Witness Name: Dr Sara Mumford

Statement No.:

Exhibits:

Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR SARA MUMFORD

I, Dr Sara Mumford, will say as follows: -

I am Dr Sara Mumford, Medical Director of Maidstone and Tunbridge Wells NHS Trust. During the pandemic I was Deputy Medical Director and executive Director of Infection Prevention and Control. I am a consultant microbiologist with a specialist interest in Infection Prevention and Control. The Medical Director during the pandemic, Dr Peter Maskell, has stepped down from the role.

The information in this statement relates to the period between 1 March 2020 and 28 June 2022.

Background

1. Maidstone Hospital is a large acute hospital which serves a patient population of 175,797 and covers a geographical area of West Kent, including Maidstone, Sevenoaks, Tonbridge and Malling, Tunbridge Wells. The demographics of the patient population are shown below:

Ethnic groups	
White:	157,864
Asian, Asian British or Asian Welsh:	8,216
Black, Black British, Black Welsh, Caribbean:	3,611
Mixed or multiple ethnic groups:	4,015
Other ethnic group:	2,091

Age	
0-14 years	31,672

15 to 29 years:	28,983
30 to 44 years:	35,574
45 to 65 years:	46,036
65 to 84 years:	29,127
85 years and over:	4,405

2. The levels of socio-economic deprivation within West Kent are variable with Tunbridge Wells ranking as the least deprived local authority in Kent and Tonbridge & Malling experiencing the largest increase in deprivation relative to other areas during the period. Maidstone Hospital provides services in: medical care (including older people's care); services for children and young people; critical care; end of life care; maternity; outpatients and diagnostic imaging; surgery and urgent and emergency services. Our Maidstone site also hosts the Kent Oncology Centre, providing specialist Cancer services to around two million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET/CT (Positron Emission Tomography – Computed Tomography) services in a dedicated building. The Trust also provides sexual health services to the population of Kent and Medway. The Maidstone site has a Birth Centre and a dedicated ward for respiratory services. Up to thirteen wards were in operation at Maidstone Hospital during the relevant period.

Staffing capacity:

3. During the period, we experienced challenges in staffing capacity due to sickness absence (due to contracting COVID-19); absence due to suspected COVID-19 symptoms; absence due to household members contracting COVID-19; the need to self-isolate, shield, redeploy, or provide childcare. Overseas recruitment was also stopped/restricted. Amongst the most affected were the Trust's intensivists, who had multiple changes on their rota throughout the totality of the period. Doctors working in areas where activity was reduced due to the pandemic, were upskilled to boost capacity and fill gaps wherever possible. These changes affected all grades of doctor: consultants, SAS and doctors in training. Recruitment of bank doctors was increased, purely for covering gaps due to COVID-19. Additionally, doctors who had retired/recently left the Trust were recruited to help with additional staffing, supported by GMC arrangements for them to have temporary registration where this had lapsed. The Trust was also provided with candidates by NHS England. Of 28 candidates, 13 doctors completed the recruitment process and were added to the bank. In April 2020 over 170 people were recruited to our Staff Bank team to support clinical, administration and

facilities roles. A number of retired nurses, doctors, midwives, laboratory assistants and therapists also returned to the frontline.

4. Whilst reasons for staff shortages during the period included sickness absence, staff required to self-isolate, shield or re-deploy, etc., pre-pandemic staff vacancies also contributed to the situation. Over time, staff absences reduced (in terms of episodes and length) with introduction of vaccination, COVID-19 testing, self-testing, better understanding of COVID-19, changes in working practices to safeguard staff i.e. social distancing, mask wearing, infection control measures and change in Government guidelines. This in turn led to a reduction in temporary staffing levels. Additionally, the creation of temporary registers for doctors, nurses, midwives and pharmacists to enable trainees and retired staff to work in these roles created a greater pool of resource to cover vacancies/ absences. Volunteers were also used and paid weekly as bank staff. The recruitment process was shortened to facilitate such initiatives. The fact that all health providers were experiencing similar staffing challenges increased the obstacles we faced in increasing our staffing capacity. The Trust total vacancy rate in April 2020 was 9.6% and remained above this level until March 2021 when it peaked at 15.1% ; it then continued to slowly decrease to 11.4% by September 2022. Nursing and Midwifery was the staff group with the highest vacancy rate throughout the COVID-19 pandemic. In addition to this, there was a large recruitment campaign for staff bank and One Team Runners (volunteers), which is not captured within the vacancy rates, but did involve significant recruitment activity and supported our vacancies in a variety of roles throughout COVID-19.

5. We worked closely with partners across the region and nationally to put preparations in place to respond to the challenges of staff shortages during the COVID-19 pandemic. Following national guidance, we were able to postpone non-urgent planned procedures from 18 March 2020, to ensure we were sufficiently staffed for caring for potentially significant numbers of patients requiring specialist clinical support.

6. Medical/ clinical staff were re-deployed into non-elective areas and administrative support was shared with critical areas. Where possible, staff were redeployed to the site closest to their home. Where staff were redeployed, we followed NHSE national guidance for the process. The period had an inevitable impact of staff morale, and well-being provision for our staff was a priority during this time with increased risk of burnout etc. a recognised threat. Staff were enabled to work from home wherever possible.

7. The impact of Long COVID in our staff had minimal impact on staffing capacity as the number affected by Long COVID were small. Very fortunately, we did not experience the death of any members of our staff.

8. Working with the Kent & Medway system, the Deputy Chief People Officer led work into COVID-19 vaccination as a condition of deployment ("VCOD") on behalf of the Trust. They worked closely with Divisions on identifying individuals who indicated they did not intend to have a vaccination and worked with them, their managers and HR colleagues to support any next steps required. Of the Trust's staff, 154 staff were in scope and without a first dose as of January 2022. Of these 154, 33% (39) indicated they were unwilling to receive a vaccine. Of the remainder, 34% (40) were hesitant but willing to discuss having a vaccine, 18% (22) agreed to be vaccinated, 12% (14) believed they were exempt and 3% (4) had a maternity exemption.

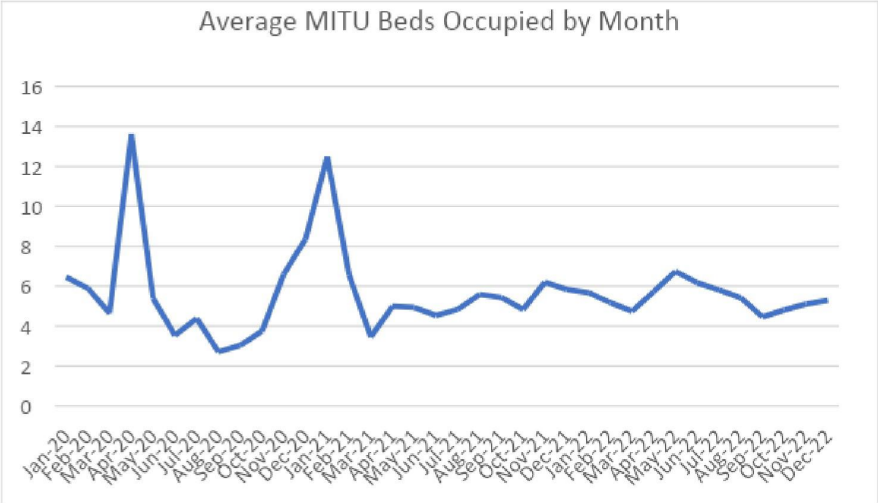
9. As VCOD was a national (rather than local) policy (and we did not depart from national policy / guidance), there was limited impact on engagement between management and staff. There was an agreement, when working with trade union / staff network colleagues and individuals to treat everybody with respect, including their personal decision relating to the vaccine. Medical experts were offered (and used) to discuss the merits and risks of the vaccine with individuals, with supportive manager-individual-HR sessions booked in the run up to the anticipated roll out of VCOD. While a challenging time, feedback from individuals was that they felt supported and respected throughout the process. The HR department were significantly challenged by the policy, having to deal with an intense workload arranging and holding 500-600 meetings with staff over a six-week period. No grievances or Freedom to Speak Up concerns were raised in response to the VCOD policy, however two staff resigned, with one resignation later rescinded when the policy was cancelled.

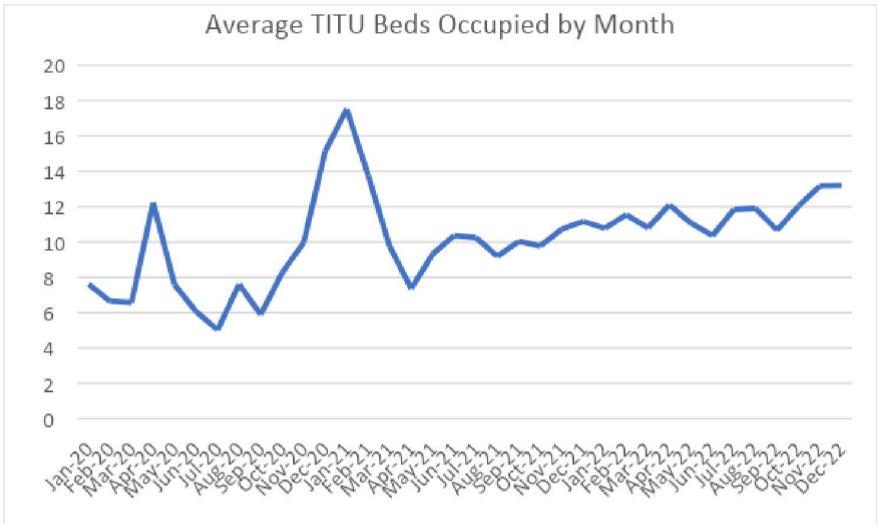
Bed capacity:

10. In terms of bed capacity, we had an escalation plan for ITU that illustrated the stages at which escalation should take place and the COVID-19 escalation triggers for a medical COVID-19 rota for anaesthetic cover, exhibited to this statement as Exhibits: SM/01 – INQ000477357 and SM/02 – INQ000477358. A comprehensive document entitled "Maidstone & Tunbridge Wells ITU Expansion Plans in Response to Increase the Substantive Baseline Number of Adult Critical Care Beds" was developed in June 2020 exhibited to this statement as Exhibit SM/03 – INQ000477359. This plan was

developed in response to the NHSE request for Maidstone & Tunbridge Wells NHS Trust (MTW) to increase the substantive baseline number of adult critical care beds in normal use from 17 to 31 beds, and to accommodate anticipated capacity required for both critically ill patients with COVID-19 whilst allowing restoration of other critical services, which was estimated at requiring a 30% increase in capacity. In addition, it addressed the historic relative under provision of critical care per head of population in the South East. Whilst the planning decisions were taken at Trust level, there was an expectation that the request would be complied with and support was provided at regional and national level.

11. A business case was completed to increase baseline capacity as identified by the adult expansion capacity letter and decisions about expanding capacity were at a local level (what we thought we could do), Network regional level (what we needed to do to support the whole) and national level. There were daily network/regional meetings, and discussions regarding mutual aid. The number of critical care beds available within the Trust pre and during COVID-19 is exhibited to this statement as Exhibit SM/04 – INQ000477360. We experienced obstacles to expansion, including availability of trained staff and indemnity for staff working outside of their area. There were some patient safety incidents that could be directly linked to the Trust not having ITU trained staff to care for ITU patients; these included an air embolus and increased line infections. There was also an increase in pressure damage which is evidenced through the Trust incident reporting system. Staff were understandably anxious about working in ICU and about the potential impact on their own and their families' welfare, and the psychological and physiological risks to the wellbeing of all staff within critical care areas during the period were recorded within the Critical Care risk register. Other challenges included availability of equipment, including of adequately sophisticated ventilators for the sickest patients. We also experienced challenges relating to space, i.e. availability of areas in which to expand its activity and also oxygen supply; although there was no need for oxygen to be rationed during the period of COVID-19, the situation required very close monitoring on an hour by hour basis. The nature of the issues encountered and measures taken in response is addressed in paragraph 13. The number of occupied ITU beds varied as shown in the graphs below:





12. In terms of provision of medical equipment/medicines during the period, we received 8 additional ventilator units supplied from National Stock, and also periodically used the Ventilators built into our Anaesthetic Machines. Fortunately, we had taken delivery of 50 new units prior to COVID-19 and still had the old units on site in service. Our theatres had received new patient monitors, and we were therefore able to use these along with the old patient monitors on site.

13. Issues were experienced on the Maidstone site in relation to the supply of piped oxygen to departments. This was addressed by reconfiguring the location of patients in need of

oxygen to maximise capacity. Specifically, there were some issues on AMU-ITU[1] in April 2020 with the low-pressure alarm sounding on the oxygen supply. This was potentially related to an overly sensitive pressure alarm (alarm not due until 3.5 bar, but was alarming on testing at just under 4 bar). Issues were also experienced with the VIE icing up, which were addressed. The revised plan included: All future ITU CPAP[2] to be delivered on main ITU; If ITU CPAP patients required intubation, this was to be done in one of the main ITU intubation rooms and transfer to AMU-ITU; Ward/ED patients requiring intubation transferred directly to AMU-ITU for intubation and subsequent ventilation; once 20 beds (i.e. all bays on AMU-ITU but NOT the 2 intubation rooms are full) subsequent admissions to be transferred to MOU[3] following intubation; any issues with oxygen supply occurring on admitting a new patient to AMU-ITU to be transferred to MOU and no further patients admitted to AMU-ITU until the issue was resolved. This created challenges in terms of the increased movement of patients from area to area. The impact of additional NIV[4] ventilators on existing infrastructure was closely reviewed in August 2020, exhibited to this statement as Exhibit SM/05 – INQ000477361; a further assessment of the estimated medical oxygen demand and availability at Maidstone Hospital and Tunbridge Wells Hospital was conducted in January 2021, exhibited to this statement as Exhibit SM/06 – INQ000477362.

14. We continued to work closely with the private sector to make use of its capacity for our emergency surgery patients and other appropriate patient groups. We temporarily transferred our stroke rehabilitation patients to KIMS private hospital in Maidstone to finish their therapeutic care; 18 beds were allocated for stroke rehabilitation patients at KIMS Hospital between March 2020 and August 2020; from data collected it is believed that there were 26 patients who experienced this pathway. In addition, the fractured neck of femur pathway was moved to the Horder Centre (an independent provider of orthopaedic services) from 31/3/2020 to 31/05/2020; and other minor trauma surgery to the other independent service providers, such as the Spire and Nuffield hospitals in Tunbridge Wells.

Infection prevention and control:

15. In terms of Infection Prevention and Control (IPC), we followed national guidance with a few exceptions: Clinical teams were concerned about the mismatch between the

[1] AMU-ITU - this was expanded provision sited in a closed acute medical ward at Maidstone Hospital which had been replaced by a new build Acute Admissions unit at the end of 2019. This acted as the COVID-19 positive ITU during the pandemic
[2] CPAP – Continuous positive airway pressure non-invasive ventilation
[3] MOU – Maidstone Orthopaedic Unit
[4] NIV – non-invasive ventilation

Resuscitation Council's guidelines and the national guidance for basic life support. The Trust Resus Committee recommended that the Trust followed the Resuscitation Council guidance to use FFP3 masks during resuscitations. This recommendation was endorsed by myself and discussed at the Ethics committee. In wave 2, we had a large number of staff off sick with COVID-19 infection and many staff reported to me that they were fearful of looking after COVID-19 patients. The 'Kent' variant early in wave 2 had a worse impact than wave 1 with COVID-19 patients on almost every ward. National Infection Prevention guidance throughout the pandemic reserved the use of FFP3 masks for aerosol generating procedures only.

16. The guidance for staff caring for COVID-19 patients was to wear type IIR surgical masks. In January 2021, in response to a staff sickness rate of 7.25% for December 2020, I recommended to the Executive Management Team that, as a Trust, we should allow staff to wear FFP3 masks to nurse COVID-19 patients. This resulted in a reduction in staff sickness and an improvement in staff morale. The sickness rate fell from 7.25% in December 2020 to 3.7% by February 2021. My experience was that the staff thanked me for making the decision and openly discussed how much more protected they felt in FFP3 masks. I also agreed that ultrasound staff could wear FFP3 masks on a sessional basis as they were in a workplace with no natural ventilation and at close proximity to patients. When the national guidance was stepped down we were slow to relax some of the elements of the guidance such as surgical mask wearing. This was as a result of local risk assessments.

17. Staff were informed of guidance and of any changes to existing guidance in a variety of ways, including visits to wards and clinical areas by the IPC Team; email dissemination of documents; display of posters; Trust communications and newsletters; a monthly Team brief, which included a COVID-19 update, and our Trust Facebook page.

18. The release by NHSE of guidance on Friday afternoons represented a big challenge, as it required the IPC Team to work all weekend to prepare for implementation on the next Monday morning. In early 2021, this issue was relayed through our regional IPC leads at the weekly teleconference between Trust and regional IPC leads. They gave assurances that they would relay the message up to national level, however the next guidance that came out after we had fed back (as a system) was at 5pm on the day before Good Friday. This did more to damage morale in IPC teams than anything else. We took a pragmatic approach and did not attempt to make changes at the weekend.

19. Some issues were experienced in relation to provision of respirator hoods. These were difficult to source and were needed for those staff who failed Fit testing or could not remove facial hair for religious and cultural reasons. IPC and procurement worked closely together to ensure that supplies were available and suitable.

20. There were some challenges in implementing IPC guidance presented by the hospital layout: Maidstone Hospital has 6 bedded bays and few side rooms. One ward was reconfigured to provide additional side rooms and the chronic pain clinic was repurposed to provide negative pressure isolation rooms for neutropenic patients who had COVID-19 infection. The Emergency Departments were reconfigured to provide red, amber and green pathways[5]. ITU provision was reconfigured with an escalation ward at Maidstone Hospital repurposed to provide COVID-19 positive ITU care whilst the main ITU cared for COVID-19 negative patients. In order to provide appropriate ventilation on the wards, mobile HEPA filtered air conditioning units were used. This was partially compliant with guidance but maintained ventilation as well as possible on the wards. It was a challenge at times to maintain staffing ratios, particularly during wave 2. Staffing ratios varied from day to day, but at its lowest point dropped to one ITU nurse to four patients with non-ITU nurses to help; this was the National model at that time when we could no longer meet the normal ratios.

21. The hospital was initially dependant on the regional testing services whilst awaiting equipment and reagents to develop in-house testing. MTW worked with other NHS Trusts in the county and the University of Kent to significantly expand the system's capacity for staff and patient COVID-19 testing with the potential to process 1500 tests a day. In April 2020 MTW tested more than 1,000 NHS and other frontline staff with their labs processing around 400 tests a day with the ability to scale up to approximately 750 tests a day. In addition, MTW opened a local drive-through swabbing centre based at the Hop Farm, Paddock Wood, and two pods[6] at both hospitals for symptomatic swabbing for staff and their families. This enabled us to swab around 150 staff a day. We did not conduct asymptomatic testing. We experienced no shortages at any time of test kits or other testing equipment once testing started in our own laboratory in April 2020.

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[5] Red pathway – known COVID-19 positive, Amber pathway – respiratory symptoms but not yet tested or indeterminate result, Green pathway – COVID-19 negative/asymptomatic

[6] Externally accessed portakabins with basic clinical space including donning and doffing area, wash hand basin and swabbing area.

22. We saw a number of nosocomial outbreaks of infection. We followed national guidance as far as practicable. Some outbreaks affected staff as well as patients. Most were due to patients testing positive on day 3 and 5 of an admission. At Maidstone Hospital where patients are cared for in 6-bedded bays, the index patient was moved to either a side room or to a designated COVID-19 cohort ward. The remaining patients in the bay were quarantined, initially for 10 days, although this was reduced to 5 in the later months of the pandemic, and tested if they became symptomatic. In the second wave, with the Kent variant, the secondary infection rate was exceptionally high, usually with all 5 of the contacts developing infection. Staff on the ward were also tested to ensure that they did not spread any infection. This created difficulty with patient flow due to blocked beds. We introduced a process of merging contact bays where they had a close onset date in order to maximise bed capacity. All of this was done with the infection prevention and control team working closely with the operations team to make safe decisions. In my opinion, the national messaging for the second wave onwards could have been stronger to encourage patients and the public to wear masks. The lack of messaging encouraged disregard of masks and although we had a policy in place to ask patients and visitors to wear a mask at all times whilst in the hospital, many members of the public did not wear them. We had several nosocomial outbreaks of COVID-19 due to symptomatic visitors not wearing masks.

Personal Protective Equipment and Respiratory Protective Equipment:

23. In order to obtain sufficient levels of personal protective equipment (PPE) and Respiratory Protective Equipment (RPE), we created our own internal central PPE store and inventory management system to book goods in and out. This allowed us to keep accurate records of stock levels and also manage use across the various wards (e.g. highlighting that one ward was using double the PPE of others which indicated either a mis-use of PPE that required re-training or potentially PPE being removed from the Trust and used elsewhere).

24. Trusts within Kent built effective links that allowed direct requests for mutual aid. Mutual aid requests were also circulated vie the CCG but this was dis-jointed at times i.e. a clinical dept would reach out for mutual aid via CCG without actually having contacted their own Procurement dept first. There were a number of instances when we responded to mutual aid requests from the CCG only to find that the Trust's procurement department knew nothing of the request and had stock available themselves. On many occasions we procured PPE on behalf of the local Community Trust as it did not have the resource or contacts to do this itself.

25. As the Trust's principal supplier of PPE was unable to supply the necessary equipment, we were forced to secure our own supply routes to keep our clinicians safe. We therefore built relationships with a number of import businesses that were able to facilitate procurement routes direct from China. Appropriate due diligence was undertaken on these suppliers and any requests for up-front payments were rejected. We also ensured that quality certificates were obtained to verify the products being bought (specifically Type IIR masks). Things improved once Foundry was fully operational, but this was many months into the Pandemic and even then, they could not always supply stocks to the levels required. Local decisions to extend PPE to all staff (as opposed to just clinical) put additional pressure on our stock levels. In short, the national response to the provision of PPE was insufficient to meet our needs and our hand was subsequently forced to find alternative supply routes. Use of Foundry as a supplier was effective. Linked to the data produced by our inventory management system we were able to accurately forecast usage and Foundry was broadly able to meet our requirements.

26. Daily delivery of PPE to a single site was problematic. Whilst it ensured a regular supply of PPE, the logistics of storing it and distributing it between our multiple sites was a challenge. As an indication, we were using circa 75,000 items of PPE a day so the space required to store this was the biggest challenge. At one site we were having to use the corridor outside the plant room to hold pallets of stock. We eventually took the decision to rent warehouse space from a local stationery supplier to manage this off site, but that added a layer of complexity to managing the flow of PPE.

27. At no time did we run out of any items of PPE, however we did access the emergency request system on 3 occasions – always for thumb-loop gowns – when we forecast that the Foundry delivery wouldn't arrive in time. It was effective and responsive. The only criticism was a lack of clarity on contact routes and processes. Regional teams tended to get in the middle of such processes which just served to confuse and blur the lines of communication.

28. There were a number of instances where a particular make of type IIR surgical mask was recalled. This created anxiety in the clinical teams as well as creating a logistical nightmare as the make of type IIR masks was not consistent, as such a manual search of all ward areas was required to remove a particular make from the shelf. The other product that was not deemed fit for purpose was a particular batch of aprons. These were rejected and alternatives were obtained locally. The returns process for rejected

items was not particularly smooth and there was a long period between notifying that stock was unacceptable to it being collected. This created storage issues and introduced a level of risk that these quarantined items might inadvertently get back onto the wards as the limited space made it very difficult to keep things separate.

29. The Trust created a dedicated fit-testing team and utilised the Project Management Office (PMO) dept to start monitoring and recording which employees were fit-tested on what mask. The aim was to get all employees fit tested on at least 2 masks to build resilience. This was a rolling programme as national stocks of various FFP3's expired so staff who were fitted to those had to be re-fitted to whatever was available at that time. No consideration had been given to the challenges of fit-testing when the central emergency pandemic stock had been created. It stocked a make of FFP3 that no Trust used, so every single clinical person at every single Trust had to be fit-tested on this one. 70% of those Trusts use a particular make of 3M mask, but that wasn't the one stocked.

30. Access to re-useable masks and respirators was not available from central stores. We procured these locally to provide resilience and flexibility. The hooded respirators could be used by anyone who could not access a mask that they had been fit-tested on (or who had failed all fit-testing). This was an essential back-up solution to keep staff re-assured and safe.

31. Staff safety was not impacted by shortages of PPE or RPE (i.e. there were no shortages). We worked to ensure we had back-ups (such as Tyvek suits) to assure staff that we had alternative options in the event that standard PPE ran out. There was anxiety within our clinical staff cohort, but this was largely driven by the national media and not by their local experience. However, over time there was a recognition that what was being stated in the media (e.g. some media outlets reported that hospital staff were having to use bin bags as PPE and that re-use of PPE was going to be necessary), did not reflect what they were actually experiencing – i.e. good supplies of PPE and no shortages, so it did not create a major issue for us. Having senior procurement officers working as part of the Incident Command team helped to create an open line of communication on PPE concerns from Execs down to nurses. As we, at no point, ran out of any PPE items, we did not consider that staff or patient safety was compromised in this respect.

Visiting restrictions:

32. Once visiting guidance was issued by NHSE, daily staff bulletins began from 17th March 2020 – in accordance with the national NHS policy. Visiting guidance was applied by issuing information via all Trust communication channels. This included website, intranet, social media, stakeholder briefings, posters, digital screens and patient text messaging and all staff messaging, so ward and clinical staff were able to communicate directly with any potential visiting family or friends. Initial visiting guidance was brought in on 26 March 2020 which advised no visitors were allowed from this date with the exception of certain groups including neonatal visitors, end of life, and maternity departments allowing one birthing partner. In March 2020, patients receiving end of life care were allowed one visitor for one hour. Specific clinical guideline for parent visiting on the Neonatal Unit (NNU) was developed in May 2020, as exhibited to this statement as Exhibit SM/07 – INQ000477363. Further changes to the Trust's overall visiting policy were then made through to June 2022 (including in November 2020 - further restrictions to visitors at Maidstone Hospital, in the light of increased COVID-19 cases in the community and hospital), and in October 2021, setting out visiting arrangements across the different patient cohorts), to allow for additional visiting and these changes were based on community infection rates as well as the number of COVID-19 positive admissions. To help patients speak with their loved ones throughout the visiting restrictions, staff were asked to ensure they were supporting patients as a priority to speak via specially issued iPads which were delivered to ward and clinical areas. Our visiting policy was reviewed in conjunction with national guidance. Restricted visiting had a negative effect on parents and healthcare workers, e.g. in the case of maternity and neonatal services: Partners were not able to have 24/7 access in the same way as the mother of the baby; not able to share at the cot side progress and challenges; difficulty bonding with baby; lack of support from the wider family and friends, lack of support from other parents. The restrictions at MTW were constantly changed in line with guidance and due to a spacious environment visiting was flexed taking this into account. In my experience, in comparison to other hospitals, MTW appeared to manage visiting well in the circumstances. A pragmatic approach was taken towards enabling end of life visitors and every effort was made to facilitate this including enabling visitors to patients dying of COVID-19 to visit wearing respirator hoods on occasion. My view on visiting is that it was too restrictive at times. There was no reason to prevent end of life patients having visitors as long as they were informed of any potential COVID-19 risk and were supplied with masks and PPE. The staff on the wards found it very difficult when visiting restarted. They told me that they were apprehensive of the risk, with visitors being non-compliant with mask-wearing being a particular factor

33. The single-room environment at Tunbridge Wells Hospital enabled the Trust to continue to provide elective cancer surgery safely by effectively isolating every patient on admission. Any fully single-roomed ward requires a higher nurse to patient ratio and this became more difficult to maintain as the staff shortages and staff sickness levels increased. I took the decision to continue to cohort patients; the respiratory ward was divided into COVID-19 and a non- COVID-19 area. This was important to ensure that the staff were able to be consistent in their PPE use and prevented staff going from a COVID-19 patient to a non- COVID-19 patient wearing the same mask or other sessional PPE. For patients who did not require non-invasive ventilation (NIV) (and therefore, respiratory ward admission), COVID-19 patients were cohorted on a single ward and once recovered, moved to a step-down ward. Again, this allowed staff to be consistent in their practice. Despite the single rooms, our experience was that elderly, confused patients tend to wander out of their rooms and this would have created an additional risk if on a mixed COVID-19 and non- COVID-19 ward. In fact, we saw this cause outbreaks where patients who tested negative on admission became positive on day 3 or 5 testing despite single rooms. Later in the pandemic it was recognised that we had reached the point where COVID-19 numbers had decreased and patients would be better cared for by restoring the specialty-based system and COVID-19 patients were isolated individually on their specialty ward. The respiratory ward maintained a smaller area to cohort COVID-19 patients requiring NIV. Overall the number of outbreaks observed was very similar in both hospitals.

Patient treatment and care:

34. In terms of the impact on patients with conditions other than COVID-19: Cardiology procedures were initially significantly reduced and only very urgent procedures and those required for inpatients were performed from 23rd March 2020. Elective cardiology work moved to KIMS private hospital to keep the risk of exposure to COVID-19 for these vulnerable patients to a minimum. Procedures restarted on the Trust site from 2nd June 2020. They were then reduced again from 7th December 2020 and reinstated from 15th January 2021.

35. Capacity for 26 medical inpatients was provided by the Benenden hospital, regular medical infusions were undertaken off site at the Nuffield Hospital in Tunbridge Wells, all out patient consultations were converted to telephone calls or virtual clinics initially and then, in certain specialties, telephone clinics were used to triage patients to see if there was an urgent need for them to attend a face to face appointment. The very swift

conversion to telephone and virtual clinics made it much easier to maintain our outpatient activity and enable a faster recovery of activity than many other organisations. Diagnostic lists (e.g. Echocardiograms and Lung function tests) were reduced to allow for air changes between patients. Elective Orthopaedic surgery moved to the Horder Centre, a private orthopaedic provider. Colorectal cancer surgery continued and the national cancer targets continued to be met throughout the pandemic. As a tertiary oncology centre we needed to maintain our cancer services as far as possible. Day chemotherapy services continued with patients tested frequently and provision made for patients who tested positive but were not unwell, to continue treatment. Radiotherapy services also continued, again with patients undergoing frequent asymptomatic testing.

36. In terms of maternity provision, the following changes were made over the period:

2020:

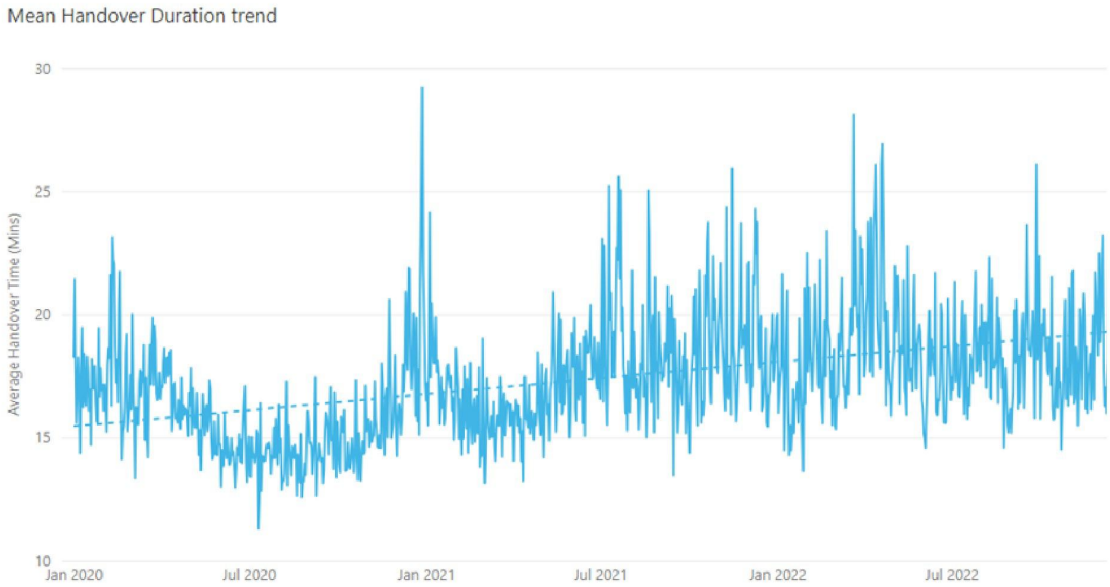
- Gap and Grow pathway- reduced service with no 28, 32- or 34-week scans on either sites
- Post-natal visits - some moved to telephone follow up. Antenatal bookings conducted by phone
- Early days parent education and ante-natal education moved to alternative provision on video
- Tongue tie service suspended
- No partner presence for ultrasounds scans (restarted September 21)
- Home births stopped March 2020 and restarted June 2020
- Breast feeding support moved to online consultation
- Change of Glucose Tolerance Tests and Anti D pathway in April 2020 in alignment with RCOG guidance
- Staffing movement to meet clinical need due to sickness
- Staff training moved to online such as PROMPT, Foetal Monitoring etc

2021:

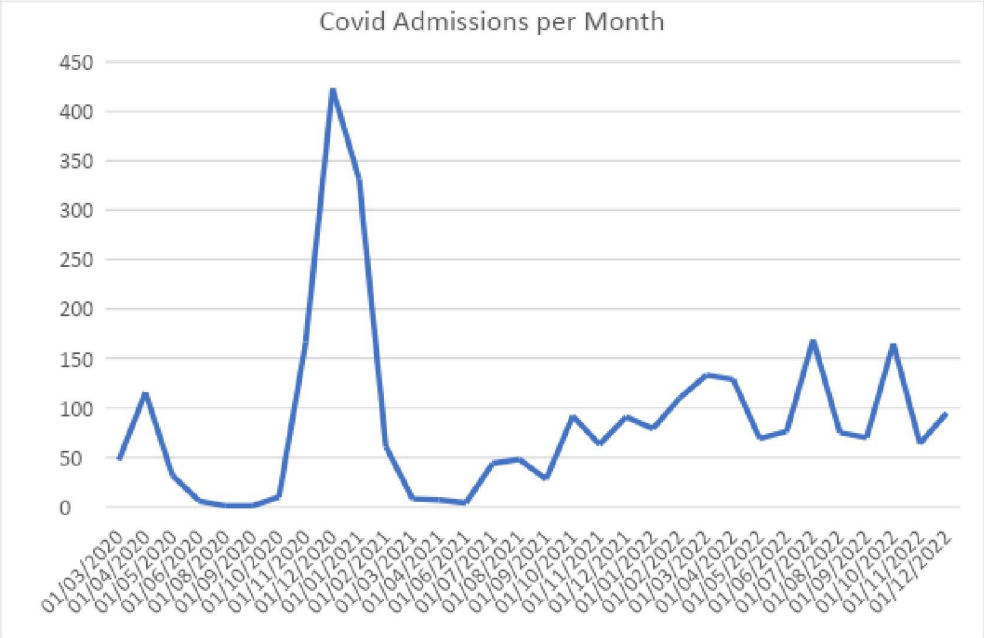
- Sonographers wore full PPE including FFP3 masks and visitors or partners allowed into scanning room
- Birth centre closed over Christmas/New Year 2021-22 as SECAMB[7] was experiencing delay times for Category 1 calls
- 28 and 32 growth scans cancelled over festive period due to lack of staff
- Home births again stopped due to significant sickness in April [reopened July 2021]

[7] SECAMB – South East Ambulance Service

37. The Emergency Dept space was redesigned and the fracture clinic was moved to accommodate the Urgent treatment Centre (UTC) so that the clinic rooms could be converted to allow for an orange and Green Rapid Assessment Point (RAP). This was following national guidance around orange (symptomatic but not tested or indeterminate COVID-19 test result) and green (non COVID-19) pathways. The time taken for ambulance handovers gradually increased over 2020-2022 inclusive. The highest peak (29 minutes) was in December 2020 when COVID-19 admissions and staff sickness rates also peaked. This is shown in the graph below:



COVID-19 positive admissions for Maidstone Hospital by month are shown below:



38. There was general recognition that initial demand and capacity modelling had indicated that the Trust would exhaust its supply of ventilators during the COVID-19 period, and it had therefore been acknowledged that guidance would be required for staff on the potential rationing of care in the event of that happening and in other circumstances of demand exceeding capacity.

39. The Trust established a dedicated COVID-19 Ethics Committee to consider all clinical (and other) ethical issues relating to the pandemic. At this point, on recommendation from the COVID-19 Ethics committee, the Trust Board approved decision-making processes for both within ITU and outside of ITU, including protocols for escalation to NIV/CPAP and withdrawal of NIV/CPAP, all of which were consistent with a decision-making tool originally developed by the National Institute for Health and Care excellence and Intensive Care Society for NHSE/I. In short, clinical decision-making within MTW throughout the pandemic continued to be based upon the patient's individual circumstances, and likely response to treatment, independent of resource availability. The guidance was reviewed regularly by the COVID-19 Ethics Committee (with relevant ITU and respiratory specialist input) for continued relevance during the pandemic and specifically during the second wave of the pandemic.

40. In the second wave of COVID-19, a protocol was developed for decisions around escalation to and withdrawal from NIV/CPAP (which assessed a patient's suitability (or otherwise) for a trial of NIV/CPAP; the protocol was predicated on national guidance and

set out the clinical parameters upon which a clinical decision could be made regarding which interventions were appropriate; the protocol recognised that, due to the complexity of the decision and the need for the individual circumstances of the patient to be considered, it was not possible to identify absolute indicators for withdrawal of CPAP).

41. The potential to have to ration care was a concern and was discussed regularly at meetings of the abovementioned COVID-19 Ethics Committee, but thankfully we did not reach the point of rationing care based on resources. Admission decisions were made, as per our usual practice, by weighing the potential benefits of treatment against the burden of critical care support. Where an ITU bed was felt to be appropriate we provided this, albeit with reduced nursing /doctor to patient ratios and/or utilised "mutual aid" to transfer patients to other units with available space. By reconfiguring our critical care areas, avoiding hyperoxia and working closely with our estates teams we were able to ensure that oxygen supply was maintained.

42. As a trust we utilised a Treatment Escalation Plan (TEP) form to encourage early consideration of appropriate levels of escalation by admitting teams. This did not change the decision making but ensured that it was properly documented. Where there was uncertainty around whether ITU support was appropriate this could be, and was, discussed with the Intensivists. From an ITU perspective the presence of a DNACPR form does not and did not preclude escalation to Intensive Care support or any other intervention for that matter, it simply means that treatment will not extend to cardio-pulmonary resuscitation in the case of cardiac arrest.

43. DNACPR notices do not form part of the patient's electronic record and are paper based on ITU and the wards. No concerns were raised to/within critical care about disproportionate issue of DNACPR notices to patients with protected characteristics and we are not aware of any concerns more widely in the trust. From an ITU perspective, DNACPR discussions were conducted with families as per our usual practice, the only difference being that this was done by telephone rather than in person. Over the period 2020-2022, 15 complaints were received which included concerns about the communication related to DNACPR forms

Impact on hospital staff:

44. In order to minimise the impact of the pandemic on staff members, we implemented a wide range of staff wellbeing measures. These included, but were not limited to, provision of psychological support, development of a health and wellbeing inbox and

committee, “Wingman” tents, wobble rooms, limiting of the staff restaurant for use by staff only and adoption of NHSE initiatives like “wellbeing Wednesdays”.

45. We are not aware of any official Equality Impact Assessments (“EIAs”) that were undertaken in respect of any hospital specific IPC guidance, fit testing or risk assessments. However, we did create a risk assessment for staff who were shielding in direct response to concerns for the health and wellbeing of staff who were protected by the Equality Act 2010. This was not a risk assessment that was available pre-pandemic. There was particular concern about staff from ethnic minority backgrounds in relation to PPE and fit testing, with some staff with facial hair due to religious reasons failing fit tests and a small number of staff who also could not wear a hood due to them not fitting over turbans. Respirator masks and hoods were issued to permanent staff who were unable to find FFP3 masks to fit them. Additional respirators were available for temporary staff and cleaning protocols were in place for these.

46. Communications between management and frontline staff developed throughout the pandemic. A daily sitrep was circulated to all managers with information about inpatient numbers and any new guidance. A newsletter was sent out to all staff with updates on new guidance, changes in operational activities etc. The executive team were visible to staff and maintained a presence in the hospitals. There were effective routes of communication for any staff who wished to raised concerns including the Freedom to Speak Up guardian and the wellbeing team. With respect to infection control there was little response to any feedback shared through regional network routes. Information webinars were transmission only with no opportunity to ask questions. In my experience, national guidance appeared to have been written with little awareness of what the realities of working on the frontline were. One such example was around reporting outbreaks, where the tool we were asked to use needed to be updated daily for each outbreak but we could update an already submitted outbreak, and therefore had to submit each outbreak from scratch every day. When we inquired as to what happened to this data, we were told that no-one was looking at it. Another example was the early guidance that said that masks should not be worn in public areas of the hospital, only in clinical areas, which resulted in excessive numbers of masks being used and staff confused and put at risk. Staff working in offices were put at risk from each other. Another example is the guidance on outbreak management. It was known that the incubation period of COVID-19 was no more than 14 days and yet the guidance stated that an outbreak could not be stood down until 28 days after the last new case. This made managing the patient flow and bed occupancy really challenging. I found that there was little support from national bodies or decision makers and where it was

present, it was slow. When guidance finally became collaborative between PHE, NHSE and the Royal Colleges it was really helpful. This should have happened from the outset as prior to this, the Royal colleges and other national professional bodies were issuing guidance which was at odds with national guidance. The issue with definitions of aerosol generating procedures was a typical example where Royal Colleges and the Resus Council recommended FFP3 masks for resuscitation but the national guidance did not. As a Director of Infection Prevention and Control (DIPC) I found that guidance did not come directly to me, even when it was stated as being sent to DIPCs. When I asked regional colleagues why this was I was told that there was no nationally or regionally maintained list of DIPCs. This seems to be a basic requirement when dealing with a pandemic.

47. MTW was lucky in having an excellent emergency planning team which had pandemic plans in place ready to be taken off the shelf. In preparing for any future pandemics I think there needs to be much more collaborative planning between national, regional and local teams.

48. Although the pandemic was a very challenging period for the Trust and our staff, it was also the source of some notable successes exhibited to this statement as Exhibit SM/08 – INQ000477364.

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.

Personal Data

Signed:

Dated: 28th June 2024