Witness Names: Louise Stead
and Jacqui Tingle
Statement No.:
Exhibits:
Dated: 05/05/2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF LOUISE STEAD AND JACQUI TINGLE ON BEHALF OF THE ROYAL SURREY NHS FOUNDATION TRUST

We, Louise Stead and Jacqui Tingle, will say as follows: -

1. Overview of the Trust

1.1 The Royal Surrey is a public benefit corporation, licensed as a Foundation Trust under the National Health Service Act 2006 since December 2009. We are an award-winning, multi-site Trust across Surrey, providing core hospital services and adult community services to around half a million people, and NHS specialised commissioning services as a tertiary cancer centre to around three million, including radiotherapy and robotic surgery. We are a core partner in the Surrey Heartlands Integrated Care System (ICS), working with other partners to strengthen out-of-hospital services, improve access to the right urgent care services, and align and join up care across Surrey and Guildford and Waverley, thereby reducing inappropriate admissions to hospital.

2. External communication and guidance

2.1 During the pandemic, we attended regular briefings by the Secretary of State for Health and Social Care, the Department of Health and Social Care, NHS England, the Chief Medical Officer for England, and the Deputy Chief Medical Officer for England, and maintained regular contact with key individuals as required. We also

maintained communication channels with Public Health England (PHE), the UK Health Security Agency (UKHSA), Ventilator ChallengeUK Consortium, the Cabinet office, government commercial functions, NHS Race and Health Observatory, Trade Unions, the MHRA, and other relevant bodies and organisations throughout the time period in question. We adhered to guidance shared by the Government and health authority organisations, and submitted data returns as requested.

2.2 Initially, the national team did not have a direct link to the Infection Prevention and Control (IPC) Team, and shared guidance through various other routes such as the Medical Director, Chief Nurse, or Emergency Preparedness Resilience and Response (EPRR) Team. The Gov.net website was difficult to navigate to locate required guidance. Subsequent Government Covid-19 web alerts were established by the IPC team, and communication was improved from July/August 2020 via direct link between the Regional IPC Lead to IPC Team.

2.3 In the initial phase, national guidance was updated frequently, sometimes daily, due to the evolving situation, which led to continuous internal guideline review and challenges managing this at Trust-level. Frequent updates were provided at varying times, often toward the end of the week, leading to challenging turnaround of internal communication, particularly prior to weekends. The IPC team moved to a seven-day service in March 2020 to ensure enough available experts to quickly mobilise changes received at any time. However, changes were challenging to manage with local communication and minimal national communication to support to staff who began to mistrust national guidance. For example: when Covid-19 was re-classified as a high consequence infectious disease (HCID), staff felt this was due to a lack of PPE to manage the situation from a national and local level; changes in PPE provision for staff led to challenges with staff mistrust in the national guidance and relied heavily on the local communication; changes from routine use of FFP3 masks for possible/confirmed cases to fluid repellent face masks posed challenges for the IPC Team delivering communication to staff as they did not feel this then offered them adequate protection; when guidance changed for FRSM to be worn at all times and FFP3 for AGPs, staff were confused and IPC Teams felt undermined.

2.4 National guidance was at times ambiguous or vague, causing variation in interpretation and application. It also devolved decision-making to the Trust based on local risk assessment, leading to challenges in dealing with the unknown, and staff scared of making the wrong decisions. For example: initial guidelines indicating when to use fluid repellent face masks and FFP3 respirators were indicative of high risk units and for possible/confirmed cases, there was reduced clarity on classification of all areas, so decisions were made based on risk review and guideline interpretation; clinicians felt that certain patient groups should be classified as 'extremely vulnerable' for PPE provision although not strictly identified within guidance, leading to variation in individual practice; there was a lack of provision and guidance for staff who experienced adverse reaction to fluid repellent face masks; there was no correspondence from UK Government bodies relating to critical care ventilator capacity. Furthermore, guidance was largely acute hospital-focused and lacked clarity for other settings, such as for PPE classification on home visits, so local practices and procedures were agreed. The IPC Team regularly liaised with the UKHSA Team and Regional IPC Lead Nurse on discrepancies or queries, and would receive national feedback signposting to guidance or advising local risk assessment review from application in practice. We established support networks with neighbouring Trusts to discuss and produce local guidelines in an aligned approach to areas of uncertainty, and attended and contributed to Regional IPC meetings (from July/August 2020) to ensure a collaborative working within the region.

2.5 Other health authority organisations issued their own guidance, at times directly conflicting with national guidance, and there appeared to be no collective or definitive thought. This variance reduced staff's trust in national guidance, feeling that advice was not safe or evidence-based, leading to significant unnecessary worry, and the IPC Team were often challenged by clinical teams, leaving them feeling conflicted and further undermined. For example: Royal College of Gastroenterologists guidance that FFP3 masks should be worn for colonoscopy; Resuscitation Council UK variation of guidance on classification of aerosol generating procedures and level of PPE required for cardiopulmonary resuscitation, in contrast to UKHSA at the time (March 2020); Royal College for

Speech and Language Therapists discrepancy in view of the whether dysphasia screening warranted increased PPE due to risk of a cough, in contrast to the UKHSA guidance at the time (June 2020). This was raised with the UKHSA and at regional level, although response was re-iteration of the national guidance. Different teams within the Trust had varying response to this, with some following national guidance and others following that of another organisation.

3. Internal communication and guidance

3.1 Updates on the national picture, PPE advice, and provision of available PPE were communicated to key individuals through Daily Covid Response Incident Management meetings. Critical care was discussed at least twice a day, including a network discussion, with assessment of capacity, bed availability, and any arrangements required to expedite the discharge of patients ready to leave the hospital.

3.2 Daily Trust-wide briefings were issued by the Executive team from 11th March 2020, to communicate changes to all staff. This was then de-escalated to weekly briefings further on in the pandemic. There was a strong narrative within communications to ensure that any miss-messaging was addressed by senior leadership in the form of the daily/weekly briefings or Trust-wide communications. Question and answer sessions were also provided for staff Trust-wide.

3.3 As national UKHSA guidelines were followed, the Trust did not have a separate internal policy for Covid-19. It was, however, incorporated in the Acute Respiratory Virus Guideline.

3.4 The Trust utilised action cards to support implementation of national guidance and ensure that correct information was available for all staff, as agreed by the Executive team due to previous successful use of action cards in response to viral haemorrhagic fever in 2013-14. The first Covid-19 action cards were produced on 29th January 2020. Versions one and two were hand delivered to ED and a few other relevant departments. All subsequent versions were emailed

to all senior clinical managers with a brief description of changes, for dissemination, communicated Trust-wide via 'operational update' emails, and publish on the Trust's intranet. See exhibits LSJT/01 [INQ000503310], LSJT/02 [INQ000503311], LSJT/03 [INQ000503312], LSJT/04 [INQ000503313], LSJT/05 [INQ000503314].

3.5 This messaging was the supported by the IPC team who carried out daily ward visits and verbally communicated changes to teams, including the delivery of any posters or action card changes, and information/guidance to individuals and teams as required on specific queries or concerns. The Trust's 100+ IPC Champions ensured communication across the Trust, in different teams and professions, through departmental-based IPC support, signposting, and communication. They identified gaps in knowledge and communication, which the IPC team then addressed with targeted teaching/communications. They were named on departmental notice board to ensure staff could identify them. The IPC champions were also a great asset in regards to FFP3 fit testing support at departmental level. The Trust also established PPE champions within teams to support and drive best practice. Posters were produced and distributed to all clinical areas, for visual reminders.

4. Fit testing

4.1 An FFP3 Mask Resilience Project Meeting was established for oversight, monitoring, and to ensure good communication with all divisions on fit testing assurance and compliance, which then fed in to the board assurance framework.

4.2 Fit testing was managed through at a departmental level throughout the period in question, with ward-based fit testers across the Trust. Due to initial rapid escalation, fit testers were promptly expanded within departments, supported by the IPC Team, Practice Development, Covid Response Team, and departmental fit testers. Individual fit testers were identified by name on notice boards. From December 2020, two National Fit Testers were also on site five days per week.

4.3 Additional supportive training sessions were implemented Trust-wide, available to all staff, including fit testing and drop-in donning and doffing PPE sessions.

There was significant pressure to ensure training, and 'train the trainer', and all fit testers competency assessments. We also produced additional Trust-specific videos alongside national guidance for staff to use, including implementation of a fit check video and PPE donning and doffing videos on our intranet on 9th April 2020 and 28th October 2020 respectively, and a PPE donning and doffing video on our internal e-learning platform on 29th September 2020.

4.4 The Trust initially used qualitative hood fit testing, however, a staged roll out of alternative quantitative methodology was introduced from 8th June 2020. This meant that fit tests could be carried out back-to-back without the need to allow the palate to clear, and when there was insufficient supply of fit testing solution and kits, or a fit test failed, a repeat test could be facilitated after the wearer's palate had cleared, at a later time or another day. Use of this method depended on the situation and clinician availability.

4.5 There were no specific issues raised in relation to PPE fit for specific ethnic groups or gender groups. There were some staff throughout the organisation across different ethnicities and genders, and staff who had smaller faces, who were not able to be fit tested to disposable FFP3 masks that were being provided by NHS supply chain. The IPC team provided the list of available masks to local and national fit testers to enable them to try a range of masks for staff. These staff were offered an alternative use of a mechanical FFP hood when introduced in the Trust from 4th June 2020.

4.6 The Trust and several other Trusts were informed by 3M that the 1863 and 1873V were interchangeable masks not requiring re-fit testing, however, a number of staff had to be re-fit tested when correct information was known.

5. Lateral Flow Testing (LFT)

5.1 The Trust was one of six early adopter Trusts for LFT roll-out within the South East region. Initially, we engaged in weekly meetings with the South East Covid-19 Testing Capacity and Resupply Lead, part of NHS England, to discuss consent, delivery, storage, and appropriate IT systems for staff to register results.

5.2 The Trust commenced roll-out on 17th November 2020 with a 'big bang' approach, and began daily meetings with the South East Covid-19 Testing Capacity and Resupply and other Trusts to monitor progress.

5.3 This was a positive experience with real collaboration and equal effort for all partners, and we cannot recall any concerns or issues being raised during this process. We embraced the LFT roll-out and maintained adequate stock due to the robust governance process put in place.

6. Oxygen supply and ventilators

6.1 In approximately 2017, the Trust's main oxygen supply pipework was reviewed and was upgraded to allow increased supply, which proved very important during the pandemic, and would have impacted our ability to use the new oxygen tank and supply the demand required so quickly had it not been done.

6.2 No issues of procurement of the gas were experienced during the period in question. Our provider, Air Products, were extremely helpful, supportive, responsive, and recognised the risk to our patients. Having this partner to work with was very important.

6.3 Due to issues with national oxygen supply, we were concerned about our ability to meet the increasing demand, particularly as we were building a new 20-bed isolation ward which would require sizeable increase of oxygen use, and therefore reviewed our usage in the early stages of the pandemic. We identified a risk to suppling the required capacity and ability of the current oxygen unit being able to meet demand, determined that a secondary system was required. Our provider supplied a temporary oxygen plant to site in less than two weeks (subsequently changed to a permanent system post-pandemic), which was put into service on 10th April 2020. Both systems worked in unison and no supply issues were experienced.

6.4 Oxygen cylinder availability was restricted by our supplier, BOC, on the instruction of NHS England, which caused supply issues in the face of increasing demand. Ambulance crews regularly requested to exchange empty cylinders which we were

unable to provide due to a strict 'empty for full' policy adopted by BOC. This was managed through close communication with BOC and regular stock checks.

6.5 There were concerns around sufficient provision of additional oxygen to all potential areas in the hospital that may have required it. The Medical Gases Committee held an emergency meeting, and a flow-mapping exercise was undertaken by a multidisciplinary team who understood the key requirements and potential limiting steps, to identify the additional medical oxygen required, where, and how it could be provided. An exercise was also undertaken to understand which areas could receive the most oxygen dependent on their piped supply and maximal flow rates. Obtaining equipment to undertake this and creating a flow map of potential supply was without issue and allowed forward planning

6.6 The Department of Health and Social Care provided us with 10x GE R860 ventilators; 80x UCL Ventura CPAP; 80x Flo-Ox Oxygen Monitors; and 26x Visionaire 5 Portable Oxygen Concentrators. Other than the Visionaire 5 Portable Oxygen Concentrators, these devices were not used, primarily due safety concerns of non-standardised devices, lack of appropriate consumables, and no competency training for clinical teams. For example, UCL ventilators had labels advising they 'should not be used for clinical use'.

6.7 We independently procured 8x PB 980 ventilators to standardise with our current fleet of ventilators; 5x EV300 ventilators; and 22x Trilogy EVO ventilators. These were standardised devices, so no additional training was required, and they could be used safely.

6.8 Our distribution of ventilators was sufficient during the pandemic. There were no delays in obtaining equipment, and no major incidents declared on the basis of such equipment being full or near full capacity in intensive care. Critical care networking within the local healthcare systems was a significant factor in this, with all such units declaring their capacity at least once per day, allowing mutual aid to be arranged, or patients to be moved between providers if required. At no stage was any patient requiring ventilation refused the equipment due to a lack of availability.

6.9 When we were required to expand intensive care capacity there was an occasion that we were offered a ventilator by the national team that was not a known product or manufacturer. The same occurred for different type of CPAP, and was therefore not accepted due to pressures on clinical teams to learn and operate different equipment. We also experienced challenges on maintaining one manufacturer for our vital sign monitors. Despite this, strong relationships with our existing manufacturers and suppliers meant that we were able to source our preferred equipment directly rather than using the national model.

7. Procurement of other key equipment and supplies

7.1 Overall, approximately 90% of the PPE we used was provided by the UK Government, and the remainder was from local sources.

7.2 Initially, the NHS Supply Chain did not provide any procurement support, and FFP3 masks were unavailable. PPE was donated and homemade visors were used. PPE was procured directly, under the responsibility of the Procurement Team with clinical sign-off of all requests. There was no additional staff training for this. Our Procurement and IPC Teams held a close relationship to ensure that appropriate products were sourced. Existing suppliers were used where possible, and systems already in place were used for any ad hoc orders. A new system with Foundry was established to manage procurement, although this required manual intervention. No contracts were awarded to other suppliers for PPE. No separate supply chains or systems were established. No Direct Awards, Dynamic Purchasing Systems of Framework Agreements were used to purchase PPE. We were not reliant on any local businesses or voluntary or community organisations for our procurement. We were not affected by any issues regarding access to appropriate stock of healthcare equipment held by commercial organisations. We took part in mutual aid, using one drop location and no option to return stock, although mutual aid was not required for PPE. Once the NHS Supply Chain 'push' model was in place (see below), only surgical gowns and specific gloves were being procured directly.

7.3 When any new suppliers were engaged, they were vetted using standard due diligence processes, with the manufacturers of any goods they provided being

those already known by our organisation. Due diligence and company check processes meant that no cases of fraud or counterfeiting were identified. There were no concerns regarding the ability to undertake these processes or their effectiveness. Any conflicts of interest relating to procurement decisions were declared at the beginning of the meetings that were held every morning, and action taken appropriately.

7.4 The NHS Supply Chain subsequently implemented a 'push' model to provide equipment and supplies, however, there were a number of issues with this model. Equipment was allocated based on expected numbers of Covid-19 patients, not provider choice, and PPE was acquired based on modelling created at the start of the pandemic, with a reliable inventory only being achieved manually. This meant that we were not always aware of what PPE supplies were going to be received, often differing. There were a number of issues with efficacy, including the frequency of deliveries, over delivery of some unwanted stock, putting pressure on storage facilities, and under supply of required equipment. Products were of insufficient quantity and quality, such as weak IIR masks, thin aprons, lack of gowns and clear IIR masks. No hoods were supplied. There was at times insufficient supply of fit testing solution and kits. Additional fit testing was required for each type of mask, and there were occasions where some staff were unable to be fit tested to masks that were available. Expired FFP3 masks were received with letters to explain rationale and advise they were safe for use, however, staff were not confident about their use and it felt uncomfortable to advise staff to use them. We questioned the validity of the CE mark that accompanied IIR face masks. Yellow gowns and FFP3 & IIR face masks were recalled. In addition, costs were subject to significant fluctuation with prices for gloves, surgical masks, and FFP3 coverings increasing by over 400% during the period. We were unable to purchase blood bottles through this model. See exhibits LSJT/06 [INQ000503315], LSJT/07 [INQ000330809], LSJT/08 [INQ000339128].

7.5 The central procurement portal was helpful once in place, and there was transparency of goods being shipped to all other neighbouring Trusts, although it remained hard to return any unwanted stock.

7.6 Sessional use of PPE led to issues with overuse/extended use of PPE and so the Trust worked hard to secure all single use PPE items. Some re-usable equipment was procured, including 3M & person hoods and JSP masks; this was roughly 2% of the PPE deployed during the period.

8. Demand and stock management

8.1 Demand management was very poor at the start of the pandemic, and there was a high level of competition of key healthcare equipment, with challenges experienced on getting equipment through the national team as new wards were established at our hospitals, and particularly when supplies were required for additional intensive care capacity. Suppliers were directed to use the national model for the majority of PPE, and adhere to a policy of providing goods directly to the NHS Supply Chain, meaning that new supply chains could not be established and making it hard to procure equipment or supplies directly.

8.2 PPE was managed at a departmental level by the clinical teams and the materials management team, and manual checks undertaken by the Material Management Team were used to keep track of PPE stocks. We did not stockpile any key equipment or supplies. Stock and demand were reviewed on a daily basis and any issues escalated. An internal Personal Protective Equipment Group was established, comprising the Director of Infection Prevention and Control, staff from the IPC Team, Health and Safety Team, Procurement Team, and divisional representatives. At weekly meetings, this group reviewed processes, stock, storage, risks, and challenges, and escalated any issues. Grab boxes with the appropriate PPE were disseminated along with hard-copy action cards in the initial phase. All staff, regardless of the contractual arrangements governing their work for us, had access to PPE from our stock if it was available. This was used on a sessional basis rather than for single patients, in line with national guidance, however, it was felt by the Trust to be against general IPC principles.

8.3 We regularly updated the list of FFP3 masks that were available on our intranet, and contacted manufacturers directly to understand timelines for alternative masks being available. In the event of no mask being available, staff were removed from high risk Covid-19 areas.

8.4 There were insufficient masks for staff to use when speaking to patients who relied on lip reading as their main means of communication. To mitigate this, staff were advised to stand at least two meters from the patient and remove their FRSM in order to adequately communicate. Clear masks were not officially available until July 2022, after this inquiry was constituted.

8.5 Lack of central blood bottle supply was addressed by working collaboratively across our pathology network to ration stock across the six connected hospital, with collaboration with the pathology/phlebotomy teams at these organisations helped us to identify the range of bottle tops to be issued to clinical areas and the supporting information required. Blood bottles were made available on request rather than usual supply levels being held.

8.6 For dialysis, Baxter stock was subject to demand management, with close monitoring and work with the national team and mutual aid required.

8.7 The following volumes and values of excess PPE were held by the Trust at the end of the pandemic:

PPE	Quantity	Value (£)
Aprons	111,000	2,220.00
Coveralls	0	0
Goggles	1,300	1,014.00
Visors	10,400	4,576.00
II / IIR / FFP1	200,340	22,037.40
FFP2 / FFP3	57,649	117,603.96
Gloves Nitrile	519,400	15,582.00
Gloves Vinyl	0	0
Gloves Latex	0	0
Gowns Non Sterile	11,626	3,022.76
Gowns Sterile	7,248	10,147.20

All excess stock remaining was all provided by the Department of Health and Social Care. This was not used as the numbers of patients being treated for Covid-19 decreased more rapidly than the amount of stock being provided.

9. Funding of key equipment and supplies

9.1 From February 2020 to March 2020, Covid-19 expenditure was recorded in separate cost centres, then claim submitted for additional funding to NHSE for these costs.

9.2 From April 2020 to September 2020, the Trust received funding direct from NHSE to ensure that it broke even each month, so pressures from PPE purchases were included in this funding.

9.3 From October 2020, we received a set amount of funding from our ICS to cover likely costs of Covid-19. This reduced over the next year and a half, as the impact of the pandemic reduced.

10. Lessons Learnt in relation to Module 5

10.1 We undertook a Trust-wide lessons-learnt review following phase 1 of the pandemic, reflecting on key challenges and how these were overcome, as described in this statement, and additional learning that we could take forward to inform our response to further phases and any potential further pandemics. Examples of good practice we implemented include the IPC team seven-day service (paragraph 2.3), and regular communication and collaborative working between different departments within the Trust and supply chain (section 3).

10.2 A further lessons-learnt review was undertaken in December 2022, highlighting a requirement for more efficient distribution of supplies from our Guildford hospital site to our community services, and the importance of maintaining training standards, such as fit testing, and keeping full and accurate records of staff information across the NHS, such as doctors' fit-tested mask types to inform procurement as they rotate between providers.

Statement of Truth

We believe that the facts stated in this witness statement are true. We 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: PD PD

Dated: _____30/10/2024_____