Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MICHAEL VAN DER WATT

I, Michael Van Der Watt, will say as follows: -

1. I have been the Chief Medical Officer of West Hertfordshire Teaching Hospitals NHS Trust (formerly West Hertfordshire Hospitals NHS Trust) ("the Trust") since 2013. I joined the Trust in 2000 as a Consultant Cardiologist.

2. The Trust is an acute Trust with three hospital sites, Watford General Hospital ("Watford"), Hemel Hempstead and St Albans. Its main site is Watford which this statement specifically deals with.

WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST: WATFORD GENERAL HOSPITAL AND ITS POPULATION

3. Watford provides unplanned emergency care for the whole of the Trust catchment area including Watford, Hemel Hempstead and St Albans. It serves a patient population of over 500,000 people. Demographically, the population served by Watford is growing, aging, and ethnically and socially diverse. There are pockets of socio-economic deprivation, but overall deprivation falls within lower levels.

4. During the relevant period, Watford employed over 4900 staff and almost 600 volunteers. Services were and continue to be delivered across all 3 hospital sites, and staff frequently work from more than 1 site. At the start of the period in question, Watford had 613 beds and 9 theatres, delivering inpatient and intensive care, planned care for higher risk patients, women's and children's services, plus

outpatient and diagnostic services. Of the 613 beds, 19 beds were ICU beds, 16 of which was occupied.

5. The main Watford site has the following wards:
   - Intensive Therapy Unit ("ITU")
   - Acute admissions Unit: 2 levels each with 4 bays
   - Medical wards: 16
   - Surgical wards: 6
   - Women's and children's wards: 5

   A map of the site is exhibited to this statement as [MVDW/1 – INQ000414365].

6. In 2019/20 at Watford there were 106,011 emergency attendances plus 289,002 outpatient attendances. 53,066 non elective patients were treated and 30,239 patients received planned treatment in an inpatient or day case setting. Trust wide figures were shared in the 2019/20 Annual Report.

IMPACT OF COVID ON WORKFORCE CAPACITY, RECRUITMENT AND DEPLOYMENT

7. During the relevant period, staff shortages were experienced most notably in the intensive care unit ("ICU"), the Emergency Department ("ED"), and in healthcare sciences as some staff were self-isolating and some shielding. These shortages primarily affected doctors, nurses, healthcare assistants and biomedical scientists. They were almost exclusively as a direct result of the pandemic. In March 2020, the Emergency Medicine Division had a 10.3% vacancy rate, the Medicine Division had a 7.0% vacancy rate and the Surgery, Anaesthetics and Cancer Division had a 9.2% vacancy rate. Staff that were not required in their usual workplace, i.e. outpatients, were redeployed to other areas to mitigate staff shortages. Also staff unable to work in front facing roles were found alternative roles, such as the COVID hub. Some of the vacant posts were temporarily covered by bank staff. I exhibit to my statement a table of vacancy rates by department for December 2019 – April 2020 [MVDW/2 – INQ000414376].

8. In its early stages, diagnostic testing of staff for COVID-19, which began in April 2020 under national direction, did impact on workforce capacity. Antibody testing of staff which commenced some weeks later demonstrated that approximately 30% of staff

had by then been exposed to the virus and had developed antibodies. Antibody testing did not significantly impact on capacity or deployment at Watford.

9. All recruitment was paused temporarily when the first lockdown was implemented whilst new and temporary measures were developed which allowed the Trust to recruit remotely. Interim pre-employment checks as set out by NHS Employers were created which allowed for remote checks to be undertaken instead of face to face which was the usual practice.

10. There were constraints on the ability of Watford to increase staffing capacity. Recruitment of overseas nurses was stopped due to border controls across all countries. As recruitment restrictions were eased, the Trust saw fewer candidates, with people less likely to switch employers during the initial COVID phase.

11. To alleviate capacity challenges in the medical workforce at Watford, doctors and nursing staff were redeployed to areas with the greatest need and they were required to work outside their practice area. Regional support included redeployment of GP trainees from the community back to Watford. Junior doctor rotations were also paused in April 2020. Non-clinical staff were largely moved to home working very early on. This presented practical challenges linked to availability of equipment, digital connection and information governance constraints. A register was created by NHS England along with the Integrated Care System to allow student nurses, student allied health professionals to work in the NHS to support workforce during a very difficult time. Students were given a choice of work area. These initiatives did provide some assistance in alleviating staff shortages. The private healthcare sector was not used to increase staffing capacity.

12. A memorandum of understanding was created across the region to allow for the deployment of staff to other hospitals when needed. Additionally, each hospital was required to hold a reservist list dedicated for Nightingale deployment should it become necessary, potentially exacerbating staff shortages. Ultimately, no Nightingale deployments were necessary. Staff were anxious and some scared to move clinical areas where COVID patients were being treated. Where staff were redeployed to St Albans City Hospital, which was a designated COVID controlled zone, they were required to test before each shift.

13. Challenges did arise in staffing ITU and other nursing areas and the Chief Nurse had to reduce the ratio of nurses in some areas, particularly when staff themselves were off sick with COVID. Pre-pandemic nursing ratios in ICU were in accordance with the Guidelines for the Provision of Intensive Care Services (GPICS), produced through a collaboration between The Faculty of Intensive Care and The Intensive Care Society, This means that there was 1:1 nursing provision on ICU for level 3 patients and 1:2 provision for level 2 patients. The staffing in other nursing areas was managed using revised safe staffing templates which were flexed according to the needs of the different areas. During the pandemic period, the Trust worked to staffing levels in accordance with national guidelines set out in the COVID-19 NHS England staffing assurance framework 'Deployment and assurance of clinical nursing workforce during the COVID 19 emergency (February 2021)'. Twice daily safe staffing meetings took place and a monthly tabletop meeting was also held. This was chaired by the Chief Nurse with the purpose of agreeing staffing templates. The templates took into consideration the professional judgement of clinical leaders, patient need and the skills required to meet that. The environment of care was also a consideration. Staff numbers varied from ward to ward and day to day, depending on ongoing professional judgement of patient need and the necessary skill set. Staffing was not determined by set ratios, the mechanism was instead fluid and responsive to change in demand.

14. 36 members of staff were absent during the period with Long Covid. This contributed to localised staff shortages in affected teams. Watford sadly lost 6 staff colleagues during the pandemic; an outpatient administrator, a nurse, a biomedical scientist, a housekeeper and two healthcare assistants. This of course had a significant effect on other staff.

15. The proposed legislation for COVID-19 vaccination as a condition of deployment impacted negatively on the morale of some staff. I attach to my statement an update from NHS England and NHS Improvement on the proposed legislation [MVDW/3 – INQ000414383]. The hospital adopted the national policy and not a local policy. To assess the impact, steps were taken to establish how many staff would decline the vaccine. I attach to my statement guidance that was issued to line managers when discussing the vaccine with members of staff [MVDW/4 – INQ000414384]. Less than 1% of staff indicated they did not intend to have a vaccination and therefore would be unable to continue in their role. Feedback sessions called 'here for you' were held and demonstrated that at least some of those not wishing to take the vaccine felt

devalued and that they felt forced to accept it in order to secure their positions. Some expressed the opinion that their personal circumstances and beliefs were not prioritised, and raised their concerns with the Chief Executive. The hospital worked with colleagues to provide one to one support, frequently asked questions and myth busting information was made available. Hospital staff networks helped by providing safe space conversations where individuals could talk through their concerns with peers. This approach had a positive impact.

16. I am not aware of problems in relationships between vaccinated and unvaccinated staff.

PATIENT SURGE, HOSPITAL ZONING AND VIRTUAL HOSPITAL

17. During the first wave of COVID 19 (March 2020 – August 2020), the Trust admitted to the Watford site more than 600 COVID-19 patients and in the height of the second wave (in early January 2021) a further 880 between December 2020 and January 2021. Capacity of critical care was doubled, with expansion of the ICU into a number of areas. 19 ICU beds were available prior to the pandemic. This was increased to a maximum of 35 in the first wave and a maximum or 34 in the second wave. Patient safety was constantly of concern and under review as the numbers needing intensive care increased.

18. On 17th March 2020, NHS England/Improvement circulated a discharge policy in response to rising COVID-19 cases. On that day, of 629 general beds at Watford, 538 were occupied. Of 22 ICU beds, 9 were occupied. One week later, on 24th March, of 585 general beds available, 455 were occupied, leaving 130 beds free. There was variation in the total number of general beds available because infection prevention and control protocols necessitated periodic closure of beds and bays to limit hospital acquired infections. Of 27 ICU beds, 17 were occupied leaving 10 ICU beds free. During the period under review by the Inquiry, 64 patients were transferred out to the ICU of a different hospital and 48 patients were transferred in. Many of these transfers occurred within the Region's Critical Care Network. Prior to the NHS England discharge notice being released, steps were being taken to increase bed capacity as COVID was already making a significant impact on admissions. Bed capacity was monitored routinely and daily integrated multiagency bed meetings took place when capacity levels were triggered. The trigger would be

when demand exceeded capacity and would be agreed as a collaborative decision between an ITU consultant and a senior ITU nurse in communication with the outreach team. Assessments of capacity were not based solely on bed numbers, they incorporated situational, professional judgement influenced by clinical levels of need and the available staff pool to meet that need. The multiagency bed meetings aimed to facilitate discharges, as did 'fresh eyes' floor walks to identify patients fit for discharge or relocation. The 'fresh eyes' floor walks involved a senior clinician, a senior nurse and a member of the integrated discharge team. This group of professionals would assess patients on a ward to establish whether any were medical fit for discharge, or were awaiting packages of care to be delivered at home or with an alternative provider. Those patients well enough to go home would be discharged and those needing packages of care or 'step down' care would be flagged to the discharge team for coordination with the relevant organisation. The 'fresh eyes' approach was initiated before COVID and continues to take place when demand exceeds capacity. The primary purpose of the 'fresh eyes' approach is to improve patient flow and it is a method which has been in place for several years, initiated before COVID, it was however particularly helpful during the early stages of the pandemic, when there were many discharges. As time went on discharge restrictions were put in place. The 'fresh eyes' approach then ensured that once the discharge conditions were right, there were no unnecessary delays,

19. It became evident in the spring/summer of 2020 that the number of patients with COVID-19 in the geographical area that Watford served, was very high compared to regional and national figures. A COVID admission pathway was established early on and continually evolved from April 2020 until April 2022. The pathway was initiated at the moment a patient was referred or received after a positive diagnosis. It utilised measures including oxygen saturation, obesity, age, respiratory rate and stroke history to obtain a risk score and place the patient on a specific branch of the pathway. This risk score is also termed the SOAR score to reflect the measures used. The SOAR score was developed to correlate COVID severity across low, medium and high risk of mortality and discriminated well with in hospital deaths. Patients with milder disease scored between zero and one. These patients could be identified as safe for outpatient monitoring. Prediction of a non-fatal outcome in this group was 99.2% The COVID admission pathway addressed initial management, escalation decisions, supported ventilation requirements, ceilings of care, active treatment with medications and medications for palliative care. Oxygen saturation therefore contributed to the type of intervention provided and to whether or not this

intervention included hospital admission. A copy of the pathway is exhibited to my statement as [MVDW/5 – INQ000414385]. While patients awaited a COVID-19 test result, they would be cared for in the appropriate place, depending on their risk profile. This could mean being cared for at home if stable, in a ward area if intermediate, or in ITU if ventilated. The diagnosis did not determine the place of care, this was determined instead by the patient's clinical status. A COVID suspected patient would however be cared for in cohorted areas for infection control.

20. Steps were taken to increase the number of ICU beds and ensure capacity at Watford. This was a local initiative to begin with, but subsequently national guidance was issued. ICU mobilisation plans were drawn up in March 2020 and initially included increasing capacity utilising theatre recovery areas, then day surgery, theatres and the endoscopy unit. A copy of the mobilisation plan is exhibited to my statement as [MVDW/6 – INQ000414386].

21. Local critical care surge standard operating procedures versions 1-7 were sequentially drafted as the pandemic evolved and as more effective reconfigurations were designed. Changes to ICU admission criteria were set out in each. The standard operating procedures focused on reconfiguration of ICU beds, consolidation of patients by type and sickness levels, enabling improved staff efficiency, improvement patient flow and providing a recognised pathway for recovery. By 21 April 2020, ICU bed capacity had increased to 35 bed spaces with 20 in ICU, 4 in day surgery, 6 in theatres 3 and 4, and 5 beds in main theatre recovery. By May 2020, ICU had expanded into the Endoscopy suite. With each revision of the critical care surge standard operating procedure, a revision to the associated critical care infection control standard operating procedure was made. The key changes to the standard operating procedure related to allocated areas, overall staffing and equipment requirements. I exhibit to my statement standard operating procedure version 1 [MVDW/7 – INQ000414387], version 2 [MVDW/8 – INQ000414388], version 3 [MVDW/9 – INQ000414389], version 4 [MVDW/10 – INQ000414366], version 5 [MVDW/11 – INQ000414367], version 6 [MVDW/12 – INQ000414368], and version 7 [MVDW/13 – INQ000414369].

22. The Trust is part of the East of England ITU Network. NHS England was very supportive when ITU capacity was under pressure. NHS England ran the East of England ITU Network and when capacity was exceeded, the network coordinated the

transfer out of patients to other trusts with capacity in the network. Equally, the hospital provided support to other hospitals when appropriate.

23. During the relevant period, the threshold for transferring out to other hospitals was 92% of ICU capacity, which allowed Watford to always have an admitting bed for those patients that were too unwell to transfer. The Trust baseline for occupancy to enable fast admissions to ICU is 85%. As mentioned above, 64 patients were transferred out to the ICU of a different hospital and 48 patients were transferred into Watford during the relevant period. In the first wave, patients were only transferred out because of capacity limitations during the oxygen incident which is discussed in paragraph 84. Expansion of ICU meant that transfers out at other times during the first wave were not necessary. During the second wave, there were 48 capacity transfers out to other hospitals. The Trust aimed for a maximum bed occupancy of 85% in ICU. When occupancy reached 92%, patients were transferred out, this ensured that occupancy did not reach 100%.

24. A local decision (subsequently ratified by national guidelines) was made to pause routine and non-urgent elective care on 23 March 2020An isolation unit was established, where patients requiring Optiflow (heated and moistened air or oxygen) were treated and the hospital was then divided into zones for the treatment of COVID and non-COVID patients . A local private provider, Spire Bushey, was contracted from 1 April 2021 to undertake elective urgent planned procedures and cancer care. This contract ran until 30 September 2021 and when it expired, a new Spire Bushey contract was agreed, led by Herts Valleys Clinical Commissioning Group on behalf of West Hertfordshire Hospitals NHS Trust and East and North Hospitals NHS Trust. Over the period in question, 2768 patients were treated under this contractual arrangement.

25. The Trust sought innovative solutions to reduce admissions safely for patients presenting with COVID-19 and to enable safe early supported discharge of suitable patients from the wards for their treatment safely from home. This led to the creation of a highly successful Virtual Hospital with the first patient seen on 14 March 2020. The Trust's research and use of the Virtual Hospital model was well publicised both in the scientific and medical community and on the national news.

26. The initial pilot for the Virtual Hospital required the team to call every patient daily but with increased technology and product development, the Virtual Hospital came to

utilise oximetery (to measure blood oxygen through light transmission) and HUMA MEDOPAD-designed software with a patient-facing app in combination. Oximetry was used from 14 March 2020, but in combined use with the app, remote monitoring became much easier. The Virtual Hospital enabled patients to recover at home whilst keeping the respiratory team looking after them fully updated via the app. The provision of treatment and care from home was specific to each patient and generally followed a schedule for uploading key health data including heart rate, temperature and oxygen levels in their blood using an oximeter. Any subtle changes in patients' symptoms were detected by algorithms on the app, sending alerts when measurements moved out of a set range thus alerting the medical team of any concerns. Monitoring of patients' symptoms in this way enabled patients to be transferred to hospital if needed or for an online consultation to be arranged. I exhibit to my statement the standard operating procedure for the Virtual Hospital [MVDW/14 – INQ000414370] and a list of questions asked of patients following their admission to the Virtual Hospital [MVDW/15 – INQ000414371].

27. Creation of the Virtual Hospital helped prevent Watford from becoming overwhelmed by the Covid-19 pandemic and had a significant impact on the Trust's pandemic response with 4591 COVID admissions at Watford, saving 37,194 bed days. For clarity, a patient could be admitted on more than one occasion, so 4591 admissions is not necessarily equal to the number of COVID patients admitted to the Virtual Hospital. The service was staffed by respiratory consultants, specialist nurses and physiologists. Rotas were made and there was good continuity of care. Specific Virtual Hospital training and ongoing support was provided for doctors and physiologists from March 2020. Training was provided via webinars and face to face. Policies, standard operating procedures and question and answer sheets were created to support. Regular supervision and team meetings occurred, along with regular case discussion. I exhibit to my statement a copy of the Virtual Hospital Report as [MVDW/16 **INQ000470239**]. This report draws the following conclusions: An observational study of a real-world remote monitoring virtual hospital service, with a sample size of 900 patients demonstrated that it was possible to set up a service providing a safety net to both provide a safe alternative to hospital admission and support early discharge. The 900 patients included 455 patients admitted directly from the community and 445 admitted to virtual hospital after an inpatient admission. Patients were followed for 15-46 days. Virtual hospital services resulted in a low incidence of deaths (18 patients, 2.0%) and in readmissions (76 patients, 8.1%) overall. When planning and commissioning services in primary and secondary care

to manage patients with COVID-19 during this ongoing pandemic, the study suggested that the risk factors for deterioration identified, namely age, significant renal impairment (CKD stage 4–5), history of cancer and history of mental health problems, may be of use in helping to identify those requiring more intensive follow-up and monitoring. The study however was considered to be underpowered to detect all predictors and the sample size was relatively small with two cohorts. The report recommended that the findings be validated using an external data set.

28. I am not aware of any concerns or issues raised about the Virtual Hospital Service.

29. During the first wave of COVID in particular, there were shortages experienced with CPAP (continuous positive airway pressure) machines, leading to the use of Optiflow. There was additionally a shortage of ventilators, End Tidal CO_2 monitors, oxygen and other medical equipment and medicines, with some items like heat moisture exchange filters and the drug Remdesivir (an antiviral) later in short supply nationally.. Remdesivir shortages were managed through a Trust approval panel ensuring strict adherence to inclusion criteria set out in the Interim Clinical Commissioning Policy. The heat moisture exchange filters used preferentially were swapped for more available alternatives. There was a regional standard operating procedure in place to protect the supply of specific haemofiltration consumables and haemofiltration fluids, which involved a centralised allocation process with notice periods. Before COVID the hospital had 28 ventilators but eventually during the first wave it became possible to purchase a further 4 to meet demand. On three occasions during COVID, the ICU needed to use anaesthetic machines and non-invasive ventilation to support patients because of a shortage of ventilators. This response was decided upon within the Trust. At that time, it was not possible to obtain additional machines. As an alternative method of ventilating patients using anaesthetic machines was possible, all patients who required ventilation received invasive support and therefore, to the best of my knowledge, no patients came to harm.

30. Renal equipment also presented difficulties. During the first wave, Watford was rotating renal equipment, running cycles of 12 hours and then changing patients. When the renal replacement filters began being issued from a central point, this became more challenging. Supplies were less readily available and it became necessary to borrow stock from neighbouring Trusts. No patients came to harm as a

consequence of rotating renal equipment or from the need to borrow supplies. The Trust did not need to restrict access to renal support due to mitigations put in place.

MANAGEMENT OF INFECTION PREVENTION AND CONTROL, TESTING AND NOSOCOMIAL OUTBREAKS

31. During the relevant period, Watford followed national guidance for infection prevention and control ("IPC") and undertook risk assessments for staff wearing FFP3 (filtering facepiece) masks.

32. Dissemination and implementation of IPC guidance to staff, including any changes, was shared via electronic updates and posters in all areas. Changes to IPC guidance happened on various days of the week and various times of the day. In all cases, even if it was late on a Friday afternoon, as soon as the hospital was made aware of the change, an email communication was sent to all staff and a revised, laminated chart put up on each ward, setting out the requirements. This information was also reported in the Infection Prevention and Control Board Assurance Framework, which was shared at the Trust Quality Committee. Guidance was communicated through the Trust's regular online staff briefing 'Live for 5' delivered by the CEO and members of Executive Team. Microsoft Teams meetings were held with particular staff groups, and Infection Prevention and Control Team members also visited clinical areas. There were some challenges in disseminating IPC guidance to staff as not all staff had access to email or to a computer. Walk rounds and posters were particularly helpful in addressing this challenge.

33. Code of practice audits were undertaken, which included PPE compliance, the cleaning of equipment and the physical environment. The results were triangulated with transmission rates and risk factors and areas that were found to be below standard were provided with extra infection prevention and control support and educational sessions. Every outbreak and cluster was considered to be a trigger, During the period 12 outbreaks and 7 clusters were identified.

34. Implementing IPC guidance was at times difficult due to layout of wards and waiting areas. Maintaining 2 metres between bed spaces was not always possible. In these circumstances, barrier curtains were used. Ward ventilation was below the required

standard and ventilation risk assessments were completed both overarching and for specific areas. Mobile HEPA filters/air scrubbers were used in partial mitigation. There were also specific risk assessments in theatres where issues were identified. Some areas did not have separate entrances and some waiting areas needed to be segregated using screens. In some outpatient areas specific risk assessments were needed in the context of room type and procedures carried out. The specific dates when ventilation risk assessments were carried out is not available.

35. The age of the hospital buildings at Watford and their layout meant issues with shared bathroom facilities which necessitated enhanced cleaning regimes. Such regimes were also implemented in public areas and areas of high footfall. Lobbies were created to support "Donning & Doffing". Entrances to ward areas and other parts of the building were segregated to enable zoning. I attach to my statement the hospital one reconfigurations for May 2020 [MVDW/17 – INQ000414372] and for January 2021 [MVDW/18 – INQ000414373]. Risk assessments were undertaken regarding the lack of single rooms at Watford and also, the lack of rooms with en suite facilities.

36. A staffing matrix was in place during COVID and COVID templates were developed for staffing in view of the changes and challenges. This helped to ensure that areas were adequately covered despite the reconfigurations and changes to layout.

37. In line with national guidance, PCR and lateral flow COVID-19 testing of asymptomatic staff was introduced as an infection control measure. For patient-facing staff at Watford, this began in the week commencing 23 November 2020. These members of staff were asked to test twice weekly. As new guidance was issued, policy changed. Testing of symptomatic patients was also in line with national guidance and all risk assessments and algorithms went through the Trust's Clinical Decision Panel (see further below) and Incident Management Team meetings. There were no known shortages of test kits, reagents or other testing supplies during the relevant period.

38. Delay to test results being available to clinical teams was not an issue, although there were several occasions when the PCR machines broke down. Mitigations were in place however and a move was made to lateral flow testing in keeping with national guidelines. The immunocompromised and those in enhanced care areas or

those needing enhanced care were prioritised for testing. This was reported upon regularly within the Quality Committee.

39. The frequency of staff and patient testing was according to national guidance and similarly with other testing aspects. As the guidance changed, so too did Trust risk assessments and algorithms at Watford. Hospital policy did not differ from national guidance at any time. By way of example, I exhibit to my statement a risk assessment concerning the step down of screening regimes in line with national guidance on "living with covid" [MVDW/19 – INQ000414374].

40. In response to nosocomial outbreaks, 2 thematic reviews were undertaken in February 2020 and December 2022 covering the periods July 2020 – May 2021 and August 2021 – July 2022. I exhibit the reviews as [MVDW/20 – INQ000414375] and [MVDW/21 – INQ000414377] respectively. The reviews identified 650 cases, of which 109 were categorised as serious incidents on the basis that COVID was the primary or contributory cause of death. Under the Serious Incident Framework (2015), a serious incident was defined as if a patient had come to severe harm, i.e chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or - psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days). The Trust reported 12 outbreaks and 7 clusters during this period. The term cluster was defined in Public Health England (PHE) guidance as the detection of unexpected, potentially linked cases. PHE noted that some cases and clusters of communicable disease may not require a formal outbreak to be declared. Such cases must be appropriately recorded and managed for audit purposes and to support surveillance and any future outbreak management. An outbreak is defined in PHE guidance as two or more cases in a single setting (for example, in a single ward or having shared a location) that have become symptomatic or detected on screening on or after day eight of hospital admission. 8 outbreaks were declared as serious incidents. Of the 650 cases identified between July 2020 and May 2021, 450 were associated with outbreaks and clusters; this included 47 of the incidents declared as individual serious incidents. The remaining 200 cases during this period were not part of an identified outbreak or cluster, and this number included 62 of the incidents declared as individual serious incidents. Outbreak and cluster investigations identified six common themes. These

were inconsistent standards related to PPE use, missed/late screening (day 5-7), environmental issues including bays with no doors, multiple introductions of COVID infection to areas, movement of patients around the hospital and within ward areas, staff movement between areas, predominantly enhanced care workers. The Trust took steps to monitor the process for assurance purposes including infection prevention and control audits and walk rounds by senior managers and members of the executive. A check and challenge culture was adopted with staff encouraged to challenge each other. Compliance with screening was monitored by the COVID hub screening team and reported back via divisional governance arrangements and board reporting. Concerning the environmental issues including bays with no doors, screens were implemented at the end of bays to encourage good infection prevention and control practices and a reminder to remove PPE and encourage hand hygiene. The Trust conducted infection prevention and control risk assessments to reduce movement and management of contacts. In addition, a screening regime of any patient re-admissions or transfers to areas was in place. Furthermore, a reduction of patient movements was actively put in place and patients were screened before being moved to different areas. Also, the allocation of staff to dedicated areas was overseen by the deputy chief nurse and heads of nursing and extra screening regimes of staff that were required to move around the organisation was established.

PERSONAL PROTECTIVE EQUIPMENT AND RESPIRATORY PROTECTIVE EQUIPMENT SUPPLY AND CHALLENGES

41. Personal Protective Equipment ("PPE") was initially obtained from NHS Supply Chain, subsequently supply was contracted out to Clipper by NHS England. PPE was delivered on a 'push' stock basis for the first year of COVID. The push stock system resulted in shortages and surpluses, and was very heavy on administrative time for hospital staff. Over time, a system which allowed Trusts to order what they needed was developed. This was called Palantir. Palantir continued until March 2024 and worked very well for a year or more.

42. The Trust's Procurement Team attended weekly meetings with the East of England Procurement Hub which allowed utilisation of mutual aid. The Team is Integrated Care System ("ICS") based, so was able to borrow from and lend PPE to East and North Hertfordshire NHS Trust and The Princess Alexandra Hospital NHS Trust.

43. A large amount of PPE was purchased directly from suppliers in the early months of COVID. Later using the Palantir system, the delivery period was always acceptable. If the PPE was available, it took 2 or 3 days to come.

44. Hundreds of calls were made over the relevant period to the National Supply Disruption Response ("NSDR") call centre (the emergency request system) and certain PPE items such as gowns were only available in this manner. This process was cumbersome and PPE was delivered to incorrect locations many times. There were several examples of PPE being delivered that was unfit for purpose and NHS England emailed around asking for PPE to be quarantined on a number of occasions.

45. Pre-pandemic all FFP3 fit mask testing was managed within Watford by the Health and Safety Team, part of the Division of Environment with a small number of appropriately trained staff. From the start of the pandemic, it was apparent that the manufacturer of the FFP3 that the Trust was using could not provide adequate supply so various other manufacturers had to be used, which meant an individual might need several different face fittings.

46. From April 2020, the Trust began to experience a shortage of FFP3 masks. The shortage meant that half face masks were issued. Fit testing for half masks had already started from 24 March 2020. This required a decontamination unit to be designed, built, and made operational within a period of three weeks. Over 4,500 mask cleanings and over 11,000 cleanings of re-usable eye wear took place up to August 2020. The half masks were phased out as they were difficult to wear and were not good quality, and powered air purifying respirator ("PAPR") hoods were issued in April 2020 to critical medical and nursing personnel who could not wear any of the available FFP3 masks. The shortage of FFP3 masks continued until around April 2022 and the decontamination unit remained in use until July 2022. There were no concerns raised by staff around a shortage of FFPs masks as every effort was made to locate supplies and therefore staff were not aware.

47. Priority for fit testing was given to high-risk areas such as ICU, A&E, theatres and all other COVID-designated areas in January 2020. However, from February/March 2020, fit testing was ultimately offered to all staff for their safety and assurance.

48. In April 2020, after extensive accreditation checks and risk assessments, the Trust engaged the services of an external contractor called 'Ease' to manage the fit testing demand. Ease facilitated a schedule 7 days a week from 7.00am and, when required, evening sessions to ensure staff on all shift patterns could be provided for. At least 30 staff could be fit tested per day, approximately 200 staff per week if all appointments were filled.

49. The Trust liaised routinely with Ease to ensure consistency with the testing programme and provide assurance on compliance with FFP3 requirements and staff safety. The majority of fit testing was undertaken at the Watford site.

50. In early February 2021 NHS England issued new guidance on valved masks both respirator type and FFP3. As a result the CFO1 full face respirators, the HY 9632 FFP3 masks and the PAPR hoods were suspended from use. To ensure the ongoing safety of our staff, stock of non -valved masks was secured and fit testing commenced on these as soon as they were available within the Trust.

51. Ease continued to provide a reduced fit testing programme to the Trust to ensure that new starters, compliance with test expiry dates (over 2 years) and mask changes were adequately covered at Watford. This arrangement continued until the end of 2022, the Trust then engaged the services of Ashfield Health and RPA, an accredited training company. These were part of the Supply Chain Coordination Limited (NHS Supply Chain), FFP3 Fit testing Teams where the option of free testing and training was available.

52. While Ashfield Health supported a fit testing programme, RPA supported in facilitating 'Train the Tester' training. At the end of this training the Trust had 27 'Fit to Test' trained staff in place.

FACILITATION OF CONTACT BETWEEN PATIENTS AND THEIR LOVED ONES DURING VISITING RESTRICTIONS

53. NHS England guidance changes regarding visiting and restrictions were adopted and shared on the Trust intranet and reviewed at Incident Management Team meetings. Watford did not produce its own visiting guidance during the relevant period. To facilitate contact between patients and their loved ones, there was a volunteer HUB

and message to a loved one, along with a family liaison line and a visiting helpline. 250 iPads were purchased to enable patients and their families to video call and maintain visual contact. For patients with communication difficulties, cognitive impairments, or limited English, a variety of communication methods were used, including language line and translators, in order to facilitate communication between patients and hospital staff.

54. For patients approaching end of life, the paired hearts initiative was created. The patient and their families were given matching handmade paired hearts, one stayed with the patient; and the identical other was given to the patient's family. This enabled them to symbolically hold each other's hearts in their hands since they could not be together. Visiting restrictions during the Coronavirus outbreak meant many patients and their families were separated at the worst possible time. This initiative helped patients feel more connected with their relatives, and given the restrictions that were in place, was generally well received by family members and loved ones. Visiting restrictions however were extremely difficult for patients and their families and inevitably led to significant emotional distress Staff also found the restrictions distressing at times, particularly in end of life situations.

55. As NHS England visiting guidance changed, digital updates were provided by the Communications Team. Revised guidance was also made available on the internet. A visiting standard operating procedure was available and posters were used. The policy was reviewed each time national guidance was updated. A copy of the visiting process is exhibited to my statement as [MVDW/22 – INQ000414378].

56. The hospital supported the national guidelines regarding visitation policy and considered that they struck the right balance between minimising risk of infection and enabling patients to benefit from the support and comfort of their loved ones and carers.

ADAPTATION OF CARE AND TREATMENT PATHWAYS, THE UTLISATION OF PRIVATE SECTOR FACILITIES AND THE WATFORD GENERAL HOSPITAL OXYGEN INCIDENT

57. While most non-urgent elective clinical pathways were subject to pausing, throughout COVID, ischaemic heart disease care pathways remained intact. Elective hip surgery was suspended during this period under national directive and the last admission for

elective hip surgery in Watford was on 19 March 2020. In late June 2020 several elective hip operations were carried out at Spire Bushey, the local private sector hospital utilising their facilities. The colorectal cancer service was fully maintained by moving NHS staff to Spire Bushey.. Watford was one of very few hospitals in the London area to maintain this service. Cancer services more generally and other urgent elective cases were also maintained through the contractual agreement with Spire Bushey, which benefitted Watford and its patients significantly. No staff members from Spire Bushey or any other independent sector hospital were redeployed to Watford General Hospital. Spire medical equipment was utilised at the Spire site. I exhibit to my statement a brief guide setting out the transfer process to Spire Bushey [MVDW/23 – INQ000414379].

58. For other services which were non-COVID, many virtual and telephone clinics were established for both new and follow up patients.

59. Despite maintaining high levels of urgent services during COVID, a backlog of routine patients awaiting procedures at Watford did occur and this is taking time to alleviate. In April 2019, 23,656 patients were awaiting treatment. In April 2020, this figure had reduced to 17537 but by the following year had risen to 25025. In April 2022, there were 57,611 patients, this reduced slightly in April 2023 to 56383, but by December 2023 had risen to 58,735.

60. Inpatient and outpatient maternity services are provided at Watford. The service in Watford at the start of the pandemic was across the ground floor, second and third floors of the building. In 2019/20 there were 5424 antenatal bookings and 4359 births. For 2020/2021 there were 5378 antenatal bookings and 4252 births and for 2021/2022, there were 4970 antenatal bookings and 4162 births.

61. At the start of the pandemic, in line with the national and Trust guidance, changes were implemented across the entirety of maternity services. Posters were displayed around the unit and on the website with the aim of providing families with the most up to date, and sometimes fast-changing information.

62. Pregnancy care cannot be delayed as there are milestones which need to be met. Steps were taken to do everything possible to provide safe ongoing care during the Covid 19 pandemic. These changes were reviewed and updated as the pandemic evolved.

63. Prior to the start of the pandemic, partners, families and friends accompanied patients to antenatal clinic appointments including booking and dating scans, 20 week anomaly scans and other appointments. At the start of the pandemic, appointments were restricted to the patient only. This was a significant change. Similar arrangements were put in place for the maternity day assessment unit, maternity triage, antenatal and postnatal wards. COVID surveillance was in place for any antenatal positive women and Clexane (a drug which stops blood clots from forming) was prescribed for them according to national guidance. The surveillance was through a telephone helpline.

64. Watford's two obstetric theatres are adjacent to each other and there was concern about the potential for cross contamination of the air handling system. The obstetric emergency theatre was therefore moved to the gynaecology theatre. There was the possibility of COVID positive patients in spontaneous labour, but elective caesarean section patients were all known to be COVID negative or if not negative, following the COVID pathway.

65. Labour rooms were used as normal with restrictions on the number of people in the room. Numbers and visiting were restricted in all rooms. Temperatures were taken of birthing partners, together with lateral flow tests. Extra IPC equipment was provided outside each room to house PPE.

66. Birthing partners were restricted to one named person instead of two. This person was called before the birth and allowed to be present for the birth of the baby only. Following the birth, mothers and babies returned to the postnatal ward and no visiting was allowed, which meant partners/fathers did not see their partner or baby until they were discharged from the ward. No visits from families, friends or siblings took place. Exceptions were put in place for some women (primarily perinatal mental health and complex needs), and a side room allocated to allow their partner to be with them either side of the birth.

67. The bereavement suite was converted to a COVID isolation room with an adjacent room for donning and doffing. PCRs were undertaken for all elective patients and their partners. Green bands were provided for partners who tested negative. Positive patients were given red bands. A pathway was put in place for patients who were COVID positive who were going to theatre. The Alexandra Birthing Centre was

closed for most of the period of the pandemic due to staffing issues. Care for low-risk women was provided on the consultant led labour ward.

68. With some staff shielding, numbers on site were reduced and a decision was made to give conditional offers of employment to Year 3 student Midwives in order to expand the workforce for the coming September

69. During the period under review ambulance handover times increased overall, although there was some variation. At the start of pandemic in March 2020, 140 handovers exceeded 60 minutes. This peaked in December 2020 at 514. Handovers of less than 15 minutes improved during March to May 2020 with a high of 47%, this dropped to 15% by December 2020. A second phase of improvement followed between February 2021 and April 2021 before declining to a low of 6% in December 2021.

70. To facilitate handover time, phased emergency medicine plans were agreed in succession, with the first signed off through the Incident Command Centre by myself, the Chief Nurse and the Chief Operating Officer.

71. This first plan came into effect in March 2020 and set out clear handover pathways and roles, in particular the roles of the Hospital Ambulance Liaison Officer, the Manager of the Day, the Nurse in Charge and the Emergency Physician in Charge. Escalation pathways were agreed with the Ambulance Service.

72. The Hospital Liaison Officer ("HALO") was tasked with guiding patients to the correct area, highlighting clinically unwell patients in the queue and ambulance conveyances with respiratory symptoms were directed to a COVID designated area. Ambulance handover meetings were held to improve efficiency and the ambulance service worked alongside hospital staff to care for patients in the corridor waiting to be offloaded. A rapid release process was initiated. In August 2020, resus bays were made into cubicles with doors to receive more unwell COVID patients. Further assessment plans were put in place when in November 2020 the mink variant emerged in Denmark. As the Majors department had doors in the middle, in December 2020 it was redesigned to allow the area to be flexed for designated COVID beds. There were six trolley spaces which could be increased to 11 if the doors were opened. This left one bay with four chairs for ambulance patients.

73. Doctors at Watford did not express concern about the lack of a national decision making tool. Instead, two groups were established at the start of the pandemic to support clinical decision making and resource allocation, the Clinical Advisory Panel (later renamed the Clinical Decision Panel) and the Ethical Advisory Panel. The Clinical Advisory Panel was chaired by the chief medical officer with executive support and senior clinical leadership, and met as needed. Initially these meetings took place every few days, settling into a weekly pattern by the summer of 2020. The Ethical Advisory Panel provided clinical support when ethical considerations were important in determining how to make the fairest use of resource and capacity. Decisions were based on the 'three wise people' principles, whereby 3 separate options or opinions were sought in an individual patient's treatment, and be proportionate to demands, aimed at minimising the overall harm caused by the pandemic. The Ethical Advisory Panel was led by the director of governance and chief nurse, and consisted of a doctor, a nurse, and a layperson. These roles were rostered since the panel was available for consultation 24 hours a day, seven days a week.

74. The Ethical Advisory Panel was established early in the pandemic to assist staff if rationing of therapy was being contemplated. Fortunately, this situation did not arise and the panel never had to make decisions about rationing treatment.

75. The Inquiry has queried the use of recommended summary plans for emergency care and treatment ("ReSPECT") forms, these were not in use at the Trust during the COVID period. Their introduction was discussed at the End-of-Life Care Panel and at the Resuscitation Panel and both panels identified that introducing an additional form to the existing documentation was a risk. The DNACPR remained in use as this was the form familiar to staff to identify patients who are not for resuscitation. The Trust documentation for this period for do not attempt cardio-pulmonary resuscitation ("DNACPR") and treatment escalation plans ("TEP") were a DNACPR form and TEP. I exhibit to my statement the DNACPR form [MVDW/24 – INQ000414380] and TEP [MVDW/25 – INQ000414381] that were in use. Watford was not using electronic records at this time so digital copies were not stored. Paper copies were kept in patient notes.

76. It is best practice to review any existing documented DNACPR decisions on and during admission. The patient's and/or family's wishes are taken into account when reviewing any DNACPR documentation and decisions regarding ceilings of care or

treatment. If a patient is admitted to the hospital with an existing DNACPR, the clinician would ensure a Watford Hospital DNACPR form is completed during the review, as appropriate.

77. Ceilings of care or TEPs are an important part of DNACPR decisions. Decisions related to treatment escalation are appropriate to the individual patient. A treatment escalation plan can include oxygen therapy and admission to ICU when a DNACPR decision has been made.

78. The Trust provides DNACPR e-learning which is mandatory for all clinicians to complete every 3 years. This e-learning includes guidance on DNACPR decisions and advanced decisions to refuse treatment ("ADRT") forms. Palliative care and the Liaison Team, with the Safeguarding Team worked differently to support end of life care patients with learning disabilities, a review was also undertaken.

79. No specific extra guidance was offered during this period with regards to advanced care plans ("ACP"). If a patient was admitted with an ACP, all wishes were respected (as appropriate). The situation may not have been that which the patient had anticipated (e.g. they were unwell with COVID and not their original illness).

80. No concerns were raised regarding DNACPRs being issued disproportionately to patients with protected characteristics. I know of no concerns raised regarding unequal impact on patients of measures adopted by the hospital in response to the COVID-19 pandemic

81. An audit of 100 -150 DNACPR forms was undertaken during this period. These forms were either posted to the department or retrieved from the notes of patients who had died. This number did not reflect the total number of patients with DNACPR forms in the hospital within the monthly audit window. All forms audited appeared to be clinically appropriate. There is no data available to determine whether there was an increase in patients arriving at the hospital with a DNACPR notice on their notes.

82. Watford's DNACPR e-learning addresses difficult conversations and DNACPR conversations. A patient information leaflet was already available in five languages as a resource for clinicians, patients, and their relatives. An 'easy read version' was also available as a resource for patients with specific learning needs. DNACPR champion training was rolled out in 2017/2018 prior to COVID to promote good

communication regarding DNACPR decisions and conversations which equipped clinical staff with skills to communicate decisions during COVID.

83. During the pandemic, palliative care education was provided. In addition to e-learning, rapid response training was given to Oncology and Cancer Nurse Specialists, who were redeployed to work with the palliative care team. The educator delivered end of life care training to all clinical areas, with the aim of supporting staff with early recognition of the dying, symptom control and communication skills. Training was face to face and was supported by an information pack with all key documents and guidelines. The educator also met with consultants who were redeployed to COVID-19 wards, providing training and emotional support and with ICU nurses. Allied health professionals received face to face training at Watford Football Club in April 2020, covering the basics of palliative care and end of life care, along with information on palliative discharges.

84. On 4 April 2020, a critical incident was declared as a result of oxygen supply issues. On 18 March, before the incident, a request and purchase order was raised with BOC the supplier of oxygen, for urgent upgrade works to increase the supply of oxygen to provide the previously (misreported by BOC) capacity of 3,000 litres per minute via the vacuum insulated evaporator. In reality, the system configuration at Watford was only created to provide 1,850 litres per minute as a result of the evaporator design. On 27 March BOC responded to say that the Department of Health and Social Care ("DHSC") had instructed the cessation of all additional work on bulk oxygen systems that had not been prior approved by DHSC. The Trust was not aware of DHSC's direction to cease additional work prior to 27 March 2020 only that work was being prioritised. The matter was escalated to the regional East of England Incident Control Centre (ICC) on 30 March. It was also escalated to Hertfordshire Strategic Coordinating Group (SCG) and to the Resilience & Emergency Division, Ministry of Housing Communities & Local Government via the SCG. The reason for escalating was that the Trust had requested in preparation for COVID to increase ITU capacity along with all other acute trusts and was advised by BOC that the oxygen capacity was less than BOC first indicated which needed urgent work. On the morning of 1 April, alarm panels in Watford were triggered, indicating high pressure in the oxygen delivery system, which occurred as a result of the control panel 'icing up' because of the increased volume of oxygen passing through the system The matter was escalated again to the Regional East of England ICC and to

NHS England's East of England Director of Urgent and Emergency Care as the limit for oxygen capacity had been or was about to be reached. By the evening, low-pressure alarms were also triggered in ICU, raising concerns that the oxygen system was being run above safe capacity. On 3 April the problem was escalated to NHS England East of England and also our Chief Medical Officer escalated to NHS England's Chief Medical Officer. The issue was escalated when it first arose which was prior to 3 April. NHS England East of England contacted BOC for additional updates and tried to assist in having a mobile unit delivered to Watford Hospital. All escalations were made through NHS England East of England, which was the route to escalate to DHSC.

85. A critical incident was declared at 10.50am on 4 April 2020 and an ambulance divert was instigated. Approximately 60 ambulances were diverted throughout the period and 7 inpatients were transferred out after assessment by the lead clinician and matron of ICU. 3 of these patients went to Papworth, 2 went to Addenbrooke's and 2 went to Lister. To my knowledge none of the patients transferred out to another hospital came to harm as a consequence of that transfer.

86. There were 30 patients in ICU that day and care proceeded as normal with the usual ward rounds. Where appropriate in all clinical areas, patient oxygen flow was adjusted as some were receiving a faster flow than was necessary.

87. By the end of the day, oxygen capacity had been increased to 2300lpm. 7 days later new evaporators were delivered and capacity increased to 3000lpm. The Trust's Estates Team uses a BOC monitoring system to daily check chlorate levels and if these rise above 1700lpm, daily oxygen reviews are instigated for all areas. A full review of the incident was undertaken by the Healthcare Safety Investigation Branch (HSID). The HSIB report noted that whilst the components were available NHS England and the DHSC were aware of many trusts observing limitations to their ideal oxygen delivery systems and needed to control where best to utilise the immediately available assets.

88. The Inquiry has asked for further detail about use of COVID Assessment Pods at Watford. The first standard operating procedure for utilisation of these pods was dated 7 February 2020. It set out the arrival process, the process for NHS111 assessment via telephone from the pod, the process for physical assessment by the ED, the decontamination process and emergency procedures. A copy of the

standard operating procedure v2 is exhibited to my statement as [MVDW/26 – INQ000414382]

89. Pods were introduced in response to national mandate, with the purpose of streamlining potential cases of COVID to the right patient pathway. The system aimed to enable cases not requiring intervention by a hospital to be diverted away from hospital urgent and emergency care services. There were Pods at each of the three hospital sites. Each site worked under its own standard operating procedure. Daily COVID situation reports were compiled which included the status of the pods and their usage.

90. Clinicians in the ED found the pods to be of limited success. Queues which formed were difficult to manage from an infection control perspective and numbers of patients exceeded those anticipated and prepared for. It was felt that the pods did not have a significant impact on the number of patients arriving in ED for assessment and that if anything, they added to the burden of Watford because of the close management required to order queues safely. Overall was the sense that the acute Watford site was not the optimal place for the pods to be located.

IMPACT ON THE PHYSICAL AND MENTAL WELLBEING OF HOSPITAL STAFF

91. COVID understandably had an enormous physical and mental wellbeing impact on hospital staff. Steps taken by the Trust at Watford to help included the provision of selective single room accommodation and free daily meal vouchers, provision of free meals and rest facilities for staff to take breaks provided in partnership with Watford Football Club, along with the provision of extended pastoral care. Recharge rooms were also accessible at Watford Football Club for staff who needed to spend some time alone. Counselling, befriending and coaching services were made available, along with access to clinical psychologists. Training was provided on recognising the signs of stress and trauma for clinical staff and clinical managers. The Trust also ran NHS Elect debrief sessions for staff and updated frequently asked questions with staff support, guidance and information. The Trust refurbished wellbeing rooms and facilities on all sites.

92. A memorial service was held on 21 November 2021 for staff and families at Watford Football Club paying tribute to those loved ones who sadly died during the pandemic and memorial garden was built, providing a place for quiet reflection.

93. NHS England wellbeing initiatives were useful as a general guide, but Watford liaised with staff throughout the pandemic to provide locally relevant support. This included the development of a dedicated wellbeing team. A fully functioning absence hub was created to provide support to staff sick, those shielding, stranded abroad and those identified as vulnerable. Specific areas of support and advice included: household symptoms, staff testing, redeployment, wellbeing, change in activities, working from home, on call rooms for clinical staff, childcare, transport, emergency accommodation, pregnancy and vulnerable people. Virtual common rooms were not used.

94. 34 members of staff were absent as a consequence of Long COVID. Long term COVID-19 case management actions included contacting employees and checking on their wellbeing. Staff were assigned a dedicated absence hub advisor with whom to build a relationship. These were clinical staff who needed to be redeployed as they could not work in their clinical area due to COVID risk. In April 2022, the ICS launched a Long COVID staff support service.

95. The Trust COVID risk assessment for staff was introduced in June 2020 and was in line with government guidance. The Trust reviewed guidance on safe redeployment during the pandemic and these risk assessments were implemented. This was facilitated centrally within the HR team. The Trust reflected on the deployment of staff and the psychological impact it had, including anxiety, stress around communising across different sites and areas and moving onto wards where they had never worked before and which could potentially put them and their families at riskSafe space sessions were arranged to support staff that had been affected by the changes imposed by the pandemic. The sessions ran on 5 February 2021, 30 March 2021 and 3 June 2021. The sessions were intentionally held off the hospital site to provide a safe space environment. In addition, a larger support programme ran for the respiratory team from late 2021 to early 2022.

96. From June 2020, all staff were asked to complete a risk assessment which included an equality impact assessment and incorporated details of their characteristics. This was done to ensure fairness and equity and to protect vulnerable staff or those within the remit of protected characteristics. The risk assessment/equality impact assessment also helped to inform decision making on where to redeploy staff in

areas where they could remain in work safely, taking into account their specific needs. The risk assessments were an ongoing process and included all new staff.

97. Three specific issues of fairness and equity were fed back via pastoral care and the freedom to speak up team. The first related to staff wishing to wear PPE but being restricted as they were not in mandatory areas and PPE was in short supply. Although staff concerned were recognised, the Trust continued to follow government guidelines on the use of PPE, however, when this changed to all staff expected to wear PPE, Trust policies were amended accordingly. Regular updates were circulated to staff on specific NHS guidance about PPE and also national guidance. The second was an ethnicity concern raised within one clinical team relating to the removal of clinicians from the frontline. In that particular team, fewer BAME clinicians were removed and therefore more remained on the frontline, leading to allegations of a racist application of the staff risk assessment. Each member of staff however was assessed as an individual and any removed from the frontline that had a clear health risk in accordance with national guidance. The Trust did not routinely review equality impact assessments, however national guidance was applied in relationship to risk assessments. Thirdly, in the reverse, a number of individuals considered the risk assessment biased on the basis of additional point scores awarded if the staff member was part of the BAME community. Again, the structure of the risk assessment was subject to national guidance.

98. The Trust worked closely with relevant staff networks to ensure that support was relevant and at all times took consideration of the needs of all of our staff.

99. Throughout COVID, staff communication from the front line to hospital management was consistent and a new staff app was introduced. There were monthly staff forums led by the Chief Nurse and supported by the Chief People Officer. Regularly updated frequently asked questions were provided in line with NHS and government guidelines.

100. The COVID absence hub tracked feedback from staff and was able to ensure that it was appropriately addressed at senior level.

101. National bodies communicated extensively with the Trust and NHS Elect in particular provided good support, for example running a number of reflective debrief sessions as mentioned in paragraph 91. National guidelines were at times updated on a

weekly basis. The Trust implemented them, but it was difficult. At the start of the pandemic there were concerns about accessing PPE supplies and on occasions, Watford was down to 12 hours' worth of supplies particularly theatre gowns. It was only by working closely with neighbouring Trusts and local providers that supplies did not run out and patients were not put at increased risk of harm or anxiety about safety.

102. Recommendations which may improve the way that both hospitals and national decision makers for the healthcare system respond to a future pandemic would include the provision of adequate supplies and a clear rationale behind PPE usage. Also, earlier guidelines and support from regulatory bodies regarding clinicians undertaking duties that would normally be done by others. More frequent updates from national decision makers and the rationale behind those decisions would be advantageous.

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: 03/05/2024