IN THE MATTER OF

MODULE 3 OF THE UK COVID-19 PUBLIC INQUIRY

OPENING SUBMISSIONS ON BEHALF OF THE ROYAL COLLEGE OF NURSING

1. The Royal College of Nursing ("RCN") extends its thanks for the opportunity to participate in and contribute to the UK Covid-19 Public Inquiry ("the Inquiry") in respect of the Module 3 hearings which will consider the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland.

2. As the Inquiry will be aware, the RCN is the representative voice of nursing across the four nations of the UK and is the largest professional union of nursing staff in the world. It is a registered trade union with over half a million registered nurses, student nurses, midwives, nursing support workers and healthcare associates. Members work across NHS hospitals and specialist health facilities, in care and nursing homes, the community and independent healthcare sector, amongst other settings.

3. The RCN continues to offer its condolences and its heartfelt thoughts to everyone who has lost loved ones during the pandemic. It will never forget the sacrifice of healthcare professionals, including those who passed away as a result of the pandemic and those who continue to feel the impacts on their health as a consequence of Covid-19 including Long Covid. The RCN is committed to continuing to advocate for and support those of its members that were impacted by the pandemic.

4. This submission sets out some of the RCN's key concerns in respect of the impact of the pandemic on healthcare systems in the four nations.

<u>Impact on nursing staff</u>

5. Since nursing staff played a central role in health care services during the pandemic, it is essential to place consideration of the impact on them at the heart of this module. The RCN's members were impacted in terms of the work they had to do day in and day out, what support was available to them in order to facilitate that work and the toll that their work took on their mental and physical health. Many nurses continued their

professional commitment despite the risks to them as they were pregnant or clinically vulnerable. The impact on nursing staff included suffering from Covid-19 themselves, often on multiple occasions. Many continue to suffer from Long Covid.

6. It is well known that nursing staff across the UK carried the heavy burden of the Covid-19 pandemic. Our nursing community responded to the global health crisis in extraordinary ways, coming out of retirement, putting aside their studies and being redeployed to specialised or new clinical areas.

7. Throughout the pandemic, the RCN engaged with its members through existing interactive support services via a call centre and online platform known as RCN Direct ("RCND"). The RCN received approximately 28,604 contacts from members on Covid-19 related issues during the period March 2020 to the end of June 2022.

8. From these member contacts, much of the impact felt by RCN members was documented contemporaneously. Nurses and healthcare workers reported, amongst other things, that they were:

    a. Attending work despite not feeling well enough to perform their duties;
    b. Being asked to work in conditions they considered to be unsafe;
    c. Isolating themselves from their families in order to protect them;
    d. Spending extended periods of time wearing PPE which caused damage to their skin and contributed to fatigue and heat stress;
    e. Feeling depressed, anxious and stressed;
    f. Experiencing symptoms indicative of probable post-traumatic stress disorder.

9. Alongside these difficult experiences, nursing staff were confronted with professional dilemmas, such as: whether or not to treat patients without wearing appropriate RPE and PPE; how to delegate tasks appropriately when there were insufficient or insufficiently-trained staff available; whether or not to undertake work at a higher level than they were familiar with; and ensuring they balanced their unpaid overtime with considerations of patient safety so that their overwork and exhaustion did not present a risk to others.

10. Nursing staff from ethnic minority groups, as in the general population, suffered poorer outcomes of Covid-19 infection, exacerbated by existing structural inequalities and institutional bias within the healthcare system.

11. The pandemic worsened the financial difficulties experienced by many RCN members who reported difficulties in establishing their entitlement to sick pay, and issues around the level of pay that shielding members were entitled to from their employers. The RCN's position was that health and care staff should not suffer any financial detriment for being away from work in order to protect public safety.

12. Nursing students suffered as a result of Covid-19, including concerns about academic deadlines, clinical placements and deployment, testing and risk assessments, registration, pay and sick pay, indemnity and life assurance, and stress levels.

13. Pregnant members and those on maternity leave raised queries about their rights and obligations in relation to attending work in high-risk areas, and those already with children experienced childcare difficulties. This was in addition to concerns for their personal health and the health of their unborn child/children.

14. Members contacted and continue to contact RCND in large numbers with queries about Long Covid. Although exact figures are not known, the prevalence of Long Covid amongst staff working in health care is significantly higher than in the wider population. Many RCN members who contracted Long Covid via exposure to Covid-19 at work have either already lost, or are now at risk of losing, their employment due to ongoing health issues and the lack of workplace support to enable them to remain in employment. Further, the impacts of the pandemic have been unequal across the population, exposing long-standing structural inequalities that have impacted RCN members as members of the groups subject to inequalities.

15. Evidence shared with the Inquiry from RCN members highlights the feelings of fear, panic and dread and their sense of vulnerability, as well as the emotional and physical toll of dealing with death, pain and suffering daily at levels they had never experienced before.

<u>Short staffing of the nursing workforce and the inability to scale-up capacity</u>

16. Crucially, the size and characteristics of the healthcare nursing workforce, across all sectors, was inadequate to meet demand for care and service delivery prior to the pandemic, during the pandemic, and continues to be so after the pandemic. For many years the RCN has been advocating for the Government and Devolved Administrations to take more urgent action to fill vacancies, retain existing staff and bring new entrants

into the nursing workforce. Too few nurses have studied at university and joined the profession, too many have left their nursing careers and, of our colleagues that remain, too many feel overstretched and undervalued.

17. The likely impact of nursing staffing levels on the ability of the UK to react to the pandemic, however, was known well before the events of 2020 and after. As early as June 2003, Exercise Shipshape highlighted the importance of standing NHS surge capacity. A report by the Health Protection Agency in 2005, however, suggested there were limited resources to surge staff in the event of an extended outbreak such as SARS. The report by the Chair in respect of Module 1 also highlights severe staffing shortages in the NHS and social care as one of the factors directly adversely impacting the ability to 'surge up' capacity during the pandemic.

18. Low nursing staffing levels during the pandemic impacted patient care and staff morale and contributed to increased numbers of nursing staff considering leaving the profession. Elevated staff sickness levels (in addition to those self-isolating and shielding) during the pandemic further exacerbated the workforce shortages and had a direct impact on the sustainability of services and the ability of staff to deliver safe and effective care, placing patients at risk of missed episodes of care. Nurse-to-patient ratios were diluted, impacting the level of care that could be provided. Members had to adapt to new ways of working at a rapid pace and often without adequate support. This put additional pressure on nursing staff, contributing to increased levels of anxiety and burn out.

19. The RCN considers that a workforce crisis was well entrenched in the health and care service before the Covid-19 pandemic struck, which significantly impacted the ability of the UK to appropriately prepare for the impact the pandemic would have on the healthcare sector. The Covid-19 pandemic shone a spotlight on the critical role undertaken by nursing staff across the UK. RCN members continue to report feeling overstretched and undervalued today.

20. Many student nurses and nurses who had retired were mobilised during the pandemic to address the shortfall in the workforce numbers. Nursing staff of all grades delayed retirement, and retirees returned to work. Many were redeployed to unfamiliar clinical environments, and organisations redesigned their service delivery model to maintain services to patients, residents in care homes, and the wider community. The impact on the nursing workforce and nursing students cannot be underestimated. Staff were redeployed to areas where they had no experience or expertise. The understaffing left

inexperienced staff with too much responsibility which consequently had a significant detrimental impact on their mental health.

21. Policy makers in UK Government hid behind a narrative that the pandemic was to blame for the ongoing collapse of the healthcare system, refusing to acknowledge the extent of the workforce shortage until June 2023. This failure in accountability and transparency further damaged an already depleted system and workforce, the effects of which cannot be remedied quickly enough to ensure patient safety and to meet the expectations of the wider UK public.

<u>The supply, distribution and use of Personal Protective Equipment ("PPE") and Respiratory Protective Equipment ("RPE")</u>

22. As the Chair's report for Module 1 indicates, the importance of PPE arose regularly in preparation exercises prior to the Covid-19 pandemic. The Chair's report also confirms that the need for a stockpile of fit-tested PPE in sufficient quantities prior to a pandemic was clear. Existing stocks of RPE and PPE, based on modelling for an anticipated influenza pandemic, however, were insufficient. Without adequate and proper RPE and training in its use, nursing and midwifery staff put their own lives, and the lives of their families and patients, at risk. These supplies should have been modelled on Health and Safety Executive recommendations concerning the need to comply with Health and Safety legislation, and the adoption of a 'precautionary approach' to the protection of healthcare workers. The level and quality of supplies should not have been dictated by cost or opinion or confusion over non-UK adopted frameworks such as the 'hierarchy of controls'. In our submission, the pandemic stock levels were vastly underestimated and that global demand, as expected in a pandemic, was not sufficiently considered.

23. It is the view of the RCN that a lack of clarity on use of the term "PPE", combined with a culture of assumptions that historical influenza guidance and views on its transmission and impact on a UK population in the 21st century, was inadequate, placed healthcare workers at unacceptable risk in the workplace when faced with a novel pathogen. Challenges around distribution and the inequality in supplies/distributions for healthcare and other non-NHS services were among the main issues. Due to those challenges, there were reports that RCN members had been required to reuse single use equipment, to use equipment previously marked as out of date, to clean used gowns with alcohol wipes and to use alternative 'protective' equipment which had been donated and did not provide adequate protection or meet

the required standards. Whilst public donations of supplies were signals of support to frontline staff, they did not replace the legal responsibility of system leaders and governments to ensure that correct PPE was provided. The RCN received reports of members wearing makeshift gowns out of bin bags, ski-masks or swimming goggles when PPE of the required standard was not available. Health care professionals described feeling like "*lambs to the slaughter"* or *"cannon fodder"* and that they were *"scared"* and were left feeling *"let down and frustrated".*

24. The RCN regularly expressed its concerns in correspondence to the UK Government, Devolved Administrations and other relevant bodies including the Health and Safety Executive throughout 2020-2022, regarding the difficulties its members had in accessing adequate supplies of PPE. Further, one-size-fits-all protective equipment was a problem for frontline healthcare workers who had to wear this life saving equipment for up to 12 hours at a time. At the time of the pandemic a number of brands were not producing masks which fitted female faces, particularly with the shape and design of masks being too big and causing many female nurses and doctors to fail the fit-testing process. Nor did the masks meet the needs for an adequate fit for members of ethnic minority groups.

<u>Fit testing, fit test training and difficulties which arose due to physical attributes</u>

25. Fit testing became a cause of significant concern. The Inquiry is aware that FFP3 respirator masks offer a high level of protection and require users to undergo fit testing by a person competent to do so in line with health and safety requirements. This ensures the mask fits the individual correctly and a tight-fitting seal is achieved to protect the wearer from inhaled hazards, in this case the SARS CoV-2 virus. Problems with a lack of trained and available staff to fit-test PPE resulted in staff being withdrawn from clinical care at the height of the pandemic response to undertake the necessary face-fit training, which in turn caused friction between the RCN and employers.

26. Nursing leaders reported being given up to 17 different types of masks within one Trust which meant that the fit testing of all staff was repeatedly required, and some members reported that equipment needed to undertake the fit testing faced additional procurement and supply issues. Some members reported that equipment to undertake fit testing was not available to them and that demands to 'fit check' not 'fit test' (as per legal health and safety requirements) placed nursing and midwifery staff at risk due to issues with masks not providing an adequate facial seal due to different face

sizes/shapes. This created additional pressure and delays for staff and the system at this critical time.

Airborne transmission of Covid-19

27. Intrinsically linked to the adequacy and provision of PPE were the impacts caused by multiple agencies advising the Government's understanding and application of how the virus was transmitted, which was contradicted by historical evidence of other coronavirus incidents such as SARS and MERS CoV and the emerging scientific evidence. The RCN lobbied the UK Government and Devolved Administrations to review and accept that Covid-19 was an airborne virus rather than one transmitted predominantly by droplets. However, in our submission, the Government allowed or were persuaded to accept the belief that the virus was transmitted via droplets (unless in specific Aerosol generating procedures ('AGPs')) to permeate and inform every decision and guidance issued by its official agencies in relation to infection prevention and control during the pandemic. The RCN notes this advice contradicted the advice provided to the wider public who were encouraged to open windows to remove infective particles lingering in the air in their homes as described in the Hands, Face, Space Government video of November 2020.

28. Given the extent of its concerns, and its inability to influence alternative thinking and action to support the prevention of infection, the RCN commissioned an Independent Review of the UK IPC guidance, written by Professor Dinah Gould, an Honorary Professor of Nursing at London's City University and Dr Edward Purssell, also from City University and published this on 07 March 2021. The report questioned the methodology used and evidence reviewed to inform UK wide-guidelines for infection prevention and control 12 months into the pandemic when opinions about the way that SARS-CoV-2 was transmitted had changed and it was becoming apparent that airborne transmission beyond the technical process of aerosol generating procedures was possible and likely.

29. The RCN's own independent expert report was shared directly with a number of key stakeholders, but at no time did these parties suitably address the concerns raised by the RCN and initiate their own independent reviews, to critically challenge the accepted dogma at the time, as per the original request of the RCN. The later decision by the World Health Organisation to categorise Covid-19 as an airborne virus vindicated the RCN, but it came too late for those who had acquired Covid-19 as a result of inadequate PPE.

30. Ultimately, the RCN found that there was a serious lack of critical thinking and engagement by the UK Government and its agencies to consider the growing international scientific evidence of airborne transmission of Covid-19; the UK Government and health leaders dismissed such evidence and found in favour of ongoing enforcement of droplet transmission dogma despite the absence of any supporting evidence. The impact of these decisions on the healthcare sector requires to be critically examined by this Inquiry.

IPC guidance

31. The RCN found that there was a serious lack of engagement from the UK IPC Cell, PHE/UKHSA, HSE and the Department of Health, amongst others when developing, reviewing and updating IPC guidance, specifically in relation to IPC guidance development despite previous experience and recommendations to do so. The RCN's expectation was that stakeholders such as the Royal Colleges, BMA and other relevant professional societies would be proactively engaged, especially given the seriousness of the situation, in the development of guidance as per our previous experience of major incidents of infectious disease incidents to ensure appropriate contextual content and implementation in practice. As the pandemic progressed our correspondence and professional offers to support the development of such guidance were often ignored or offers to meet to provide evidence turned down. The RCN expected that, given the fundamental role of the nursing profession as the largest professional workforce in implementing IPC measures, that guidance-making bodies would want to engage with the nursing profession. Nurses had, and have, unique and useful expertise in order to inform those who developed and approved IPC guidance and are ultimately responsible for implementing such guidance in practice.

32. This lack of engagement prevented the RCN from putting forward practical and clinical rationale for amendments to draft guidance in order to protect patients and clinical staff during the delivery of care. This approach also impacted on the ability of stakeholders such as the RCN to consider the implementation of guidance across different care settings where specific considerations were necessary, such as mental health inpatient settings.

Risk assessments

33. It is a legal requirement that suitable and sufficient workplace risk assessments are carried out by employers and adequate control measures identified to reduce risk as far as reasonably practicable -- Regulation 3 of the Management of Health and Safety at Work Regulations 1999 and COSHH. Given that legal framework individual clinicians should have been empowered by their managers to determine the correct level of RPE/PPE that they required based on their own dynamic risk assessments and informed by their organisation's workplace risk assessment. Anecdotal evidence from members indicated that such workplace risk assessments were absent or, where they did exist, were inadequate. The extreme experience of some members was that RPE deemed necessary by their individual assessment of risk in the workplace was physically removed from their work environment to avoid its use. This revealed a dangerous and worrying precedent and lack of understanding by employers. The Inquiry is invited to look further into this issue.

RIDDOR reporting

34. Despite evidence of healthcare workers being at significantly higher risk of Covid-19 infection, due to the nature of their work, there was a significant underreporting of cases of Covid-19 in healthcare settings.

35. The fact that the rate of death amongst nursing staff was significantly higher than the general population of a similar age group highlighted the need to properly investigate the factors contributing to their deaths, and, in the light of the lessons learned, to give nursing staff the protection from risks that they needed. The RCN believes that the HSE failed to hold employers to account for failing to make proper judgements as to whether a confirmed diagnosis of Covid-19 was likely to have been caused by occupational exposure. All frontline staff deaths related to Covid-19 should have been reported as occupational fatalities as a precaution.

36. Apart from the reporting of incidents of disease to the HSE, under RIDDOR there was no central data collection system in place to collate the number of healthcare workers who had or may have acquired Covid-19 in the workplace. This lack of data was and remains a fundamental concern to the RCN with respect to learning.

Long Covid

37. Although exact figures are not known, the prevalence of Long Covid amongst staff working in health care and social care in the UK is thought to be significantly higher than in the wider population. The most recent available ONS statistics estimate that 4.14% of staff working in health care and 5.07% of staff working in social care reported having symptoms of Covid more than 12 weeks after contracting it, compared to 2.7% in the wider population. Support for these staff members needs to continue and the impact of Long Covid in terms of increased long-term absence needs to be factored into workforce planning.

38. RCN members with the condition have reported disbelief and reluctance among the medical profession to give Long Covid the recognition it deserves. Although keen to get back to work, many RCN members have found workplace support lacking and reasonable adjustments difficult to secure. Many have therefore faced reduced pay, and some have lost their jobs. These issues cause further distress for those who are already debilitated by the condition. Nursing staff have had their lives forever changed by Long Covid. Its physical impact, coupled with long-term financial insecurity is causing them continued worry.

39. To date, despite most European countries and many countries globally classifying Covid-19 as an occupational disease, the UK government is yet to follow suit. The increased risks of Covid-19 infections faced by nursing staff from ethnic minorities, and thereby increased risks of Long Covid, require particular consideration.

Conclusion

40. As a profession, nursing and midwifery professionals deliver the vast majority of physical and psychological care to patients in all care settings. They have led the way in reducing the transmission of infection by prioritising infection prevention and control measures in their clinical practice. These measures are fundamental to our profession which is uniquely well-placed to understand the importance of infection control and methods to reduce the spread of infection, and in so doing to protect patients from avoidable harm.

41. In the context of the pandemic, the RCN's key focus was the protection of healthcare workers and patients from infection acquired as a result of work or receiving care. The protection of healthcare workers is critical not only to protect them from occupationally acquired disease, but also to ensure that staffing levels are maximised to avoid harm to patients through an under-resourced service. The Covid-19 pandemic taught us

that the experiences of those on the frontline of healthcare was often not considered or dangerously overlooked. There were inadequate opportunities for those representing frontline workers to feed into the development and delivery of guidance, particularly IPC guidance, despite learning from previous incidents of the need for this. Such a lack of opportunities resulted in guidance that was not fit for purpose and which did not address issues that clinicians and health care workers were facing on the ground. In turn this had a detrimental, sometimes fatal, impact on those who were on the frontline of care.

42. The RCN is relying on this Inquiry to establish the facts of and to learn lessons from the impact of the pandemic on the healthcare systems in the four nations. It believes that there are many lessons to be learned identified in relation to governance, decision making and clinical practice. However, in order to inform and be prepared for the next pandemic, the RCN wishes to acknowledge that the greatest lesson to be learned is to ensure that there is a suitably resourced, educated and trained healthcare workforce in place that can respond to the next challenge at speed. Staffing levels need to be based on workforce projections that reflect actual population need with safety-critical nurse-to-patient ratios enshrined in law. Without an adequate number of medical, clinical and healthcare workers, with the right mixture of skills and who are able to deliver the appropriate standard of patient care to meet the demand of the country at the present time in the absence of a pandemic, then there is a poor prospect of the demand created by a future pandemic being met.

43. Demand continues to outstrip workforce growth in the UK's health and social care systems. For too long, the RCN has been highlighting concerns about the lack of workforce planning and the gaps in the nursing workforce as a risk to patient safety. Safe and effective nursing staffing levels are critical for safe and effective patient care. Evidence shows that a combination of registered nurse shortages and higher levels of patients per registered nurse are associated with increased risk of death during an admission to hospital and when shifts or services are short of registered nurses, staff are more likely to report poor quality care, which often results in vital care left undone. In hospital settings, when fewer nurses are on shift, patients have an increased chance of missed care, longer stays and in-hospital deaths.

44. In our respectful submission, this is not just a lesson to be learned but also a warning that with the current level of staffing, the number of vacancies and the long-term effects of the Covid-19 pandemic such as Long Covid, the country's health service and its workers are struggling to meet the health care needs of the population.

Dated 23 August 2024