Witness Name: Alison Davis
Statement No.: 1
Exhibits: 1
Dated: 24 April 2024

**COVID-19 PUBLIC INQUIRY**

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**WRITTEN STATEMENT OF ALISON DAVIS**

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I provide this statement on behalf of Medway NHS Foundation Trust ("the Trust") in response to the request under Rule 9 of the Inquiry Rules 2006 dated 13 December 2023.

I, Alison Davis, will say as follows: -

## Introduction

A My full name is Alison Davis. My date of birth is 17 November 1965. My professional address is Medway NHS Foundation Trust, Medway Maritime Hospital, Gundulph Trust HQ, Windmill Road, Gillingham, Kent, ME7 5NY. I am the Trust's Chief Medical Officer and was appointed to this role on 10 January 2022. I am a member of the Trust Board, accountable to the Chief Executive for developing and delivering the direction and management of the Trust's medical services, including the delivery of national, regional and local objectives for the services. I am also the named role for the Caldicott Guardian.

B I have been asked to respond to a Rule 9 Request sent to the Trust as Chief Medical Officer during the time in which I have been in this post. As agreed with the Covid-19 Public Inquiry Team ("the Inquiry Team") by email dated 20 December 2023, the Trust's previous Chief Medical Officer, Dr David Sulch, who was in post from 1.3.20 to 31.11.21, will provide his account of the matters relevant to the Inquiry as set out in the Rule 9 letter separately.

C This statement has been prepared with information gathered from across the Trust and I have consulted with a number of individuals who were in post during the relevant period to inform my response. It should be noted that Dr David Sulch, CMO in post during 2020 and 2021 has provided a significant proportion of the response pertaining to matters in issue as set out in the Public Inquiry's Rule 9 request. His response will be supplied separately.

D. I have prepared this statement using terminology that refers to "Waves", "Covid-19" and "Variants". For clarity, Wave 1 refers to the period from February – July 2020, and Wave 2 to the period from October 2020 – March 2021 (the Trust started to see a rise in admissions between October 12 and October 19). During Wave 1, I refer to the infection of "Covid-19", and during Wave 2, the virus was widely referred to as the "Kent" or "Alpha" Variant, and I have adopted these terms in the paragraphs below to reflect these variants over the relevant period. As the "Delta" Variant was not established until May 2021, this has not been referred to in my statement.

## 1. Background

In relation to Medway Maritime Hospital, I set out below information to provide more detailed information as follows:

1 a. **Size of Population:** Medway Maritime Hospital which is a single-site hospital forming Medway NHS Foundation Trust is based in Gillingham and serves a patient population of more than 427,000 across Medway and Swale.

1 b. **Geographical area:** Medway Maritime Hospital covers a geographical area extending across Medway and Swale. The Isle of Sheppey, part of the Swale Borough, is separated from the rest of Medway and Swale by the Swale tidal channel which is only navigable by a single Sheppey crossing. These two geographical features, allied to transport infrastructure limitations, present specific challenges in making health care accessible to residents. The combined land areas of Medway and Swale covers a combined land area of 565.4 km2, with 26.3km of northern coastline.

1 c. **Demographic characteristics:**

**Ethnic diversity**

According to the latest 2021 population figures published by the Office for National Statistics, the population in Medway and Swale combined is 431,450 with 87.6 per cent of the population being white with non-white minorities representing the remaining 12.4 per cent according to the 2021 census.

| Medway | Count % | % | Swale | Count % | % |
|---|---|---|---|---|---|
| **All usual residents** | 279,773 | 100.0 | All usual residents | 151,677 | 100.0 |
| **Asian, Asian British or Asian Welsh** | 16,484 | 5.9 | Asian, Asian British or Asian Welsh | 2,312 | 1.5 |
| **Black, Black British, Black Welsh, Caribbean or African** | 15,723 | 5.6 | Black, Black British, Black Welsh, Caribbean or African | 3,487 | 2.3 |
| **Mixed or Multiple ethnic groups** | 7,859 | 2.8 | Mixed or Multiple ethnic groups | 2,741 | 1.8 |
| **White** | 235,747 | 84.3 | White | 142,341 | 93.8 |
| **Other ethnic group** | 3,960 | 1.4 | Other ethnic group | 796 | 0.5 |

There are health inequalities between ethnic minority and white groups, and between different ethnic minority groups. People from some ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts. Unpicking the causes of ethnic inequalities in health is difficult. Evidence suggests a complex interplay of many factors including deprivation, environment and health-related behaviours. COVID-19 has shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in deprived and ethnic minority communities.

### Age

In Medway over the 10-year census period 2011 to 2021 there was an increase of 24.3 per cent in people aged 65 years and over, an increase of 1.8 per cent in people aged 15 to 64 years, and an increase of 7.3 per cent in children aged under 15 years.

In Swale over the 10-year census period 2011 to 2021 there was an increase of 27.3 per cent in people aged 65 years and over, an increase of 8.3 per cent in people aged 15 to 64 years, and an increase of 9.4 per cent in children aged under 15 years.

### Healthy Dynamics

Several factors contribute to the general health of the population. Medway and Swale is comprised of rural affluent areas, large low-income coastal communities, densely populated deprived urban areas and, heavy industry with concomitant pollution associated health risks.

Additionally, the topography of the River Medway results in pollution being trapped in the river valley amplifying the effect of respiratory health risks. These environmental factors along with societal factors associated with deprivation (housing, education, employment opportunities etc.) create specific health care demands for Medway NHS Foundation Trust and its system partners.

The health of the local Medway and Swale population is mixed with 13 national indicators of health scoring better and six worse than the average in England. In addition, Medway NHS Foundation Trust provides healthcare services to some of the most vulnerable members of our community across seven prisons and young offender institutions across Kent and Medway. This population have greater health needs at an earlier age than the general population, adding to acute healthcare demands.

1. d **Type of hospital and services provided**

Medway Maritime Hospital is a general hospital which moved from a two to a four divisional structure in October 2023 as set out in our clinical strategy, which comprises:

- Women and Children;
- Medicine and Emergency Care;
- Surgery and Anaesthetics; and
- Diagnostics and Clinical Support Services.

Medway Maritime Hospital provides the following services:

- Acute and emergency medicine
- Breast surgery service
- Cancer services
- Cardiology
- Colorectal surgery
- Diabetes
- Diagnostic and clinical support services
- Elderly medicine (including therapies)
- Ear, nose and throat
- Gastroenterology
- General surgery
- Gynaecology
- Maternity
- Neonatal critical care services
- Neurology
- Orthodontics
- Paediatrics
- Pathology
- Pharmacy
- Peri-operative and critical care/pain management

- Respiratory
- Rheumatology
- Trauma and orthopaedics
- Urology.

Medway Maritime Hospital had approximately 160,000 Emergency Department attendances, more than 60,000 admissions, more than 370,000 outpatients' appointments and more than 4,700 babies born between 2022-2023.

1. e **Staffing numbers**

The Trust has more than 4,400 staff, including 1,451 Registered Nurses and 626 Doctors.

All inpatient wards at Medway Maritime Hospital fell under the responsibility of the Chief Medical Officer for medical staff and the Chief Nursing Officer for nursing, midwifery and AHP staff. I was therefore responsible for all medical staff across all wards from 1.1.2022

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| Responses to Questions 2-47 are set out in the Statement of Dr David Sulch. |

until 30.6.2022.

**48. <u>Recommendations</u>**

In September 2021, the Trust implemented a Covid-19 Policy which included an internal review of Waves 1 & 2 and protocols for addressing Winter capacity and demand planning in advance of a Covid-19 Wave 3. The review included 40 structured debrief sessions with a cross section of staff within the Trust, clinical council, listening and debriefing events with nurses, and divisional sessions on lessons and learning from an IPC perspective. The findings from the Debrief Report informed the Covid-19 21/22 planning. This debrief identified the following decisions that the Trust considered worked well and delivered:

48.1 **Management and Leadership** – It was recognised early on that the standard structure for incident control would not reach or control this event. A Strategic Group which included executive level trained leads established under which there were three main tactical groups: Medical Tactical, Nursing Tactical and Operations Tactical. During Wave 2, an additional Corporate Tactical group was also created. This facilitated escalation from the Tactical Groups to the Strategic Group and the dissemination of information at speed and played a vital role in ensuring rapid response to a changing situation on the ground.

48.2 Tactical group meetings were held early morning with information feeding into Strategic Group meetings mid-morning. An end of day meeting was also held in diaries should this have been required to assess issues identified earlier in the day.

48.3 The Trust also set up response cells, one of which was the Medical Gas Cell. This was formed in January 2020 when oxygen consumption started to go critically high. This engaged the Chief Pharmacist and the Director of Estates and Facilities . The success of this cell was due to its multi-disciplinary constituent representatives with leads from EPRR, Estates, ICU and anaesthetic consultants, clinical engineers, Nursing and BI analysis. The Trust will be adopting this approach in all future Covid-19 incident events.

48.4 Emergency Preparedness Resilience and Response (EPRR) processes worked well during the pandemic. Incident Coordination Centres and Local Health Economy Cells were especially useful and could support future management of Surge and Seasonal Pressures.

48.5 **Information Sharing and Decision Taking** - Although the Tactical teams stood down following Wave 2, the members of staff that sat on the Medical Tactical Group still continued to hold group sessions for the same top level medical staff as they felt the intelligence and information shared regularly has been beneficial even after the main waves of the pandemic. The Medical Tactical Group has since evolved into the Medical Board which reports into the Trust Management Board as part of the Trust's governance structure. For future pandemics the Medical Board would be adapted to provide senior medical input into information and decision taking processes as part of the multi-disciplinary approach to a Covid Response.

48.6 A system was created to monitor COVID patients and bed occupancy. A model was created to plan for COVID activity and this was in place during Wave 1 There was also a live dashboard created on SSRS to monitor patients confirmed positive, suspected, deceased and discharged. The dashboard also included the number of patients in critical care and the bed occupancy – all staff had access and this was displayed in the site office.

48.7 System modelling was completed and a Winter plan created to indicate the potential Wave 2 effect – this was shared internally and regionally and daily 7-day updates were created and reported to Trust Executives and pushed out to the Trust via the

Communications Team around the previous 24hrs and current COVID status alongside any themes/ risks arising.

48.8 The Trust's response to the issue of modelling and monitoring oxygen was to set up a successful multi-disciplinary team to address the oxygen capacity issue in February 2021 as more particularly described in paragraph 17 of Dr David Sulch's statement.

48.9 In terms of reflective learning, a thirst for information created and met during the Covid response is not considered a sustainable practice unless staffing numbers are increased and there is investment into software to pull the data together in any future incidents.

48.10 **Communications** - Early on in Wave 1, it was decided that a Covid-specific bulletin would be created to be sent to all staff following Strategic Group Meetings to cascade information and guidance out to staff directly without having to go through a chain of command. This worked well and staff have commented that this was a good source of information for them.

48.11 Publishing the numbers of Covid patients daily was an important tool for staff morale and helped them to feel included in the response. Some staff reported that it helped to see the data on numbers, others felt informed, and in other cases it was explained that although the increase in numbers was worrying, it served to reassure staff when the figures started to decrease.

48.12 A number of staff suggestions were proposed for future communications within the Trust. One such suggestion was for staff bulletins to be separated into sections, highlighting whether messages were related to medical, nursing, or support staff, to help triage the information within the bulletin. Another suggestion was for information to be condensed so that each bulletin prioritised only 3 key messages, in order of importance, with the remainder being available to download separately.

48.13 With regards to the strategic direction from regional and national communications, there needs to be real clarity and direction and it "can't be too much next time". The NHSE team leading the communications response should be crystal clear regarding their purpose and what's expected of the local teams and also give regard to the local communities of each Trust.

48.14 **Staff and Staffing** - It is acknowledged throughout the Pandemic response that staff morale within teams was strong despite being at the heart of the effects of the Alpha (initially called the Kent) Variant and staff accepted that there was very little that could have been done about staff numbers on wards.

48.15 Through discussions with ICU leads, it was recognised that out of a 12 doctor rotation, not one of them shielded through Wave 1 or Wave 2, despite the fact that some of the team could have stayed away under local risk assessments if they had had wished to do so.

48.16 The Vaccination Hub was recognised by staff as a success and a symbol of "things finally getting better" rather than the thought of the pandemic going on and on indefinitely.

48.17 Clinical and non-clinical NHS staff provided flexibility and deployed into roles that differed to their main employment to support the response to the incident e.g. surgical staff redeployed into Medical roles; Nursing staff into different nursing roles; and Business Intelligence and Human Resources staff into support roles.

48.18 Flexible and virtual working has been a great success, but some inequities between those who were able to work from home working and those who needed to attend the workplace surfaced.

48.19 An action to take forward is for staff at all levels to participate in training and exercising to ensure incident decision making is practiced. There should also be an increase in the frequency of incident management training so that this is not forgotten.

48.20 The Trust had a very good workforce tool, which projected staff sickness by reference to staff group and area with a 7-day look forward. This tool was limited to the Trust, and an ICS approach to workforce profiling and mobility may benefit the wider healthcare community. This was lacking throughout the pandemic, and Trusts were often left to manage the workforce issues themselves with little or no support.

48.21 **Capacity and Demand** - The decision to stop Elective Care gave the Trust a chance to focus on its covid response in the first wave and this helped support capacity where, for instance, staff could be redeployed from theatres to support ICU staff who were hit hard in the first wave.

48.29 **Partnership Working** – One positive partnership working during Wave 2 was the support of military personnel working within the Trust. The military worked in the Emergency Department and across the wider Trust to support with non-clinical tasks, such as arranging for swabs and other tasks which freed up clinical time. Culturally, it was also noted the military style of approach with "just getting on and getting the job done".

48.30 The Vaccination Hub facilitated 35,000 vaccinations from a single site which gave the staff a strong sense of pride and accomplishment. Ensuring that the Trust had similar capability in the event of a further incident would be an effective IPC tool.

48.31 Dynamic conveyancing and the 4 hourly night time calls with the Site team gained a level of stability and control over the situation but it was felt that both of these should've been proactively in place earlier in the response rather than reactively at the height of Wave 2.

48.32 **Empirical Data –** Outbreaks at the Trust during Wave 2 were occurring despite more developed IPC understanding and compliance, and more availability of PPE. This led us to declare at an Outbreak Meeting attended by regional health staff where it was noted that something had changed in the local area of Medway in October 2020, since we had more Emergency Department visits, more admissions, and more in-hospital spread . It was suggested that Public Health officials should investigate what was going on as a matter of urgency. At this time, Trust staff felt that highlighting these concerns led to criticism that the Hospital wasn't doing enough to control the outbreak, rather than being commended for noticing the patterns of change. It then transpired that Public Health England declared the emergence of the Alpha Variant, although no recognition was given to the Trust for our epidemiological awareness and noticing the change in viral behaviour when we did.

48.33 **Afterword** - I am aware from my discussions with many colleagues at the Trust that there was a collective sense that the initial response to Medway Maritime Hospital by national bodies and other decision-makers within the healthcare system was not positive, and the Trust was assessed somewhat critically in the context of our infection control practices. As one of the first affected hospitals in the country to experience the Alpha Variant, I am aware that some colleagues have used strong words such as "blame" and "abandonment" in what were extremely difficult and challenging circumstances. Dr David Sulch has addressed this point further in his statement but I

48.22 Discharge of Acute Hospital patients into Social Care created capacity - National Guidance to discharge from acute hospitals into social care was followed.

48.23 It was felt internally that it helped when the analytics between various groups within the Trust came together it was far more accurate than the Government's projected peaks of cases. This gave a sense of assurance through both waves that the Trust had people "on the case, who knew what they were doing".

48.24 It is agreed that the Trust should model on a more granular level in the future to take into account oxygen consumption amongst other granular details associated with a response.

48.25 **Equipment** - Generally the Critical Care Network across the South East worked really well, the ICU lead at the Trust would like to give special mention to East Kent Hospitals who stepped in to assist upon the onset of the Alpha Variant in regards to taking transfers via mutual aid which was invaluable to the MFT team.

48.26 The procurement team have suggested one single route of dissemination into Trust due to procurement requests and conversations coming down the chain through multiple routes (similar to the Critical Care transfer conversations) which during the pandemic wasted already stretched resources.

48.27 **PPE** - Local procurement teams worked tirelessly, but there were challenges accessing PPE, difficulties caused by changes in national guidance on the use of PPE and variations in advice to different organisations, and challenges presented by the need to 'fit test' a wide range of different face masks.

48.28 PPE Stewards were introduced in April 2020, Inspired by the Breathing Apparatus Entry Control Officer role used in the UK Fire Service. Gloucester Hospital NHS FT came up with the idea of a PPE Steward which entailed the appointment of a registered nurse/midwife, free of all other responsibilities, on a rotating basis who was competent and confident to support clinical and non-clinical workers to safely use PPE. The PPE Steward delivers ward-based advice on a rota basis. Further details of the role profile is set out in Exhibit INQ000469932. The highly visible presence of a PPE Steward, accessible at the point of care provided staff with a sense of reassurance and security at a very uncertain time.

consider it appropriate to raise here in terms of recommendations as to how we do things better going forward.

**Statement of Truth**

I believe that the facts stated in this witness statement are true.

Signed Personal Data

ALISON DAVIS

Dated 24/04/24