenge. This included working with new teams, different theatres and outpatient clinics.
    c. Maximising theatre space with limited capacity, as other hospitals also required these theatres spaces.
    d. Adapting the clinic profiles to enforce social distancing when face to face appointments were re-established.
    e. Setting up the service in the private sector hospitals which were not used to the high volume of patients coming through. This was mitigated by the operational teams on both sites setting up daily meetings where the development of a standard operating procedure (SOP) was discussed and governance arrangements put in place.

204. Innovative practices by the Colorectal Service:
    a. Setting up virtual/telephone clinics to ensure continuity of care and reduce patient wait lists.
    b. Collaboration with the NEL network to ensure good patient care.
    c. Setting up of a work rota. This was an innovation, albeit a challenging one as it was done without renumeration and was based on the goodwill of the clinicians.

d. Setting up the SOP for operational and governance compliance was an innovative piece of work which can be adapted in the event of another pandemic.
e. National guidance on non-endoscopy diagnostic pathways was also available.

Respiratory Medicine

205. Ahead of the pandemic, the hospital did not have a dedicated inpatient Respiratory ward. However, during the first wave the hospital quickly realised that there was a need for high flow oxygen and CPAP for many covid-19 patients and so a decision was made to set up a Respiratory ward where this intervention could be provided. A few of the Respiratory clinicians from Queen's Hospital moved to KGH to train colleagues and staff the respiratory ward.

206. Lung cancer and Tuberculosis services continued to run throughout the pandemic, and clinicians continued to review patients face-to-face in the outpatient clinic throughout the entire pandemic. There was a suspension of several routine Respiratory clinics, mainly the general respiratory clinics; however, this was only when there was a complete lockdown. The clinics were restarted as soon as the lockdown was lifted. We managed to convert many of the clinics to a virtual platform which enabled us to continue reviewing patients during the pandemic.

207. The Respiratory service faced some challenges in delivering patient care:
    a. The service had to set up protocols for infection control by putting measures in place for social distancing with respect to the face-to-face clinic appointments; this required changing the clinic structure.
    b. The service had to determine which members of staff would see patients who did not have Covid and those who would see patients who did have Covid. This was often a challenging exercise.
    c. There were no non-invasive ventilation/CPAP machines, which could provide high flow oxygen, during the first wave and the department had to order equipment. These came in by the time of the second wave. Therefore, most patients who required non-invasive ventilation had to be admitted to Critical Care during the first wave.

208. Innovative Practices in Respiratory Medicine:
    a. The use of home CPAP/ward NIV machines which did not deliver high flow oxygen but were adapted to the needs of the patient.
    b. The implementation of Infection Control protocols to manage face to face clinic appointments.

c. The set up of Covid-19 virtual wards to discharge patients. This was a very important innovation in how patients were treated out of hospital as it helped to free up beds. Patients who could be safely monitored and assessed at home were provided with an oximeter (to measure oxygen levels) to take home. Nurses would then call them on a frequent basis, sometimes daily, for a review and to offer advice. We also used a virtual monitoring app to help run the Covid-19 virtual ward (my health app).
d. For the most part, telephone appointments were carried out and the service rapidly converted to virtual video appointments. This helped to maintain a degree of continuity of service throughout the pandemic and the service did not have a long waiting list like many other trusts.

Critical Care

209. Although the Critical Care clinicians, for the most part, led Covid-19 treatment, they continued to provide care to non-Covid patients - especially elective cases after the second wave. A separate Critical Care area was in place for non-Covid patients and there was never a suspension of Critical Care services at the hospital; the service had to expand to meet demand.

210. The service faced significant challenges including:
a. Changing to adapt to an unprecedented rapid escalation in referrals and the type of patients coming into hospital.
b. Adapting the workforce to the situation; including the provision of more nighttime cover, and changes in the way the department operated.
c. Segregating patients and protecting non-Covid patients
d. Ensuring the supply of PPE was constant and the unit never ran out.
e. Continuing to assess the oxygen requirement across the organisation.
f. Ensuring the right support was in place for staff who were working long hours, anxious and exhausted.

211. Innovative Practices in Critical Care
a. The service adapted the use of Anaesthetics machines to provide intubation.
b. To provide dialysis for patients going into renal failure a new dialysis unit was opened in the HDU area within a very short timeframe.
c. There was a large expansion of the work base and bed numbers on the background of notable staff shortages. The working rotas for staff changed to deliver more intense service.

d. Whilst historically clinicians knew that proning patients on ventilators improved the ability to improve oxygenation this was also applied to awake patients with the same beneficial effect.

e. Research: There was no targeted treatment available for this novel virus in the first phase of the pandemic. This led to significant pressure on clinicians to prescribe novel treatments based on anecdotes or poorly conducted studies of effectiveness in other countries. The role of rapid research cannot be underestimated, and the Trust actively participated in National trials (NIHR portfolio studies) supported by NHS England, and which were very important in determining what treatment strategy would be successful.

Maternity

212. Maternity services at KGH remained operational. The hospital already provided outpatient antenatal care including midwifery and consultant obstetric-led care in clinics. It also provides an ultrasound service.

213. Women attended antenatal appointments alone due to the requirement of increased social distancing which some women found distressing.

214. Service guidelines were updated on a regular basis to reflect the guidance from the Royal College of Obstetrics and Gynaecology specific to maternity care; and national guidance in relation to the testing and follow-up for covid-19. There were some changes in practice; for example, telephone consultations were put in place, when face-to-face care was initially suspended.

Ambulance handover

215. The Trust`s operational team was not engaged in collating validated ambulance handover data for much of the relevant period. We have, therefore, relied upon data obtained from the London Ambulance Service (LAS) portal in relation to breaches. This data has been obtained from the LAS portal operating during the relevant period and it is important to note that it has not been validated by the Trust.

216. The data in figure 5 (exhibit **MS/18** **INQ000477349** below shows the number of 30 minutes and 60 minutes breaches, month by month, during the relevant period. It is my understanding that the clock starts to run at the point in which the ambulance arrives at the hospital, and the clock stops at the point when the ambulance crew hands the patient over and records this on

the LAS system. It is my understanding that this would be the usual process; however, there can sometimes be delays between the crew handing over and making a record of the same on the LAS system.

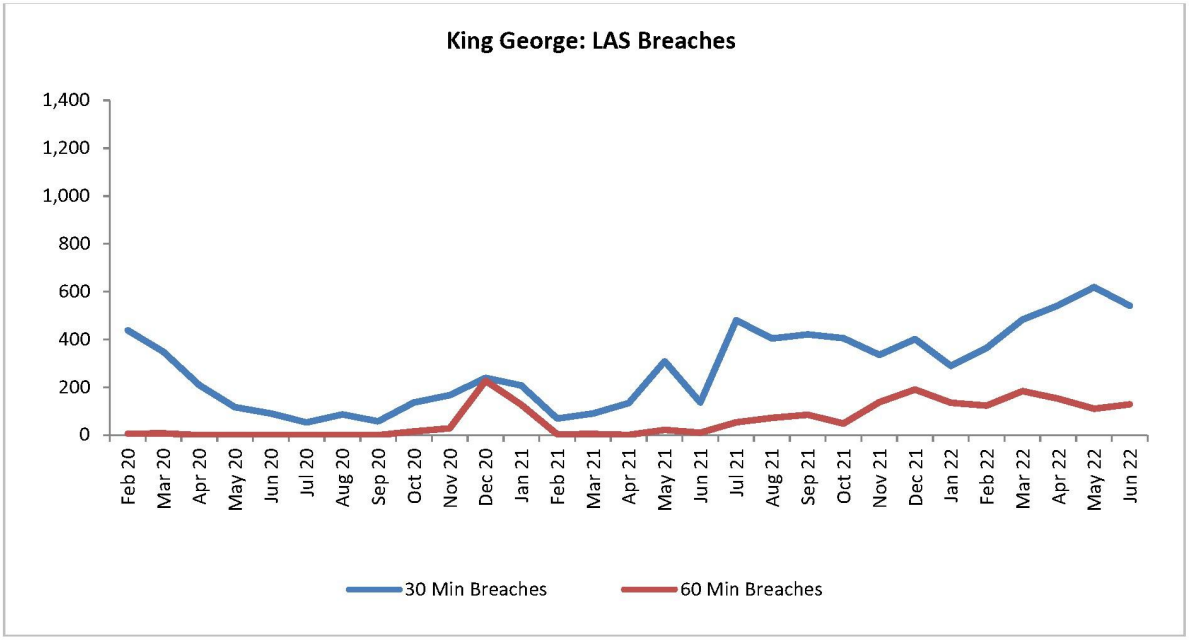

Figure 5

217. In the 30-minute category, the data from LAS shows over 400 breaches in February 2020. This then starts to taper down until September 2020 when there are 57 breaches recorded in the same 30-minute category. However, from October 2020, the numbers start to rise until February 2021 when they fall sharply.

218. The more remarkable data appears to be that presented in the 60-minute breaches category. There are less than 10 breaches in this category in February and March 2020; in the ensuing months there is none at all. However, from October 2020 the number of 60-minute breaches starts to rise until it reaches a peak of 227 in December 2020. This period would coincide with the 2nd wave of the pandemic and certainly reflects the conditions on the front lines at the time, with the increase in admissions.

219. From the perspective of the Emergency Department (ED) team at the hospital, Ambulance handover delays were a significant issue - particularly during the second wave in late 2020. The key factor causing the delay was the Covid-19 occupancy rate on the wards, reduction in bed capacity due to bed closures in outbreaks, and in response to infection control measures.

This caused patients to stay in the ED for much longer, resulting in longer ambulance offload times.

220. The hospital ED was a very small department at the time. The team recalls situations where there was little room to physically move around; despite having removed unnecessary furnishing and emptying out a number of side rooms, including some of the doctors' consultation rooms.

221. Delays were also caused by the requirement to test patients before admission. This was in a bid to maintain the segregation between covid-19 positive and negative patients; and to determine what zone a patient would be admitted to. Initially patients were placed based on symptoms and tested on admission with PCR testing which could take up to 72 hours to get a result. Initially this was for symptomatic patients but eventually extended to all admitted patients. Abbott testing was introduced in July 2021 with a 90-minute turnaround time but the use of lateral flow testing was not sanctioned for use in patients being admitted to hospital until after this time despite its introduction for staff and visitors in November 2020.

222. Staffing shortages also caused delays in the ED pathway with correspondence at the time indicating challenges touching on nurses' absence.

223. At the peak of the second wave, the wait time in an ambulance could be from 6 to 10 hours. The team members remember one Saturday when there were up to 18 ambulances waiting to offload. The team is keen to point out that this was not a daily occurrence, but it did happen on occasion.

224. In response to this issue, the department took action to reduce handover times by reconfiguring the layout of the ED by expanding outwards as much as possible. This action was repeated several times over the relevant period in response to demand.

225. Additionally, and with patient safety in mind, a mobile clinical team was tasked with going out to the waiting ambulances to assess the patients and provide necessary treatments while they waited. This would include the administration of fluids and medication at the back of the ambulance. Therefore, staff tried to minimize delays in treating patients. There was also a risk to the ambulance crew who were enclosed in close confines with Covid-19 patients.

226. The steps taken to reduce the handover times were effective to the extent that the department was able to manage the high number of patients as appropriate.

Treatment Escalation

227. I have drawn upon the input of the hospital's Medical Director at the time, as well as clinicians within the Critical Care service. Although the prospect of rationing of care was touched on, no formal concerns were raised about the absence of a national decision-making tool for rationing care; nor was there any rationing of care at the hospital.

228. There was significant concern, particularly in the very early days, that the hospital would be overwhelmed and some form of additional decision-making on care escalation would be required. There was some early discussions about the prospect of a clinical decision-making tool for the escalation to critical care at a local and regional level, but a decision was taken to continue to follow good practice and national guidance on treatment and escalation of care with a focus on increasing the capacity to be able to do this.

229. The hospital did not develop a formal document, tool or checklist to determine whether to escalate care. Clinicians were therefore advised to continue to follow best practice, and the Resuscitation Council guidance, in clinical decision-making. All cases would be considered on their individual merit by weighing up factors including clinical presentation, the impact of the disease, the likelihood of responding to treatment, the national frailty score, etc.

230. The was no separate Ethics Committee to review potential ethical decisions. If there was a need to make an ethical decision it would have gone to the NEL Ethics Committee, but this was not required. A Clinical Reference Group (CRG) was established very early on, and all clinical guidance was approved at this forum before dissemination across the Trust hospitals.

231. There were pathways for the escalation of care for Covid patients and this touched on patients indicated for Critical Care, and those for non-invasive pulmonary ventilation. Decision-making was clinically-led by the critical care team and in line with national guidance.

232. There has always been a robust process for the admission of patients to Critical Care. During the pandemic, the Critical Care team had to be more mindful of the comorbidities and the functional status of patients. The population of patients being referred from the ward and the ED were completely different from pre-Covid times. It was not common to see sick patients with stroke and cancer in hospital; the patients who presented were markedly different.

233. The criteria for admitting patients to the critical care area did change, but this was purely down to the treatment which the hospital could provide in other clinical areas; particularly by the

second wave. Pre-Covid, Critical Care would admit hypoxic patients who required non-invasive ventilation; however, during the peak surges, the unit only admitted patients who required intubation and ventilation. Hypoxic patients, who could be treated with NIV and CPAP, were treated on the respiratory ward and this increased Critical Care capacity to treat the more unwell patients. It is noteworthy that, pre-pandemic, this was already standard practice in some hospitals.

234. There was no rationing of oxygen therapy, and no patient was denied oxygen if they required it. The hospital relied on national guidance on target saturation levels. The priority was to ensure all patients were in receipt of the oxygen they required; however, where patients required escalating to more, they did receive more than everyone else and if needed above the levels set out in national guidance. It is noted that national guidance did change during this period. However significant efforts were made to ensure adequate oxygen supply was maintained at all times. This included intense monitoring of oxygen supply levels and provision of additional oxygen in cylinder form and concentrators as needed.

235. There was no decision to ration care throughout the period. There was no cause to ration access to a Critical Care bed because the bed base expanded to ensure there was enough capacity with the addition of non-invasive ventilation being transferred to the respiratory ward. Similarly, the supply of oxygen at KGH was adequate.

236. However, there were situations where systems or processes had to be altered due to supply needs. Due to significant pressures on oxygen at Queens in the winter of 2020, a decision was made in collaboration with LAS to create a directly admitting unit for patients requiring high flow oxygen. This was created in January 2021.

237. Another example of an alteration in process was in the nursing ratio in Critical Care. The one nurse to one patient care provision was suspended in line with national and regional advice. This was done in agreement with the Chief Nurse. There is one recorded occasion when the ratio was one Critical Care trained nurse to approximately 4 patients in the Critical Care unit. At other times the critical care trained nurse ration varied from one nurse to two patients or one critical care trained nurse to three patients. Additional support was provided to the Critical Care nurse by redeployed non- Critical Care nursing and medical staff; as well as redeployed therapy clinicians who were provided with training. “Turning (proning) teams” were also in place to provide additional support and turn patients to maximise ventilation. It is important to note that where the ratio of Critical Care trained nurse to patients was higher than 1:2, this was

directed towards the most stable patients in the unit. Where possible, the more unwell patients were always maintained with a better patient to Critical Care nurse ratio.

238. Consideration was given to the provisions of the ReSPECT form; however, the form was not introduced as all aspects of the form were already incorporated or captured within our local guidance and documentation. The priority was to ensure that treatment escalation was the result of clinically-led decision-making reviewed at multiple stages during admission, and ensuring good record keeping.

239. There were processes in place for managing difficult Do Not Resuscitate (DNR) decisions; especially if it was being challenged by a patient's family. The decision was taken through two clinicians; one clinician based at KGH and the other at Queen's Hospital. They would then reach a shared clinical decision on whether DNR was appropriate.

240. Guidance on the effect of DNACPR or advance care planning forms on clinical decisions around escalation of care was led by respiratory and intensive care physicians supported by our palliative care team. Treatment escalation to Critical Care was a standalone, considered clinical decision, which was made in relation to individual patients and their presentation. Training in DNR decision-making is a part of general medical training but the Treatment Escalation Plan (TEP), protocols and guidance were widely shared with all teams on via multiple portals within the Trust.

241. Please find exhibited the following documents:
    a. **MS/07 [INQ000417077]**, the Trust's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy at the time.
    b. **MS/08 [INQ000417078],** the Trust's Deteriorating Patient Management Policy
    c. **MS/09 [INQ000417079],** a proforma for a Treatment Escalation Plan

242. In addition, the palliative care teams worked hard to provide additional support to clinical teams and families when escalations of care were being decided.

243. The hospital currently does not have electronic patient records. DNACPR forms are filed in patients' paper notes.

244. There are no reports or records of any systemic concerns around DNACPR notices being disproportionately issued in relation to patients with protected characteristics. Neither were

there any escalated concerns around patients arriving at the hospital with DNACPR notices which did not appear to be clinically appropriate.

245. There was some guidance to clinical staff on communicating and explaining DNR decisions to patients and families. In particular, there were Critical Care staff whose duty was to contact patients' family members and have difficult conversations with them. These conversations were difficult because they mostly had to be done over the telephone, rather than face-to-face, due to the visiting restrictions in place. The palliative care team provided significant support in these situations. I hereby exhibit, as **MS/10 [INQ000417080]**, patient information leaflet – '*Let's talk about CPR*' for discussing resuscitation decisions with patients and families.

246. A review of patients who died with nosocomial Covid-19 infection reported that decision making regarding end of life was appropriate and well documented.

The potential unequal impact of Covid measures on patients

247. Although we have not identified any specific issues touching on an unequal impact of pandemic measures on persons with English as a second language, it is noteworthy that KGH serves an ethnically diverse area with a large population from an Asian background. It stands to reason that some patients who did not have a strong command of English, or speak it at all, would have been affected by measures such as the wearing of PPE by staff, which would have made communication that much more difficult. This would have been made worse by the restrictions to visiting as it would have removed the support of English-speaking family members who would typically be the liaison between the patient and the treating clinicians. There was provision for the use of online interpreters to facilitate communication between the clinicians and patients with limited English. Its use was limited and it usually makes for a better patient experience when a trusted family member is on hand to provide reassurance, particularly for patients within this group.

248. Another group that would have been adversely affected by measures in place would be patients with hearing difficulties. This group of patients would typically lip-read to understand what others are saying and it would have been very difficult to communicate with them with the protective face coverings staff had to wear. For this group, the presence of visiting family would have been little mitigation, as any visitors would also have been expected to have protective PPE.

249. The hospital served a diverse patient demographic of those experiencing health inequalities even ahead of the pandemic. The pandemic had a significant impact on this as it disproportionately affected those with a BME background and those with certain pre-existing medical conditions. There was further impact by way of delayed timescales for elective treatment arguably causing further health inequality within our population.

250. Finally, pandemic measures would have had an unequal impact on patients with learning disability and mental health conditions. This is with particular reference to the visiting restrictions which would have significantly reduced the family support available for this group of patients. Although by May 2020 this group of patients could have visitors, the hospital's daily visiting window was between 3-6pm each day and this did not allow for adequate time for these patients to have access to family.

The effect of the pandemic on healthcare staff

251. The pandemic was physically, mentally and emotionally draining for staff at the hospital, particularly during the early days and in the peak of each wave but also later down the line once fatigue set in. I have touched on staff shortages caused by an increase in sickness levels and staff having to shield. I have touched on the impact of the government's VCOD policy and how this affected staff morale across the Trust. I have touched on the fact that there were members of staff who could not access the emotional support of family members because they had to stay in hotels and stay away from family. I have also touched on the impact of experiencing the death of a colleague from the virus we were all fighting. All of these contributed to low staff morale and affected wellbeing.

252. Early on in the pandemic, a Wellbeing Steering Group was established to ensure targeted wellbeing support was available to members of staff. The focus of the Wellbeing strategy was to support staff with food and hydration; provide break out rooms and Wellbeing Hubs; provide nearby work areas to support rest; and most importantly, to provide various levels of mental health support. A significant wellbeing support package wMSA/as created to provide individual support, group support, and information on self-help apps; as outlined in figure 6 below, exhibited as **MS/19** **INQ000477350**

Figure 6

253. The hospital viewed staff wellbeing as crucial to patient safety and the effective delivery of its goals. In order to support staff, the following programmes were implemented:
    a. Internal Wellbeing Partners: This team was aligned to highly pressurised front-line services to support staff with bespoke wellbeing packages which had been designed based on the needs of the teams in a particular area.
    b. Let's Talk: This was a call/virtual call service put in place for staff who would prefer a peer-to-peer conversation.
    c. Covid Recovery Champions: This was a programme aligned to areas requiring high support. Its aim was to support and enable Champions (specific staff members within an area) to build resilience in their areas to respond to the pandemic and post-Covid recovery plans.
    d. Support for leaders: This was a programme designed to empower managers with tips and tools on how to support the wellbeing and morale of their teams.
    e. Wellbeing conversations: This was guidance developed to train managers on how to hold wellbeing 'check-ins' with their staff.
    f. Resilience and recovery workshops: This was Psychologist-led training.
    g. Psychologist support for the Emergency Department and Critical Care.

254. Below are additional wellbeing initiatives introduced:

a. Sleep Webinars: A support package for sleeping well.
b. The provision of food and drink options.
c. Relaxation sessions – which was piloted with Therapies.
d. Advice and guide for managers in dealing with difficult conversations compassionately.
e. People first communication - at staff events such as Team Brief and Question Time with the Executives. At these forums, the agenda was started with wellbeing to signal the importance of caring for our staff at this time.
f. The setting up of a Long Covid clinic by the Trust's Respiratory team.

Risk assessments

255. A Trust Risk Assessment was introduced at the Trust hospitals in March 2020 and its roll out was supported by HR Staff. Risk assessments were monitored, tracked and reported regularly at the Trust Executive Committee. NHS London were updated with information on the number of Risk Assessments completed.

256. Analysis was undertaken, by colleagues in Occupational Health, to consider the outcome of the risk assessments. They found that the introduction of risk assessments impacted on staff redeployment as the risk assessment scoring process required consideration as to whether adjustments were required to work, and whether they could work in the 'blue' Covid areas. The key aspect impacting staff and health was whether there were issues of comorbidity of health issues; and particularly issues such as respiratory ailments and/or diabetes.

257. The Trust did not formally carry out Equality Impact Assessments. However, the principles of these assessments were subsumed within the Trust's approach to Covid measures, which was a deep focus on risk assessments in many areas. Due consideration was given to age, disability (via factors like vulnerability and poor health), pregnancy & maternity, race, and other relevant protected characteristics.

258. Following risk assessment exercises, age-related reductions in exposure and frequencies would have been adopted; and some individuals would have been excluded from certain areas of work, thereby eliminating the risk. In recognising disability, we would have followed the

published vulnerability guidance, which was far wider than the definition of a disability with the Equality Act.

259. The hospital also operated a 'zoning' approach which placed staff with degrees of vulnerability in appropriate work areas where they would have had their respective graduated PPE; ranging from full powered respiratory protective equipment (RPE), FFP3 masks, shields and paper masks. High risk areas were identified, staffed and resourced appropriately. For example, respiratory wards and any clinical areas where 'aerosol generating procedures' (AGPs) were undertaken; some of which were stopped or restricted by length of time.

260. In terms of pregnancy and maternity, we particularly ensured that pregnant staff were shielded from 28 weeks. This is because the original guidance issued by the Royal College of Obstetricians & Gynaecologists identified the third trimester as the period of highest risk. Despite the guidance changing to a 'risk-based' approach, we maintained this policy.

261. Race was certainly a consideration in all of the above preventative and protective approaches. In recognising this, the Trust undertook an additional risk assessment for Black & Minority Ethnic (BAME) staff in May 2020.

The unequal impact of Covid measures on staff

262. A few issues were identified as disproportionately impacting on certain members of staff due to protected characteristic under the Equality Act 2010. A notable issue was in relation members of staff who did not have English as a first language and, crucially, those who are hard of hearing. Of particular concern was in the case of the latter group, who were staff who would usually rely on lip reading as part of their means of communication, but could no longer do this because of the wearing of face masks. Consideration was given to measures like keeping a safe distance to communicate with these group of staff, or the use of a full-face visor without a mask. These options were discounted as not being effective in the long term. Ultimately, we found this issue difficult to address.

263. Our staff are diverse and of multi- faith, many of whom wear head coverings or beards for religious beliefs. The requirement to wear FFP3 masks created a challenge for this group of our staff. Whilst protection and redeployment to suitable areas was provided for those who did not pass the fit test due to wearing scarves and those with a full beard, it did impact on capacity overall, and on the clinical roles they could perform.

264. Many of our staff have caring responsibilities, live in multi-generation households or lived with people who were shielding. Some staff had to make a choice to either live away from home to continue working and avoid the risk of transmitting infection or, stop working.

265. Another matter that came to light was raised by the Trust's Chaplaincy. It touched on concerns by members of staff in relation to using the hospital's prayer room. This was after the lifting of lockdown and the introduction of social distancing rules as a preventative measure.

The hospital and the healthcare system

266. The Trust recognised early on that clear channels of communication had to be established for an effective flow of information from the Trust leadership to staff working on the frontline. We were mindful that the ability of staff to have access to the correct information could be a matter of life and death. Therefore, it was important to ensure the flow of information along the Trust's command structure was effective. It was vital that all relevant operational and clinical information filtered down from Gold Command down to the clinical divisions. It was equally important that feedback from the front-line was shared with leadership and the Chief Nurse met with senior nursing staff twice weekly in locations that would allow for appropriate social distancing.

267. Although all face-to-face meetings were halted at the start of the pandemic, and in line with lockdown guidance, a key positive change was the quick introduction of virtual meetings. Starting from July 2020, team brief sessions (Meet the Chief Executive) were established on a bi-weekly basis. These sessions were open to all staff and their managers and was an opportunity for managers to obtain relevant information and feedback to their teams.

268. The twice weekly Clinical Reference Group enabled clinical leads on the front line to raise live issues and concerns which needed to be addressed. This also allowed a channel of communication from Gold Command to clinical leaders.

269. In addition, there was a daily 'covid-19 Comms' produced by the Trust Communications Team, dispatched via email to all staff, and also posted on the Trust Intranet. The comms provided details of the status of covid-19 deaths in the hospital, any operational changes and key staffing messages.

270. There were good channels of communication with our regional NHS body which were the first point of escalation for issues of concern raised by the Trust. Issues were generally resolved at North East London level, although national supply chain delays required local solutions such as the local procurement of PPE. When the Trust asked for additional national support, in oversight of infection protection and control purposes, this was given and provided helpful scrutiny and support. However, it did not always feel that the national team understood the local context of infection control rates when raising concerns. For example, the rise in nosocomial infections relating to a rapid rise of the omicron variant in late 2020, combined with the challenges of local testing capacity and long turnaround times for results.

271. A significant amount of national guidance was regularly received and it was very challenging for teams to translate this guidance into clear information for staff and patients, particularly when guidance was changed. This included changes in PPE, visiting and testing. It proved more challenging, when guidance was received, for it to be enacted with immediate effect. For example, testing patients prior to discharge to care home, or when guidance was issued just before a holiday or weekend period. It also proved challenging when guidance was publicly released before being issued to the Trusts.

272. There was guidance issued by professional bodies such as the National Royal Colleges and others which supported clinicians in practice. The role of the London Clinical Advisory Group and the North East London Advisory Group was helpful in providing context for localising national guidance where relevant. The volume of guidance was challenging to recognise and adopt at the pace needed.

Our recommendations to the Inquiry

273. Ahead of the pandemic, the hospital had a small and centralised IPC team. Significant resources were provided to this team in response to the pandemic and it is recommended that hospitals continue to appropriately invest in IPC as well as other services that support pandemic preparedness. It is important that the ongoing practice of seven-day services are in place and that staff are able to utilise PPE at all times, not just in immediate response to a pandemic. Regular, consistent, and varied Fit Test training ought to be delivered to staff in relevant areas so they are prepared to use FFP3 masks or alternatives immediately.

274. Hospitals benefit from ensuring that there are effective communication processes in place to ensure swift and effective dissemination of information that will reach all staff. We found that

some staff were not sighted on recent updates and some staff working from home and/or shielding reported feeling isolated and disconnected with the pandemic response. Innovative ways to communicate were put in place as time went on, but it is crucial that this is in place immediately in the event of a future pandemic.

275. A strong staff wellbeing offering should always be in place but there needs to be an ability to rapidly scale up certain offerings in the event of a pandemic by way of developing an escalation plan. The importance of supporting our staff and ensuring their wellbeing was critical in being able to respond to the pandemic appropriately and efficiently.

276. Our hospital's vacancy rate in Critical Care ahead of the pandemic was 19%, significantly below the acceptable rate with recruitment and retention remaining an ongoing issue for the NHS nationally. It is recommended that both hospitals and national decision makers push innovative recruitment drives and ensure appropriate measures are in place to support its existing workforce to ensure retention wherever possible. Failure to ensure sufficient staffing levels is a significant risk to patient safety in the event of a future pandemic.

277. Working across the North-East London network was of immense benefit to the hospital, the Trust and other hospitals within the network. It is crucial that focus remains on collaboration moving forward so that a systemic response, such as we have seen in NEL, can be implemented swiftly in the event of a future pandemic. This is of particular importance within Critical Care and Emergency care.

278. National guidance changed at pace and there were times that the press/media issued updates on national guidance many hours ahead of dissemination to the hospitals. There were multiple sources of information which sometimes conflicted. This caused confusion, fear and anxiety for our staff and for the public. There was a perception by some that the hospital's focus appeared to be on following guidelines instead of mitigating the risk of infection and protecting our staff and patients. People lost trust in the healthcare system due to this perception, and also due to the ever-changing guidance. It is recommended that, in so far as it is possible, new guidance is disseminated consistently, with rationale where able and at the same time to all.

279. Hospitals should ensure that a fully comprehensive pandemic plan is developed for the management and mitigation of its impact whilst reducing the risk to public health. This should include resource planning/management and recruitment and redeployment processes in the

event of a pandemic. This should be at a hospital, Trust, system and regional level to ensure a robust response.

280. There was a significant amount of innovative practice in healthcare which needs to be embedded in future commissioning and standard setting. In North-East London, this included the development of NECTAR (Critical Care Transfer Services), the ATLAS (cardiac service) and REACH (supported LAS in decision-making about place of care).

281. Critical care capacity expanded rapidly in response to an acute rise in demand. Following the pandemic, the hospitals have retained a greater clinical care capacity than before, which enables elective pathways for high-risk patients to be sustained. Planning of critical care capacity should take into account local population demand and historical usage.

282. Separation of elective care pathways within the hospital was established initially for infection control reasons but has persisted, allowing better planning and efficiency for admitted elective patients in surgical specialties.

Statement of Truth

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

Signed: Personal Data

Dated: 28/04/2024