Module 3 Week 4

1. Sir Frank Atherton (Chief Medical Officer for Wales)
2. Dr Catherine McDonnell attending remotely (Former Medical Director of the Western Health and Social Care Trust, including Altnagelvin Area Hospital)
3. Mark Tilley (Ambulance Technician – Impact evidence, Trades Union Congress)
4. Anthony Marsh (National Ambulance Adviser to NHS England and former Chair of Association of Ambulance Chief Executives)
5. Dr Tilna Tilakkumar (General Practitioner – Impact Evidence, British Medical Association)
6. Professor Kathryn Rowan OBE (Founder and Former Director of Intensive Care National Audit & Research Centre)
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8. Professor Charlotte Summers and Dr Ganesh Suntharalingam OBE (Experts in Intensive Care)

Sir Frank Atherton (Chief Medical Officer for Wales)

CMO for Wales since August 2016

We recognised that there wasn't enough detail about the Welsh context, and we wanted specific modelling of the virus and the epidemiology within Wales, so we set up the Technical Advisory Cell from 27th February. Because of how much information that was coming in, I would rely on the summary of the paper rather than reading the full paper.

My understanding of the transmission early in the pandemic was that it was primarily a respiratory infection. A respiratory infection is by its nature transmissible through airborne transmission. I see droplets and aerosols as a form of airborne transmission.

I don't believe we ever deviated from the guidance of the IPC cell. I think that was quite important to get consistency across the four nations. It's our job to receive the IPC guidelines, to understand them, to disseminate them. It wasn't our role to second-guess them. Obviously, if there were controversial areas as subsequently arose then we would discuss those with the IPC cell or we would discuss them with the senior clinicians' group. Broadly we accepted the IPC Cell recommendations on the basis that they were experts.

I do recall a divergence of opinion on whether CPR was an AGP. The Chief Nursing Officer emailed to say that many of the health boards are now rejecting the public health England guidance, and the compromise was to follow the RCUK advice. I agreed with my deputy Chris Jones that it was for each health board to decide what kind of PPE should be used rather than adopting that proposal of the Chief Nursing Officer to accept the resuscitation council's position. BJC – so they accepted the IPC Cell advice on the basis that it was important to have consistency across the 4 nations, but each board could decide for itself what PPE to use meaning there would be no consistency across Wales never mind across the 4 nations?

We did bring a consistent voice. Jean and I consistently said we should follow the PPE the IPC guidance based on the NERVTAG advice. BJC – But he has just said that the CNO (Jean) was asking to follow RCUK instead!

We have to be careful about the precautionary principle because becoming too precautionary stops the thing you want to happen. If you say you cannot provide CPR unless you have a certain level of kit, you're putting the lives of individuals at risk. BJC – This is only true if there are issues with supply, but everyone has said "we never ran out" But by not doing so you are putting the lives of HCW workers at risk

<u>The Nosocomial Transmission Group (NTG)</u>

Repeated hospital outbreaks would not mean that the IPC measures were not effective or not being followed. It's impossible to completely eradicate nosocomial transmission. No matter how good your IPC is, the only way to stop nosocomial transmission in hospitals would be to close the hospital. I don't believe the NTG ever advised that the PPE specified in the UK IPC guidance should change or that healthcare workers in Wales should have access to a higher level of PPE than that specified in the UK guidance

NTG Guidance: "The NTG also routinely monitors rates of transmission but not with the expectation there is a direct correlation between the guidance issued and lower infection rates"

Q: what was the purpose of issuing further guidance if there was no expectation that that was going to make any difference?

A: I don't know what they had in mind when they wrote that. I don't think the NTG was able to disentangle the main routes of transmission eg patient to patient or between staff or patient and staff, but its role was to monitor and reduce the levels of nosocomial transmission.

Demand exceeding critical care capacity and the need for a national decision-making tool was a material consideration for us. How we could prioritise care if we reached the point where the system could no longer cope was something we thought about. The Welsh intensive care society produced a clinical decision-making tool to assist with prioritisation.

There were discussions at the four nations through the senior clinicians group. It was trying to prepare the system for if we reached the that unfortunate position where we couldn't meet the needs of the population.

An earlier version included a numerical scoring system. We recognised it was not appropriate, so it was never agreed. Concerns were expressed particularly by organisations representing disabled people. The tool was circulated to all clinicians, but it was not approved by the Welsh Government.

I was not made aware of anyone in Wales being denied escalation of care because of their age. I think it would be appropriate for the tool to be one of the considerations which clinicians would use to determine about whether an attempt that cardiopulmonary resuscitation should be made. Age, disability or long-term condition alone should never be a sole reason for issuing a DNACPR order against an individual's wishes.

I do not agree that decisions were being made as to what level of PPE should be used by healthcare workers to avoid running out of supplies rather than due to the risk presented to healthcare workers. It may well have been something a concern a subsidiary concern but the main reason for following IPC guidance was because that was based on the best evidence. It wasn't a question of supply.

Dr Catherine McDonnell attending remotely (Former Medical Director of the Western Health and Social Care Trust, including Altnagelvin Area Hospital)

Generally, we followed guidance but occasionally it would be applied in what I would describe as a little bit of common sense. For example, guidance came through to downgrade some of our PPE just before Omicron struck. So, we delayed implementation of the new guidance until our community transmission rates dropped.

The biggest challenge to implementing IPC guidance was a concern that in the early stages of the pandemic that guidance was developed around supply issues rather than safety and that safety measures being advised were inadequate

Mark Tilley (Ambulance Technician – Impact evidence, Trades Union Congress)

For IPC – there was no mop and bucket at the hospitals for us to use. We used wipes to clean the inside and the stretcher. The masks were stored in a fridge but that made it damp. Dates on masks or gloves had expired. Some cheap and nasty gloves you just put your hands straight through because they ripped so easily.

We need to learn from it, adjust and make sure it doesn't happen but all we're seeing at the moment is things have reverted to how it was beforehand - tight spaces for working, still have out-of-date equipment and consumables and vehicles that are not fit for purpose.

Anthony Marsh (National Ambulance Adviser to NHS England and former Chair of Association of Ambulance Chief Executives)

As pressure on the ambulance service and the call handlers increased, in my role as adviser to NHS England and the chair of the NHS England 999 Ambulance Cell advised on increasing capacity.

I advised that students should be mobilised to increase capacity. That had never been done before but we were in an emergency.

There were times during the pandemic that demand did outstrip capacity in 999 call handling centres. I don't believe enough was done to prevent this happening early enough in the pandemic.

Changes to the triage pathways were introduced into 999 and 111 in response to the pandemic. I chaired the emergency call prioritisation advisory group advising NHS England on ambulance call prioritisation, triage systems and clinical coding. Initial changes were made in mid-March 2020 to ambulance dispatch codes within 999 and a new prioritisation pathway for the Covid-19 callers contacting 999 with breathing difficulties. Pre pandemic a patient with breathing difficulties would be taken through the difficulty breathing algorithm. Once the pandemic protocols were implemented, we would establish whether those patients could be safely dealt with without an ambulance or whether they needed an ambulance to be sent and, if so the speed and the category of that response.

The ineffective breathing code would receive a Category 1 response. But the new Protocol meant that it was categorised as a Category 2 response.

In August 2020 the emergency call prioritisation group conducted a review and concluded that the new code should receive a Category 1 response, so it was changed.

There was no formal impact assessment of the impact on vulnerable groups of Protocol 36 but it would remain under review.

Re loss of taste and smell - there was a delay of four days in which the script was not updated. So anybody calling in that period would not have been told it was a symptom. I don't believe that would have impacted the callers because whilst that's an important factor in recognising whether the patient may or may not be suffering Covid, it wouldn't have influenced in any way the code that was allocated to the patient once they had been taken through the algorithm.

NHS England developed clinical guidance for paramedics to aid decision-making on conveyance to hospital for adult patients in April 2020. That guidance was issued on 10 April 2020, but it was issued by mistake because it included the clinical frailty scale and that had been identified as having a potential impact on patient safety. Later that month it was reissued without the clinical frailty scale. So, there were 12 days when it was in use. I have not found any evidence that ambulance services applied that guidance.

The UK IPC cell agreed on 6 March 2020 that PPE for ambulance guidance would be downgraded. Ambulance trusts were not consulted on ambulance PPE guidance. From the very start of the publication of the guidance for ambulance staff they had the ability, having undertaken a dynamic risk assessment to upgrade the level of PPE to what they felt safe in. I absolutely accept that that is also down to availability, but they did have the ability to upgrade where that equipment was available.

I raised my deep concerns in relation to ambulance crews being unable to handover their patients promptly almost on a daily basis. There were various meetings and national meetings on the pressures across ambulance service. Despite everyone’s best efforts those delays continued

I was aware of the different positions on whether CPR was an AGP. I ensured that the experts were aware of the concerns that were being raised by ambulance staff and by paramedics. My view was that we should continue to follow the advice of the experts.

Dr Tilna Tilakkumar (General Practitioner – Impact Evidence, British Medical Association)

Was sent to an acute mental health ward, where due to staff sickness she ended up as the only doctor present.

We had one observation machine to go round 26 patients, which was required to be wiped down between each use, so it took a long time. This wasn't something that they would be doing ordinarily on the ward, so I had to show them what ranges were normal, what was abnormal, and what needed to be flagged to me as a doctor.

Everyone was wearing full PPE. So that was a surgical mask, gloves, apron, shoe-covers at all times everywhere on the ward. Then at some point in the next week we were downgraded to only having to wear that when we're in contact with the Covid patients. At that point the stock actually became hard to find. Nothing had changed in our clinical environment. We were still dealing with at least 15 patients with Covid at the time the PPE was downgraded. None of the patients were being successfully isolated due to the mental health issues. There was no guarantee that we could contain Covid to bedrooms, so the entire ward was a Covid ward as far as we were concerned and PPE needed to be worn at all times and some staff members did continue to always wear PPE.

There was an incident where a visiting manager saw a healthcare assistant wearing a plastic apron and she pulled it off her because the guidance said it was not needed. The healthcare assistant was black, and the manager was not.

Professor Kathryn Rowan OBE (Founder and Former Director of Intensive Care National Audit & Research Centre)

During the first two waves you can see this threefold and fourfold increase in the number of inter hospital transfers. Some were for more specialist reasons, but some were for capacity reasons.

Your first day in intensive care is very important in terms of setting up your care. We established pre-pandemic that patients who were admitted in periods of higher capacity strain, were less likely to survive.

In the second wave, during periods of pandemic high strain or pandemic extreme strain, a patient who went into ICU at that time with all other factors being equal was more likely to die than had they gone into ICU at another time.

Age was the most significant factor driving likelihood of not surviving to hospital discharge.

During the delta wave in mid- to late 2021, patients admitted to critical care were younger and we think that's most likely related to the vaccine policy where roll out started with oldest population. It provides potential evidence that elderly patients were disadvantaged by prioritisation decisions, but you would need to ask the care givers.

Those from the most deprived areas were also more likely to be admitted.

Patients with Covid-19 who come from an Asian ethnic group seemed to be at a higher risk of being admitted to critical care with Covid-19.

It was from 5 April 2020 that ICNARC introduced reporting by ethnic group into your weekly reports that we were providing. We were not asked to do this; it was done of our own volition after seeing on TV reporting that there appeared to be issues around non-white ethnicity.

Professor Charlotte Summers and Dr Ganesh Suntharalingam OBE (Experts in Intensive Care)
We entered the pandemic with a 10% critical care nurse vacancy. So, the staff that did have had to stretch further and further to provide care. So of course that impacted on the care that could be provided.

Scotland, Wales and NI counted the number of ICU beds it had. In England it counted the number of beds it was able to surge up to in order to give the maximum. It shows when you are in danger of reaching saturation point locally and nationally. The way this was communicated was potentially misleading, but I don't think it was through any ill intention.

Normally you transfer a patient for clinical benefit, because they need something you can't provide at that location. Capacity transfers is something you would prefer to avoid if you can. They do happen in non-pandemic times but not at the same scale. There is no evidence that transferring patients out had any impact on their mortality.

CRITCON 0 – normal

CRITCON 1 – bad winter

CRITCON 2- medium surge unprecedented, capacity surge in critical care areas, and increase in non-clinical transfers

CRITCON 3 – operating at or near max capacity and at risk of overwhelm. There is maximum mutual aid between the trusts with the network and the regional NHS E co-ordination. The prime imperative of CRITCON 3 is to prevent any single trust entering CRITCON 4.

CRITCON 4 - the ICU is an emergency. It's at risk of being overwhelmed and may resort to triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation) Any hospital can say they are at CRITCON 4 but they can only implement critical care triage on the approval of NHSE

Where CRITCON 4 was declared by hospitals, that means the alarm bells are going off, it doesn't mean they are triaging care by resource. It's really reflecting a statement of extreme CRITCON 3 which needed intervention. Alternatively, it might have been a typo. BJC – This is concerning. After carefully describing what CRITCON 4 is, he is now saying that either, it wasn't really – it was just a warning – or it might have been a typo!

We went into the pandemic without anyone being 100% certain centrally how many devices there were within the NHS. In late February it was revealed there was only 7,357 devices available and that was included paediatric devices and ventilators that might be used in an ambulance. Modelling suggested we would need 59,000 ventilators

There were also issues surrounding oxygen supply shortages. For a fit and healthy person, the recommended oxygen saturation is greater than 94%. That was dropped to greater than 92% because that was thought to be safe. I could find no evidence to suggest that that had done any harm at any point during the pandemic. Harm can be done by giving too much oxygen, it can lead to oxygen toxicity which damages the lungs. BJC - but we are not talking about lowering the level because of such a risk, they lowered the level to ration the available oxygen – it's based on resource rather than clinical need.