Witness Name: Rosemary Gallagher
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Exhibits: 84
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF ROSEMARY GALLAGHER MBE

I, Rosemary Gallagher MBE, of The Royal College of Nursing ("**the RCN**") of 20 Cavendish Square, London W1G 0RN, will say as follows: -

1. I make this statement, about the RCN's views on the UK's planning, preparedness and resilience for pandemics, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 18 January 2023, in relation to Module 1 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

2. I make this statement on behalf of the RCN and confirm that I am duly authorised to do so.

Introduction

3. I am the Professional Lead for Infection Prevention and Control ("**IPC**") and nursing sustainability lead at the RCN. I was appointed to the role substantively in July 2009 and have retained responsibility for IPC and antimicrobial resistance ("**AMR**") since then. In addition to this portfolio, I also led and supported a number of RCN member communities such as Forums or Networks across a range of nursing

practice areas including, for example, Blood transfusion, Renal nursing, Breast care and cancer nursing, Gastroenterology and procurement.

4. Prior to July 2009, whilst I was employed by Buckinghamshire Hospitals NHS Trust, I held two part-time secondments which met full-time hours of employment – one with the RCN and the other as Strategic Advisor to the Chief Executive at East and North Hertfordshire NHS Trust on IPC.

5. At the RCN, the key elements of my role are to provide visible leadership on IPC, representing and supporting the RCN, its members and key stakeholders on IPC and AMR and the impact of these on nursing practice. My role is a UK-wide role and I respond to the needs of each country as required. As a member of the professional nursing team, I also provide nursing leadership and representation as required across the RCN's portfolio of professional nursing practice. For example, I attend and support the RCN annual Congress, represent the RCN at events and meetings and undertake presentations and engagements on behalf of the College. I also lead and deliver specific internal projects as part of RCN business planning or delivery of resources and outputs.

6. My expertise in IPC is embedded in my experience in clinical practice, specifically the management of large outbreaks of infection such as the outbreaks of Clostridioides *difficile* ("**C. *difficile***") at Stoke Mandeville Hospital ("**SMH**") and the subsequent national inquiry led by the Care Quality Commission in 2004-2006. As a clinically competent senior nurse, I led the IPC service to support the delivery of safe care within the Trust, working closely with microbiology consultants and the laboratory team, health and safety and occupational health services and aligned departments such as sterile services, estates and facilities and local public health teams. I additionally supported international management of outbreaks and sharing of learning on C. *difficile* based on our experience at SMH (for example I attended a 'support' visit to Montreal and Toronto in 2004 and 2006). I also undertook many 'support' visits to NHS Trusts in England as part of an improvement initiative on MRSA and C. *difficile*.

7. On joining the RCN, I used my clinical experience and learning, including participation in and lessons identified from a national inquiry, to strengthen visibility of the RCN on IPC and improve engagement of the nursing profession in this and AMR at the national and international level. Key responsibilities as examples of representation at the national/UK level included:

    a. Representing nursing at the European level in the development of the European Council Recommendation of 9 June 2009, on patient safety, including the prevention and control of healthcare acquired infections.

    b. Representing the RCN and professional nursing on the Government Healthcare Associated Infection ("**HAI**") Task Force which included the development of HAI Standards for Healthcare Improvement Scotland.

    c. Representing the RCN on a variety of national fora on AMR e.g. the Public Health England ("**PHE**") AMR Programme Board.

8. In relation to emergency preparedness specifically, I undertook the following:

    a. Led the RCN response to the H1N1/09 influenza pandemic in 2009 to early 2010.

    b. Represented the RCN in 2009 as a member of the Pandemic Influenza Clinical and Operational Advisory Group ("**PICO**") alongside other Royal Colleges supporting the development of clinical guidance and policy for the clinical management of the H1N1/09 influenza pandemic. I also contributed to the lessons learned exercise once PICO was disestablished.

    c. In June - October 2015, I responded to a request (made of the RCN via PHE) from the World Health Organisation ("**WHO**"), through its Global Outbreak Alert and Response Network ("**GOARN**") in the Eastern Mediterranean Region, following an escalation of Middle East Respiratory Syndrome Coronavirus ("**MERS-CoV**") affecting health care workers in Saudi Arabia **[RG/1 - INQ000114384]**. The request related to the provision

of support with education and training of health care workers, specifically for IPC nursing support. The request was later expanded to cover supporting a review of practices associated with the potential spread of MERS-CoV in hospitals and the wider community, which was to involve supervisory inspections on IPC practices in major health facilities including laboratories, hospital morgues and burial services at cemeteries. In the event, the inspection trip was cancelled at the last minute and so the practical inspections work was never carried out.

d. Led the RCN response to the Ebola Viruses Disease ("**EVD**") outbreak in West Africa 2014-2016. Specifically, I provided professional nursing support for enquiries and requests for nurses involved in outbreak control with NGOs or UK government teams. I attended a summit at the request of the European Federation of Nurses in Madrid to provide recommendations based on learning for the protection of healthcare workers following the infection of a nurse in Madrid with EVD. Learning and recommendations were provided at the weekly Department of Health communications group of which I was a member (see paragraph 22 below).

e. I was awarded an MBE for my work supporting the EVD outbreak.

f. In November 2018, I joined the emergency preparedness, resilience and response ("**EPRR**") Clinical Reference Group ("**CRG**") at the request of Stephen Groves (National Director of EPRR at NHS England) in order to represent nursing in this group. This group maintained a role in pandemic flu preparation at this time under the leadership of Chloe Sellwood (National Pandemic Influenza lead at NHS England). I retain membership of this group currently.

g. I attended an ad hoc pandemic flu meeting (Exercise PICA) at the request of NHS England in September 2018.

9. This statement has been prepared following the collation and review by the RCN of documents relevant to Module 1 and discussions with colleagues. Unavoidably,

there are some gaps in the evidence as a result of the routine deletion of documents pursuant to the RCN's document retention policy, which dictates that emails are deleted after four years and other publications, working documents and records are generally deleted after six years.

10. In this statement I cover the following matters:

    a. A brief overview of the RCN and its work;

    b. The RCN's view of the general state of the UK's emergency and pandemic planning, preparedness and resilience pre-Covid-19, including: the extent to which lessons were learned from previous pandemics (namely, EVD, MERS-CoV and H1N1 swine flu); failures in workforce planning and failures to address systemic workforce shortages; the failure to incorporate community and care home sectors in resilience planning; the impacts of Brexit; and pre-existing inequalities and vulnerabilities (including the disproportionate impact on the Black and Minority Ethnic workforce and the historic underfunding of public health);

    c. The RCN's views on what could have been done better in relation to the UK's emergency and pandemic planning, preparedness and resilience, including: the availability of personal protective equipment ("**PPE**") and respiratory protective equipment ("**RPE**"); and workforce measures such as the creation of a temporary register and deploying nursing students to the workforce;

    d. The RCN's engagement with UK government on the state of the UK's emergency and pandemic planning, preparedness and resilience and lessons learned and the RCN's reflections on the extent of engagement from UK government; and

    e. The RCN's reflections on what lessons can be learned for future pandemics and whole system emergencies.

Brief overview of the RCN and its work

11. The RCN was founded in 1916 as the College of Nursing Ltd as a professional organisation with just 34 members and was granted a Royal Charter in June 1929. The RCN is also a Special Register Trade Union under section 3 of the Trade Union and Labour Relations (Consolidation) Act 1992.

12. The RCN is now the world's largest professional body and union for nursing, with a membership of over half a million registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets. The RCN's members work in a variety of hospital and community settings in the NHS and independent sector – over 300,000 members are employed in the NHS. The RCN supports members across all four countries of the UK and internationally, and has offices in Scotland, Northern Ireland, Wales and nine regions across England.

13. As a member-led organisation, the RCN works collaboratively with its members to ensure that the voices of nursing and their patients are heard. The RCN promotes patient and nursing interests on a wide range of issues, including pay and terms and conditions, health policy and workforce strategy. It does this by working closely with the Government, UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. Throughout the pandemic and its aftermath, the RCN supported its members and campaigned in the interests of the nursing profession, patients and the general public.

The general state of the UK's emergency and pandemic planning, preparedness and resilience pre-Covid-19

14. In December 2021, the RCN submitted written evidence to the Public Accounts Committee's consultation on Government preparedness for the Covid-19 Pandemic: Lessons for Government on risk **[RG/2 – INQ000114416]**. Additionally, in June 2020, RCN Scotland responded to the Scottish Parliament's Health and Sport Committee's Call for Views in relation to resilience and emergency planning and the lessons that could be learned from the Covid-19 pandemic **[RG/3 –**

INQ000114371]. What follows is a summary of the key points made in those submissions, as well as additional reflections that can be made with the benefit of hindsight.

15. The RCN considers that the UK's pandemic preparedness was inadequate and disproportionately focused on influenza.

16. There were multiple opportunities for lessons to be identified from prior major incidents such as the H1N1/09 influenza pandemic in 2009 **[RG/4 – INQ000114285]**, the MERS-CoV outbreak from 2012 onwards **[RG/5 – INQ000114290]**, and the EVD outbreak in 2014-2016, and these lessons were available to draw on, specifically the importance and benefits of meaningful engagement with stakeholders from professional bodies who may have a role in intelligence gathering, communication or the wider pandemic response. This specific point is also reflected in learning from EVD on the value of regular and two-way communication and sharing of learning (as discussed further below at paragraphs 27 to 29). The learning from these incidents does not appear to have been reflected in preparedness planning and an overt statement of the need to engage in and ensure transparency regarding multi-professional communication and integration into incident response groups.

17. Pandemic preparedness focused only on influenza and was not a significant regular agenda item at meetings of the EPRR CRG as it was usually considered as an agenda item among other incident learning or planning, including terrorist incidents. The need to consider other potential infections with pandemic potential was made public by the Chief Medical Officer ("**CMO**") for England in July 2019 and this position was supported by the RCN due to the experience it gained through its planning to support Saudi Arabia with MERS-CoV. Additionally, disease X, a previously unknown infection with pandemic potential, was added as a new category to the WHO's emergency priority list in 2019. The UK, however, continued to focus on influenza despite the experience of MERS-CoV in the Middle East and severe acute respiratory syndrome ("**SARS**") and the potential for a new coronavirus to emerge.

18. In the RCN's view, the resilience of the health system, and the quality and coherence of pandemic and emergency planning, had been undermined by a series of significant restructures and reorganisations within the NHS and the Department of Health, which started with the Lansley reforms in 2012. As a result, by 2018/19, the NHS and UK government had lost much of its corporate memory around the lessons learned from prior pandemics or incidents. Further, due to the way that public health was reconfigured, non-hospital settings lost many of the skills that had been built up in IPC which put additional pressure on the NHS during the Covid-19 pandemic.

19. The UK's preparedness for a pandemic was also significantly hampered by preparations for Brexit. I recall that meetings of the EPRR CRG were regularly cancelled in the lead up to the Covid-19 pandemic because resource and manpower had to be diverted to plan for the UK's exit from the EU and to mitigate the risks and issues that this presented to the UK health system (as discussed further below at paragraphs 55 to 59). This meant that emergency planning and preparedness for the risk of a HCID suffered as a result **[RG/6 – INQ000114408 pp.2]**.

20. The RCN considers that the Covid-19 pandemic exposed the extent to which successive Governments have underfunded and failed to plan adequately for a sustainable nursing workforce, as part of the wider health and care system. As a result, a workforce crisis was well entrenched in the health and care service before the Covid-19 pandemic struck, which significantly undermined the UK's resilience in being able to deal with a pandemic on this scale.

21. Further, the impacts of the pandemic have been unequal across the population, exposing long-standing structural inequalities. The UK government must incorporate these impacts into future planning and risk assessments.

<u>The extent to which lessons from previous pandemics had been learnt</u>

EVD

22. I worked to support the UK's response to EVD preparedness and management and was a member of the Department of Health's Ebola Stakeholder Group from 2014 to when the group was discontinued. At the height of the EVD pandemic, this group met weekly, with meetings reducing in frequency once the situation came under control and the threat level decreased. It did not have terms of reference, at least at the beginning, and there were gaps in terms of relevant representation – for example I noted in November 2014 that NHS Employers did not seem to be represented. As to my contribution to the group, I provided intelligence regarding what was being said on the ground in relation to, for example, risks in connection with stigmatised groups, the growing concerns of nurses around the potential exposure to EVD in hospital and non-hospital settings, and risks to health care workers as they were brought back to the UK from West Africa. After the incident involving the death from EVD of a healthcare worker in Spain, I contributed to discussions in relation to the lessons that should be learnt from that incident for the UK's IPC planning and handling of EVD (see below paragraphs 27 to 33).

23. In addition to the Ebola Stakeholder Group, I was aware of a number of other groups which had been established to deal with the EVD outbreak covering issues such as emergency planning and clinical operations. It was not clear what the roles of the different groups were, which organisations were represented on them, and what the governance and reporting structures of these groups were.

24. I was also part of a small group of nurses, led by a senior nurse at PHE, that looked at how to accept and then manage people who were infected, or potentially infected through exposure to EVD who arrived into the country via major termini (such as St Pancras station and Heathrow airport). This involved reviewing the facilities for conducting health screening and procedures for isolating people if necessary on entry.

25. In my capacity as Professional Lead for IPC for the RCN, I was invited to attend an EVD world summit for nurses by the European Federation of Nurses in October 2014 in Madrid. The short notice summit was convened as a direct result of the transmission of EVD to a healthcare worker in Spain. PPE supply, guidance development, communication and legislation were identified as key themes for

lessons learned from the incident. These lessons were applicable to all HCIDs, not just EVD.

26. Susie Singleton (the operational lead for Infection Control at PHE at the time) and I produced a document, dated 29 October 2014, summarising our feedback from the EVD world summit and recommending actions to strengthen the UK's resilience for dealing with EVD and other HCIDs **[RG/7 – INQ000114366] [RG/8 – INQ000114368]**. I reported this feedback directly to the Department of Health at a meeting of the Ebola Stakeholder Group on 31 October 2014, to inform current and future learning **[RG/9 – INQ000114387] [RG/10 – INQ000114388]**. I also presented this feedback to a meeting of the North Central London (Sector) Control of Infection Network on 13 November 2014 **[RG/11 – INQ000114389]**.

27. The first lesson identified from the incident discussed at the EVD world summit was the need to document, in real time, the lessons that had been learned from the EVD outbreak in the UK. We noted that this would need to include the experiences of NHS Trusts in relation to their level of preparedness for dealing with such an outbreak. We also noted the need to foster an environment of transparency where learning could be shared and where there was an acceptance that things could have been done better in the context of a new and evolving experience.

28. The second lesson was the need to sustain relationships with the international nursing and scientific community to facilitate the exchange of good practice. This is something the RCN also highlighted in relation to the UK's proposed exit from the European Union from November 2016 onwards **[RG/12 – INQ000114406]**.

29. Third, a key lesson was that the development of guidance purely by IPC specialists provided a narrow focus and posed risks to health care workers required to follow IPC policies. It highlighted the need to communicate and strengthen the role of professional nursing and midwifery more widely in the design, development and implementation of national protocols, policy decisions and operational IPC policies and guidance. To this end we recommended the establishment of a nursing reference group to share intelligence and advice and to influence policy

development. We also suggested the establishment of a UK-wide partnership with professional and organisational collaboration on the model of the PICO. The experience of both EVD and H1N1/09 influenza showed that UK-wide stakeholder engagement was key to consistent messaging, intelligence gathering and clinical guidance development and implementation. I understand that this was also a learning point that was discussed at the Chief Nursing Officer's ("**CNO**") Regional Chief Nurses team meeting on 22 October 2014, which I was not present at, but I recall the meeting taking place and the discussions that happened thereafter. I recall, from the discussions that happened thereafter, that the meeting acknowledged that there were concerns around the voice of nursing being heard, that there was a feeling among participants that stakeholder meetings were important and that a wider stakeholder group including professional organisations and the Royal Colleges should be established. As I explain later in this statement, the lessons from EVD in this regard were not taken forward into the UK government's approach to the Infection Prevention Control Guidance (the "**IPC Guidance**") for Covid-19.

30. Fourth, we identified that training, specifically around the use of PPE and RPE (and more particularly regarding the fit testing of FFP3 face masks), needed to be harmonised, quality assured and mapped to the legislative requirements contained in the Management of Health and Safety at Work Regulations 1999; the Personal Protective Equipment at Work Regulations 1992; the Safety Representatives and Safety Committee Regulations 1977; the Control of Hazardous Substances Regulations 2002; and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 across the UK. We noted that training needed to be adaptable for different settings and scenarios and should consider all staff groups. We recommended that template PPE training resources be produced, for regional adaptation and implementation, and that nursing reference groups, and other relevant stakeholder groups, be utilised to review and feed into the content of training packages.

31. Given this learning from EVD around training on the use of PPE, I was surprised that the UK was not better prepared for the Covid-19 pandemic. In addition to the shortages of PPE (as discussed elsewhere in this statement), there was also a

shortage of the skills and equipment required to undertake proper fit-testing of RPE (particularly FFP3 masks). This is surprising given the fact that fit testing of RPE was, and is, a legal requirement under the Control of Substances Hazardous to Health Regulations 2002 ("**COSHH**") and was a requirement under the Health and Social Care Act 2008 Code of Practice (England) on the prevention and control of infections, which sets expected standards that all health and adult social care providers (including NHS trusts) must meet (see paragraph 52 below). In addition, it was a clear requirement in the NHS Core Standards for Emergency Preparedness, Resilience and Response, first published on 27 July 2018, which stated:

"*In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk*". **[RG/13 – INQ00114410]**

Organisations are required to retain sufficient numbers of staff trained in fit-testing – it became apparent, (from my experience and based on members views – see paragraph 73) in the early stages of the Covid-19 pandemic that there were real limitations on the availability of staff with the requisite skills. There were huge demands on fit testers leading to additional fit testers having to be trained and employed. This leads me to conclude that the UK's pandemic planning, at least in relation to RPE, was inadequate for respiratory diseases with pandemic potential. Managing the surge in demand for fit-testing and fit-testing solutions should have been part of pandemic planning.

32. Fifth, we identified a need to ensure systems and resources for psycho-social/pastoral support were in place for patients, healthcare workers and their families dealing with EVD. The experience of EVD showed that confidentiality was incredibly important because of the fear instilled in communities where EVD patients were being cared for. In terms of actions, we recommended the

identification of what occupational support may be required and the implications of this for occupational health services and healthcare workers. I do not recall this recommendation ever being discussed or addressed at either EPRR CRG or as part of Exercise PICA. In seeking to address this gap, I worked with Gail Adams, Head of Nursing at Unison, to put together a checklist of key things which we believed employers should be discussing with local staff-side organisations in this regard **[RG/14 – INQ000114392]**. I cannot recall whether this checklist was ever completed or published.

33. The sixth lesson is not relevant for these purposes. The seventh, and final, lesson identified was the need to establish an environment that created confidence and faith in the healthcare system to ensure the best outcomes for patients and healthcare workers. The EVD outbreak in the UK had shown that confidence in healthcare systems to support and protect healthcare workers was low; many staff felt unprepared and scared. Expertise for caring for known EVD patients was limited to high security units with specially trained staff and general NHS facilities, including community providers, were unprepared. We noted that preparedness for multiple cases of EVD would need to take into account care in general hospital environments and its impact from a whole system approach.

34. Broadly speaking, I do not know, except where specifically mentioned above and below, to what extent the recommendations we made following our learning from the EVD world summit were taken on board and implemented in terms of the UK's approach to preparedness and resilience planning prior to the Covid-19 pandemic. However, following the EVD outbreak, there were significant restructures within the NHS and changes to senior Department of Health (from January 2018, the Department of Health and Social Care ("**DHSC**")) positions, including the Chief Medical Officer ("**CMO**") in early 2019, which led to a considerable loss of corporate memory and relationships to support effective pan-professional working and communication. There was also a palpable change in culture, in the years immediately preceding the Covid-19 pandemic, brought about by the successive administrations. This seemed to manifest in an attitude where engagement with stakeholder organisations seemed to be less of a priority. The impact of this during the Covid-19 pandemic is illustrated by the fact that professional nursing

organisations, representing the largest profession in all care sectors requiring and using PPE and implementing IPC practice to protect patients and their health care worker colleagues, were not consulted or engaged on the content and development of the IPC Guidance. Those representing the nursing profession were effectively shut out from key decision-making, and their voice and expertise were ignored, despite the learning from the EVD outbreak, H1N1/09 pandemic and advice on MERS-CoV, which demonstrated that the exact opposite was necessary to ensure a coherent and effective response. As demonstrated during the EVD and H1N1/09 outbreaks, even when command and control measures were in place, this did not necessarily preclude meaningful and timely stakeholder engagement and input.

MERS-CoV

35. As already mentioned above at paragraph 8, I was involved in providing support, through a WHO and GOARN initiative, to health agencies in Saudi Arabia to help manage the threat posed to health care workers by an extended outbreak of MERS-CoV in the Middle East in 2015. Whilst I did not undertake the planned inspection visit to Saudi Arabia in the event, I did undertake an in-depth review of the Gulf Cooperation Council's IPC manual **[RG/15 – INQ000114292]**.

36. I believe significant lessons should have been learnt from the experience with MERS-CoV. For example, the Gulf Cooperation Council's IPC guidance specifically addressed the airborne spread of MERS-CoV and the requirement for the use of RPE. It is my understanding that health care workers in Saudi Arabia would have required the use of FFP3 masks. This should have influenced a focus on maintaining stores of RPE and fit testing solutions and keeping fit testing up, to be escalated as necessary, in UK government pandemic planning.

37. The report from Exercise Alice in relation to planning and preparedness for a potential MERS-CoV outbreak in the UK, dated 15 February 2016, highlighted the fact that learning from the EVD pandemic was not yet properly embedded **[RG/5 - INQ000114290 pp.9]**.

38. It seemed to be, from the conversations I had at the time with a range of RCN members, a central assumption of the UK government that another coronavirus would act similarly to MERS-CoV and, as such, would burn itself out and not spread more widely. This assumption was misguided.

H1N1/09 Swine flu

39. The RCN understands that the DHSC and other Government departments had identified a pandemic as a significant risk to its operations. At a local level all community risk registers identified an influenza pandemic as a significant risk. The RCN also understands that the UK government undertook Exercise Cygnus in 2016, a simulation of a flu outbreak to test readiness to response, but, as far as I am aware, the RCN was not involved in this exercise. The UK government's report on Exercise Cygnus found that "*the UK's preparedness and response, in terms of its plans, policies and capability, is currently not sufficient to cope with the extreme demands of a severe pandemic that will have a nationwide impact across all sectors*" **[RG/2 - INQ000114416]**.

40. The RCN was invited to be part of PICO in 2009 alongside other Royal Colleges. I shared membership of PICO with Kim Sunley, National Officer (Health and Safety), and Lynn Young, Professional Lead for Primary Care at the time. We were able to feed in our expertise and intelligence and represent the needs of the RCN's membership to inform the development of clinical guidance and guidelines concerning the response to pandemic flu. I found that the PICO group worked very well with the expertise of each profession respected and their contributions valued. This was a very different experience to the approach taken by UK government during the Covid-19 pandemic.

41. On 5 September 2018, I took part in Exercise PICA – an exercise to review and explore existing NHS primary care arrangements and processes within the context of an influenza pandemic **[RG/16 – INQ000114394] [RG/17 – INQ000114395] [RG/18 – INQ000114397]**. The exercise was sponsored by NHS England as part of the Public Health England funded programme directed by the EPRR Partnership Group, chaired by the DHSC. I was only invited to one meeting, and my recollection

was that the meeting questions did not reflect the experience of, and lessons arising from, the EVD outbreak, some of which could have been translated to a future pandemic, especially in the early stages where health care workers and patients are stigmatised as early infection spreads and efforts to upscale PPE provision would be in place. I found that the scenario planning at Exercise PICA was fairly limited and certain practicalities were not considered either at all or in sufficient detail. For example, I recall that there was very little or no consideration of what would happen if significant numbers of logistics drivers became ill and could not deliver food to supermarkets, or what the arrangements for mass burials were should these become necessary. Such issues may have been covered in the UK government's plans, but these certainly were not visible as part of the exercise.

Overall reflections on the extent to which lessons were learnt from prior pandemics

42. It is the RCN's view that the UK's preparedness and emergency planning was overly focused on planning for pandemic influenza. Other pandemic threats, such as coronaviruses, should have been given equal attention. It was my experience that, prior to the Covid-19 pandemic, the nursing profession was concerned that emergency planning and risk assessments were almost solely focused on flu. Whilst it was the case that a flu pandemic was identified, one of the most significant threats, the recent experience of MERS-CoV (and, earlier, SARS) had demonstrated that coronavirus diseases were also a serious and tangible threat that should have featured more prominently in the UK's preparedness plans. As has been demonstrated by the Covid-19 pandemic, it seems that there had been an assumption at the national level that the plans for dealing with a flu pandemic were adequate, or could be easily adapted, for other pandemic outbreaks – our experience of Covid-19 shows that the emphasis in approach has to be very different for highly communicable respiratory diseases. In my opinion, this almost single-minded focus on flu was very limiting in terms of the robustness and efficacy of the UK's planning and preparedness for pandemics of HCIDs that were anything other than flu.

43. I am also of the view that pandemic planning was overly focused on the NHS at the expense of non-hospital settings. This seemed very imbalanced, given the fact

that if infection prevention and control is not dealt with properly at the local level (i.e. in public health and primary care), then it is inevitable that the impacts of this will filter through to secondary health care.

44. Overall, my experience was that lessons we identified and shared from previous pandemics and outbreaks were not visible in the experience of planning and early phase implementation of pandemic plans. If they had been, the RCN would have been present as a stakeholder from day one and not fighting to get its voice heard and offer assistance. The RCN's experience of the Covid-19 pandemic was that nursing was excluded and previous lessons were not implemented, or even considered, as no one approached us for information.

Failures in workforce planning and the failure to address workforce shortages in nursing

45. The RCN had consistently highlighted over a number of years the absence of effective workforce planning for nursing **[RG/19 – INQ000114252 pp.11-13] [RG/20 – INQ000114302] [RG/21 – INQ000114303] [RG/22 – INQ000114304] [RG/23 – INQ000114306]**. The impact of this manifested in high levels of vacant posts, escalating expenditure on agency staff, and an inability to advance the strategic transformation of health and social care services because of shortages within the community nursing workforce, upon which the refocusing of services is largely dependent. Chronic staff shortages, especially in emergency and critical care nursing have impacted on the system's ability to cope both with the pandemic as well as ongoing service demands. Prior to the onset of the pandemic there were approximately 50,000 nursing vacancies in the NHS across the UK, and an estimated 122,000 vacancies across the social care workforce **[RG/2 – INQ000114416 pp.3]**.

46. Ambiguity about responsibility for policy and funding interventions for supply, recruitment, retention and pay has led to workforce shortages. As the RCN explained in its submission to the NHS Pay Review Body for the 2021/22 pay round **[RG/24 – INQ000114341 pp.8]**, there is currently no specific legal accountability for the provision of staffing for taxpayer-funded services. As a result, costed

workforce planning is not done consistently or strategically; nor is it based on credible modelling of population health to meet patient demand.

47. The RCN had repeatedly called for governments in England and Northern Ireland to introduce legislation to create clear roles and responsibilities for workforce planning throughout the health and care system **[RG/19 – INQ000114252] [RG/24 – INQ000114341] [RG/25 – INQ000114328]**, **[RG/26 – INQ000114340]**. The Welsh government has set out legislation on how decisions about staffing should be made and scrutinised (the Nurse Staffing Levels (Wales) Act 2016). It means health boards and NHS trusts in Wales must "have regard to the importance of providing" appropriate numbers of nurses in all settings. The requirements go further in adult acute medical and surgical settings and in children's wards, where nurse staffing levels must be calculated according to a specified methodology and maintained at that level **[RG/27 – INQ000114398]**. In Scotland, the Health and Care (Staffing) (Scotland) Act 2019 has been passed setting out requirements for safe staffing across both health and care services, but the implementation has been delayed due to Covid-19 **[RG/28 – INQ000114399]**. Our members in Northern Ireland took industrial action, including strike action, in December 2019 and January 2020 over safe staffing and pay parity. The health and care system would have been in a stronger position to meet the challenges of the pandemic had legislation on healthcare workforce planning already been in place.

Failure to properly incorporate community and care home sectors in resilience planning

48. Previous resilience planning, both nationally and locally, had not adequately incorporated the community and care home sectors. From my perspective, there had not been a whole system approach to planning. This was evident at the start of the pandemic, during efforts to rapidly scale up acute capacity, when some community staff were being redeployed into the acute sector without sufficient thought being given to the services that needed to continue in the community. For example, the RCN heard reports that community nursing staff were being asked to go and work in hospitals when community services needed to be augmented at the same time to ensure essential services, such as child protection and end of life care, could continue.

49. Additionally, the PHE's '*Guidance for social or community care and residential settings on COVID-19'*, published on 25 February 2020, did not seem to reflect a scenario whereby spread of infection in the community would occur, nor did it reference further guidance on escalation. The guidance stated: "*This guidance is intended for the current position in the UK where there is currently no transmission of COVID-19 in the community. It is therefore very unlikely that anyone receiving care in a care home or the community will become infected"* **[RG/29 – INQ000114411 pp.4]**. This guidance was focused on hospital settings and seemed to seriously underestimate the potential for the virus to spread within the community including health and care facilities, which was surprising given the spread of Covid-19 in Europe at this point in time. It seems that earlier PHE guidance from January 2020 – '*Novel coronavirus (2019-nCoV): interim guidance for primary care*' – did acknowledge that people could potentially present in the community thereby potentially spreading the infection. The guidance stated: "*It is possible that novel coronavirus (2019-nCoV) may cause mild to moderate illness, in addition to pneumonia or severe acute respiratory infection, so patients could potentially present to primary care*". It is not clear why this risk was then downplayed in the February 2020 guidance **[RG/83 – INQ000114313]**.

50. The Scottish Government published *'National Clinical Guidance for Nursing and AHP Community Health Staff during Covid-19 Pandemic'* in early April 2020 the aim of which was to support planning and prioritisation of the workforce as part of the community and primary care resilience response **[RG/30 – INQ000114287]**.

51. We believe the serious challenges around accessing PPE that staff working in care homes and the community experienced, also illustrate the point that these sectors were not sufficiently considered in resilience plans.

52. In England, the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections (the "**Code of Practice**"), published in 2015 **[RG/31 – INQ000114400]**, placed a requirement on providers of regulated activity to have in place policies and procedures appropriate to regulated activity. Care homes and other providers had, in 2015, a regulatory requirement to have in place

policies to manage outbreaks of communicable infections in addition to systems in place to manage the occupational health needs of staff in relation to infection. Both policies should have included the requirement for the use of PPE including fit testing where required. There was no requirement for a policy on pandemic preparedness or management. The RCN had raised concerns verbally at national fora (including the Care Quality Commission's ("**CQC**") stakeholder group for non-hospital organisations), prior to the pandemic that, outside of the NHS, the CQC had not delivered on its regulatory responsibilities on IPC to the extent of ensuring that effective systems were in place to meet criteria 1, 9 and 10 of the Code of Practice outside of the NHS (which broadly relate to having systems in place to manage and monitor the prevention and control of infection (1), having and adhering to policies that will help to prevent and control infections (9) and having a system in place to manage the occupational health needs of staff in relation to infection (10)). In this regard, the RCN even requested that the CQC conduct a focused inspection in adult social care to strengthen non-hospital based IPC provision. Despite this, the RCN is not aware of consideration being given to providers, such as care homes, being assessed in pandemic planning with regard to meeting the fundamental requirements of the Code of Practice or their ability to escalate issues if required.

53. Additionally, the successive reorganisation of the UK's public health and health protection agencies and loss of memory, together with a failure to update national operational guidance for dealing with healthcare associated infection ("**HCAI**"), meant that fragmented leadership and operational capacity severely hampered the UK's response to Covid-19. It is my understanding that HCAI operational guidance, which outlines actions, roles and responsibilities in the escalation of local incidents as well as responding to high consequence infectious diseases ("**HCID**"), was last published in 2012 by the Health Protection Agency (the precursor to PHE) **[RG/32 – INQ000114286]**. I recall that this guidance was updated in 2016 as an internal document but was not published. The fact that this operational guidance was not published meant that NHS teams, as well as care homes and community settings, did not have up-to-date information on the roles and responsibilities of Health Protection teams, and this would have impacted directly on local, regional and national incidents, including responding to HCIDs such as Covid -19.

54. Years of under-investment in the community and care home sectors meant social care was left exposed when the pandemic hit. In order to address this major gap when the pandemic hit, the adult social care action plan, published by DHSC on 15 April 2020, set out an ambition to attract 20,000 people into social care over the following three months. However, the National Audit Office Report '*Readying the NHS and adult social care in England for Covid-19*', published 12 June 2020, to which the RCN contributed, reported that the DHSC did not know how it was progressing against that goal; there appeared to be no mechanism available to assess whether this target would be achieved **[RG/33 – INQ000114319 pp.12]**.

Impacts of Brexit

55. On 17 October 2019, the RCN published a report entitled 'Brexit: Royal College of Nursing priorities overview' **[RG/34 – INQ000114291]**. In this report, we highlighted the potential impacts of Brexit on the UK's emergency preparedness for infectious disease control.

56. In a response to an enquiry from the Chair of NHS England's EPRR CRG on 20 January 2020, Helen Donovan, Professional Lead for Public Health Nursing at the RCN and member of the EPRR CRG, shared this report with David Robinson, Emergency Preparedness, Resilience and Response Officer and NHS England **[RG/35 – INQ000114281]**. In her cover email, Ms Donovan stated:

"*In terms of emergency preparedness the key issue we have raised is around rare disease and infectious disease. The current situation with the Novel Wuhan coronavirus and the need to liaise across Europe and wider being potentially a case in point. Sharing on education and resources lessons learnt and medicines licensing would all be impacted*".

57. The report highlighted the fact that, at the time of its authorship, it was unclear what the UK's ongoing relationship with the European Centre for Infectious Diseases and Control ("**ECDC**") would be, post-Brexit, both in terms of submission and comparison of UK data on infections/antibiotic resistance and the

management of outbreaks in Europe that could impact on the UK. In the event, formalisation of the UK's relationship with the ECDC post-Brexit came very late in the day, meaning that the potential impacts were unknown for an extended period of time and this necessarily had an impact on pandemic planning for management of outbreaks across Europe.

58. We highlighted in that report that the lack of a contributory relationship to ECDC activities would exclude the UK from reporting and comparing important surveillance data on communicable diseases and health threats and that this could affect the preparedness of the UK's health and social care system if a communicable disease outbreak developed and the UK needed to respond rapidly.

59. On a more immediate level, planning and mitigation for the potential impacts of Brexit diverted resource, time and effort away from planning for other risks, including pandemic planning. It is my recollection that a number of EPRR CRG meetings were cancelled because people were diverted to work on Brexit as a potential incident.

Pre-existing inequalities and vulnerabilities

60. It is apparent that the pandemic has exposed weaknesses in the health and social care system that have restricted its ability to respond to the crisis for both planned and reactive activity. It has also exposed fundamental vulnerabilities and inequalities in our society. Ethnic minorities and deprived communities, where health was already poorer, have been disproportionately affected, laying bare our population's poor and unequal health and extensive inequalities.

61. It is not clear to what extent these inequalities were factored into the government's pandemic planning, despite the fact that evidence was available, prior to the Covid-19 pandemic, demonstrating the potential unequal impacts across different groups in society. For example, as far as I recall, Exercise PICA did not refer to inequalities (in relation to public, patients or health care workers) or the impact on vulnerable groups as an issue for specific consideration, while there was a broad reference to 'at risk groups' in the draft document supporting the Exercise **[RG/36 –**

INQ000114393 pp.7]. The RCN notes that PHE guidance from 2016 entitled '*Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings',* which preceded any pandemic guidance, refers to *"Persons most at risk of developing complications"* **[RG/37 – INQ000114288 pp.7]**.

62. The impact of the Covid-19 pandemic has been unequal across the population. However, Covid-19 has not created health and structural inequalities; it has uncovered and exacerbated existing structural and institutional inequalities and barriers which exist across health and care, but also across wider society. It is the RCN's view that the government must prioritise the reduction of health inequalities within recovery plans and deliver a national, funded cross-government strategy to tackle health inequalities and the social determinants of health with clear objectives, measurable targets, and timeframes.

*Disproportionate impact on black, Asian, and minority ethnic ("**BAME**") workforce*

63. In its written submission to the HM Treasury Comprehensive Spending Review (CSR) (September 2020) **[RG/19 – INQ000114252 pp.11]**, the RCN highlighted the overrepresentation of BAME staff at bands four to six, which represent those professionals providing care on the frontline, warning that they may be at increased risk of exposure to the viral load of Covid-19. We also highlighted the fact that, as the pay bands increase, data shows larger increases in the number of white staff at each pay grade compared to the increase in BAME staff.

64. The written submission relied on data published annually by NHS England since 2015, known as the Workforce Race Equality Standards ("**WRES**"). WRES highlights workplace inequalities and encourages action to close gaps in experiences between BAME and white staff in the NHS. The WRES data provides compelling evidence that BAME staff are over-represented in lower pay grades but, in our view, this data has not been utilised effectively to investigate and level up the experiences of BAME health care staff. I am not aware that WRES data was taken into account in relation to emergency and pandemic planning.

Underfunding of public health

65. Funding for public health services and interventions (i.e. the frontline public health services funded by local authorities) in England has not been consistent and has suffered under austerity measures. The public health grant has been cut by more than a fifth (22%) since 2015/16. Consequently, this has meant that local authorities are unable to provide vital functions that promote wellbeing and prevent ill health and the reductions in outreach services such as smoking cessation, sexual health and children's public health, which impacts population health and life chances **[RG/19 – INQ000114252 pp.18]**.

66. The RCN considers that the effectiveness and sustainability of this vital system has been undermined by chronic underfunding and diminishing resources. To compound matters, there are significant funding variations across England, and cuts to public health funding have been disproportionately higher in the most deprived areas, where health needs are greatest **[RG/2 – INQ000114416 pp.5]**.

67. It is the RCN's contention that this historic underfunding of public health undermined the capacity of local public health teams to effectively improve health and reduce inequalities and respond to the Covid-19 pandemic. This was compounded by the lack of clarity around responsibilities for emergency preparedness that arose as a result of the reforms to public health brought in by the Health and Social Care Act 2012, which saw the establishment of PHE in April 2013. As the House of Commons Health Committee's report into PHE (26 February 2014) highlighted, there were persistent and serious concerns that responsibilities for emergency preparedness across local authorities, PHE's 15 local centres and national bodies remained unclear. As a result, the Health Committee recommended that the Government should take "*urgent steps to put these important issues beyond doubt*" **[RG/38 – INQ000114289 pp.14]**.

68. Nursing plays a vital role in all areas of public health, and all nursing roles have public health responsibilities. Many nurses work in specialist public health roles, including health protection (however, it should be noted that knowledge, capability and education on IPC varies considerably). Across all settings, nursing staff play

a vital role in health improvement, promotion and protection, including in primary care and community teams. As the RCN highlighted in its submission to the Public Accounts Committee consultation on Government preparedness for the Covid-19 Pandemic **[RG/2 – INQ000114416 pp.5]**, trends in the public health nursing workforce since 2015 give serious cause for concern – there has been a 26% reduction in NHS school nurses and a 37% reduction in the number of health visitors in England.

69. Despite the central role of health protection and IPC nurses in emergency preparation and response to possible pandemics, the education and training of IPC nurses has historically been lacking. As highlighted in the Centre for Workforce Intelligence's report from July 2015, '*Review of the infection prevention and control nurse workforce',* to which the RCN contributed, there is no clear defined training pathway into IPC nursing and no baseline qualification requirement **[RG/39 – IN000114403]**. Additionally, there is also no person specification or standard job description for IPC nurses. The report recommended that commissioners should consider introducing a clearer pathway, including set training requirements and assessment (leading potentially to registration) into IPC nursing. The report also noted that it was difficult to determine how many people were in the IPC nurse workforce since training routes and qualifications were unclear.

The RCN's views on what could have been done better in relation to the UK's emergency and pandemic planning, preparedness and resilience

PPE/RPE availability

70. It is the RCN's view that the Government did not adequately plan for or have the supply of PPE, specifically RPE, needed for a pandemic on the scale of Covid-19. To some extent, I believe this was due to the fact that the UK government's planning focused on dealing with an influenza pandemic which at the time was considered to be predominantly spread via respiratory 'droplets' and did not adequately consider what RPE and PPE would be needed if dealing with a respiratory disease pandemic more like SARS or MERS-CoV.

71. A report by the National Audit Office entitled '*The supply of personal protective equipment (PPE) during the COVID-19 pandemic*', to which the RCN contributed, points to some of the shortcomings of the UK government's approach to the supply and stockpiling of PPE prior to the pandemic. The RCN contributed findings from its membership survey, conducted from 10 to 13 April 2020, in relation to the experiences of nurses with regards to the supply of and access to PPE **[RG/40 – INQ000114401]**. A similar survey was again conducted from 7 to 11 May **[RG/41 – INQ000114402]**.

72. The shortages of PPE experienced in the first wave of the pandemic, revealed serious problems with how the UK procures essential safety equipment and how it might manage in the scenario of a worldwide demand for PPE. Some settings reported adequate PPE, for example, intensive care settings in acute hospitals, but this was not the shared experience for all staff in all settings. Those working in care homes were particularly impacted by problems with stock availability and the slow distribution of PPE, despite the government and health agencies knowing they needed to equip services with PPE in the weeks before the crisis took hold. Existing stocks of PPE, based on modelling for an influenza pandemic, were insufficient and there was a lack of the correct RPE needed (i.e. FFP3 face masks). Without adequate and proper PPE, nursing staff put their own lives, the lives of their families and patients, at risk. The adequacy of these supplies should have been based on the need to follow Health and Safety legislation, specifically COSHH, and take into account infection control guidance which reflects the latest available scientific and clinical evidence from PHE.

73. During the first wave of the pandemic, from 19 March 2020 (when RCN records begin) to 13 May 2020 (when lockdown restrictions started to be lifted), the RCN received 1,572 contacts through its contact centre from members raising issues in relation to PPE and health and safety concerns at work. The following examples are illustrative of the types of issues that were being raised on a regular basis by frontline nurses dealing with the pandemic (some of the below examples are the RCN members' own words, and other examples consist of contemporaneous notes taken by the RCN call handler).

"*When we first started dealing with suspected COVID-19 patients we were told we must change into hospital scrubs, wear full plastic apron, gloves and appropriate fit tested mask and visors. now that stock is running out we are being encouraged to nurse suspected Covid-19 patients for hours wearing only our own uniform with a disposable pinny on, gloves and a surgical mask (not a fit tested one and not a visor). From what I can see on government guidance this is wrong and we need support*"

"*The PPE discussed in your email is not the PPE I am being provided by my trust. We have basic FFP3 masks without respirators. In addition to this, I had a fit test for the FFP3 mask that we will be using and I failed this and this was documented. I was told that the mask I needed was unable to get due to "stock issues". When I asked what I was supposed to do with this I was told I would just have to wear the FFP3 mask even though it will not protect me as I "have no choice". I feel aggrieved by this and do not feel my trust are meeting their legal obligation. I will be going back to work on Monday after annual leave and we have an increased number of ventilated positive COVID-19 patients in the ICU that I will be expected to look after. I feel a duty to care to my patients but worry about putting myself at risk and potentially passing the virus onto my family who are high risk*".

"*[Member] has been emailed that the trust is no longer testing fitting FFP3 masks – Staff are being told to watch you tube videos for instructions on how to do this – [Member] is caring for COVID positive patients*"

"*NHS Trust has decided that it is no longer fit testing staff for RPE as there are multiple masks in use within the trust. It is now advising staff (including those who have not yet been fit tested for any mask and those who have failed previous fit tests) that fit checking is sufficient. I am yet to be fit tested and I work in a high risk area. I do not feel safe at work with this new policy. Can I refuse to work in high risk areas i.e. resuscitation where AGPs regularly occur?"*

"*Dear RCN, I am extremely concerned and exhausted, I have decided to be away to my young kids and family in order to keep them safe. As a nurse agency worker I got ongoing shift a one hospital until the middle of May, I am keen to help and*

support my colleagues. I did work direct in covid-19 positive ward where the staff PPE has been downgraded to plastic aprons and surgical mask only....it is not acceptable, we are frontline and not respect to us, who have direct contact with the covid-19 positive in 12 hours shift. I feel that my life is so undervalued!! Do you guys know what is currently policy for PPE?"

"*Please can you help. I am a Staff Nurse working in A&E looking after both suspected and confirmed covid-19. We have had a message today stating we no longer need to wear fluid repellent gowns but a simple green/white apron with fluid repelent masks and gloves. Except for aerosol generating procedures. I do not feel I am not safe at work [sic]. Please can you advise me on where we stand as Staff Nurses in all this. We nurse flus every year with full PPE why is it being downgraded for a pandemic flu? What can we do*"

"*[Member] works in the community. Been told that she will be on the team treating suspected Corona Virus patients and also those with the disease, starting on Monday Initially she was advised that they would be using the filtering face pieces and had training on this Now been told that it will be surgical masks [Member] very concerned about this and the risks, she has done a lot of research and advised the surgical masks are not adequate*".

Workforce measures

74. Plans to rapidly scale-up the nursing workforce nationally, including through the creation of a temporary register and deploying nursing students to the workforce, had not been worked out in detail in advance. The RCN was supportive of the creation, and later expansion, of the temporary register for nurses by the Nursing and Midwifery Council ("**NMC**"). It is the RCN's view that the implementation of the temporary register was quick and effective **[RG/42 – INQ000114404 pp.1]**. However, it was not clear how those choosing to return to practice or join the temporary register from overseas would be robustly supported and supervised to ensure that they were able to practice safely, especially in the context of an already stretched workforce **[RG/43 – INQ000114405]**.

75. There was a lot of activity across the UK on developing the details of these plans at the start of the pandemic, after measures had been announced, which resulted in a period of confusion, anxiety and uncertainty for members. For example, it was announced that nursing students were being deployed to the workforce a number of weeks before any detailed plans were agreed on this. We hope that lessons around what has worked well, and what has been less successful, in this regard will be fed into future resilience and emergency plans. I consider that the NMC and NHS England are best placed to provide details as to the plans that were in place with regards to scaling up the workforce and the lessons learnt in this regard.

76. The RCN believes the initial response with regards to scaling up the workforce focused on acute hospital capacity without also factoring in sufficiently the community and care home sectors. We agree that there was an urgent need to scale up acute capacity, given the fears that services could be overwhelmed, but it is critical that hospitals are not considered in isolation. Primary and social care services that provide clinical care in our communities are crucial in reducing the number of people who need to be admitted to hospital and supporting people to return to their communities when hospital care is no longer needed. However, these services were overlooked when it came to pandemic preparedness planning and the early response to the Covid-19 pandemic. This demonstrates the need to ensure the community and care home sectors are properly represented in planning to ensure a whole system approach.

The RCN's engagement with UK government on the state of the UK's emergency and pandemic planning, preparedness and resilience and lessons learned

77. As the RCN is not a healthcare operational organisation, it had a limited role and involvement in relation to national pandemic planning. The RCN was at the mercy of national organisations and the UK government as to whether it was invited as a stakeholder to sit on planning and reference groups and to participate in table-top exercises and scenario-planning. I list below the relevant groups and entities that the RCN was involved in between 2009 and 21 January 2020 and instances where the RCN's engagement and expertise was sought by the UK government and its

agencies to feed into pandemic planning. This list reflects my recollection – I cannot say that it is exhaustive as, in many cases, records are no longer retained.

Prior to 21 January 2020

78. As noted above at paragraph 8 , prior to 21 January 2020 I engaged with the UK government and associated agencies in relation to pandemic planning and preparedness via the following means:

    a. The RCN was represented on the PICO group in 2009, supporting the development of clinical guidance and policy for the clinical management of the H1N1/09 pandemic.

    b. I was a member of the Department of Health's Ebola Stakeholder Group from 2014 to when it was disbanded.

    c. In 2015, I responded to a request from PHE in relation to the GOARN's specific request for IPC nursing support with the outbreak of MERS-CoV in Saudi Arabia affecting healthcare workers.

    d. I was invited, along with Ms Donovan and Anna Crossly (Professional Lead for Acute, Emergency and Critical Care), to represent the RCN on NHS England's EPRR CRG in April 2017. Helen Donovan and I attended quarterly meetings of the EPRR CRG from November 2018 onwards (the delay was due to security clearance procedures taking some time to complete) **[RG/44 – INQ000114377] [RG/45 – INQ000114379] [RG/46 – INQ000114380]**.

    e. On 5 September 2018, I took part in Exercise PICA.

79. In terms of less formalised engagement, in March 2017 I was sent a stakeholder consultation regarding an interim service specification for a High-Level Isolation Unit for High Consequence Infectious Diseases, (Airborne) Adult which came from an individual at NHS England **[RG/47 – INQ000114253]**. This came out of NHS

England's HCID Programme which was established in response to the challenge to the ability of the NHS to provide appropriate, scalable care for patients with suspected or confirmed EVD, and the continuing threat of 'airborne' diseases such as MERS-CoV and, in particular, a clear pathway to treat such patients. I responded to the consultation on behalf of the RCN **[RG/48 – INQ000114312]**. I noted at the time that this consultation had come "out of the blue". Whilst it was good that stakeholders such as the RCN were asked to feed into the service specification, this was at very short notice – stakeholder engagement on such issues should not have been a last-minute thought, but something that was planned in from the beginning of any new policies, guidelines and specifications such as these.

80. In May 2019, I received a request from Dr Jake Dunning, Consultant in Infectious Diseases at PHE, for comments on a draft publication - '*High Consequence Infectious Diseases, Personal protective equipment for assessing suspected cases'* which followed research on contamination following donning and doffing undertaken by the Health and Safety Laboratory **[RG/49 – INQ000114418]**. The guidance referred to known HCID's (such as MERS-CoV, avian influenza and EVD). The RCN's feedback, which I provided on 4 June 2019 **[RG/50 – INQ000130263] [RG/50a – INQ000130264]**, was detailed, highlighting the need for the publication to take into account the context of such HCID guidance due to the impact on PPE stocks locally, training requirements and demand. The draft guidance did not refer to pandemic preparation for novel influenza or coronavirus, but known infections. It is not known if this guidance aligned with the national pandemic planning or if it was ever published. I did not receive any further communications from PHE further to my feedback on the guidance. I remember remarking at the time (in email correspondence to Susie Singleton, dated 16 May 2019) that the draft publication was received by me for comment two weeks prior to a scheduled meeting of the EPRR CRG, but that I had heard nothing from the EPRR CRG on this. This would seem to suggest that the PHE and EPRR CRG were working in rather a siloed manner.

<u>After 21 January 2020</u>

81. By the end of January 2020, there was still a lack of clarity on the governance and risk management of the emerging Covid-19 incident, particularly around preparedness and escalation. At the time, I was aware that PHE had an incident group and that IPC Guidance had been issued, however, as far as I knew at the time, none of the major professional stakeholder groups had been invited to be involved in this or had been communicated with. I raised my concerns in this regard on 28 January 2020 with Mark Sewell NHS Preparedness and Response Senior Manager, at NHSE and NHS Improvement **[RG/52 – INQ000114353]** prior to a meeting of the EPRR CRG later that day. In that communication, I noted that the lessons from the EVD and pandemic flu outbreaks around UK-wide stakeholder engagement seemed to have been forgotten.

82. In a further email exchange on 29 January 2020, after the EPRR CRG meeting, I reiterated my concerns, this time to Stephen Groves, National Head of EPRR NHS England and NHS Improvement **[RG/52 – INQ000114353]**. I communicated my concerns regarding the lack of clarity on how the Covid-19 incident was being managed between the relevant agencies and how key stakeholders were being engaged with. I noted that the key lessons from pandemic flu and the EVD outbreak highlighted the crucial need to engage with organisations supporting frontline staff to ensure that guidance was both relevant and able to be implemented. In relation to emerging PHE guidance, it was unclear how the related agencies were being coordinated and what the mechanisms were for communication and escalation of concerns or risks.

83. I asked for further information as to how the incident management teams planned to engage with professional organisations, working alongside each other across the many settings and specialties, to ensure communications were consistent and that the lessons identified from previous outbreaks were utilised. I also stated that it was the RCN's wish to support those managing the Covid-19 incident through proactive advice and the development of guidance, rather than to have to feed back concerns after decisions were made or guidance issued.

84. Again, in a further email exchange with Professor Chris Moran, National Clinical Director for Trauma at NHS England and NHS Improvement, on 29 January 2020

[RG/53 – INQ000114354], I restated the importance of involving key stakeholders early, as part of a multi-professional team, to shape and develop guidance. I explained that guidance must be developed and assessed by those in practice to ensure its ability to be implemented (as we had learnt from EVD), in addition to the consideration of other supplementary factors that may impact on compliance. I further explained that interagency collaboration and engagement of professional organisations needed to extend beyond the development of guidance – it was clear that there were evolving employment questions and wider workforce issues that would need to be addressed through a multi-agency approach.

85. On 23 December 2020, the RCN's Chief Executive and General Secretary at the time, Dame Donna Kinnair, sent a joint letter along with Dr Chaand Nagpaul, Chair of the British Medical Association ("**the BMA**"), to Sir Patrick Vallance, the UK government's Chief Scientific Adviser **[RG/54 – INQ000114338]**. This was in response to the identification and communication of the new variant of SARS-Cov-2 at the Prime Minister's press briefing on 19 December 2020.

86. In the letter, the RCN and the BMA expressed their concerns, and the concerns of their members, about the implications of the increased risk of transmission of the new variants to patients and staff through exposure in health care settings. We asked that the precautionary principle be applied in terms of increased PPE, including a higher level of respiratory equipment for those working with patients suspected or confirmed as having Covid-19 based on the precautionary principle. We also called for more emphasis and tailored guidance on effective ventilation within health care environments and asked for the UK government to initiate a review of the effectiveness of ventilation in the health and care built estate. We drew the UK government's attention to the fact that the British Occupational Hygiene Society was already advising a higher level of respiratory protection than the PHE standards at the time. I understand that this correspondence was forwarded to Chris Whitty's office who confirmed receipt. I do not recall that a substantive written response was forthcoming.

87. On 15 January 2021, Dame Donna Kinnair wrote to Michal Brodie, Interim Chief Executive of PHE, highlighting members' concerns relating to the risk of

aerosol/airborne infection and requesting that PHE urgently commission a review of the evidence-base supporting the UK IPC Guidance independent of the UK IPC cell **[RG/55 – INQ000114315]**. PHE responded, on 17 February 2021, to explain that the UK IPC Cell had recently reviewed the evidence in relation to the transmission route and the IPC precautions required and that updated IPC Guidance had been published on 21 January 2021 **[RG/56 – INQ000114314]**. In response to the RCN's request for PHE to commission a review of the evidence-base, Mr Brodie simply said that the IPC cell had undertaken a review and that no changes to the current PPE requirements were needed.

88. The RCN was involved in the work of the AGP Alliance (now the Covid Airborne Protection Alliance) from January 2021. The AGP Alliance was a coalition of organisations formed with the purpose of influencing the governments and health services in all four nations of the UK in relation to recognising the full range of Aerosol Generating Procedures ("**AGPs**") and changing the government's guidance on PPE to better protect health care workers. The RCN supported a request, made by the AGP Alliance in February 2021, to meet with the CMO to discuss the implications of the Public Accounts Committee Report "*COVID-19: Government procurement and supply of Personal Protective Equipment*" published on 10 February 2021 **[RG/57 – INQ000114330]**. Professional bodies and unions, including the RCN, were concerned that AGPs had been given over prominence in the IPC Guidance because of a single-minded adherence to the dogma of droplet transmission, and, as a result the IPC Guidance was inadequate to protect frontline staff when in close proximity to suspected or known people with COVID-19.

89. On 18 February 2021, I coordinated a letter to the Prime Minister highlighting concerns about the measures in place to protect health care workers, specifically around better ventilation, PPE and awareness and research in relation to the IPC Guidance **[RG/58 – INQ000114283]**. In the letter, we called for the IPC Guidance to be amended to reflect and increase the level of respiratory protection as a precautionary principle for all health care workers, and update all guidance to reflect the evidence on airborne transmission ensuring representation from a truly multidisciplinary range of experts. We also called on the UK government to collect

and publish consistent data on health care workers who have contracted Covid-19 from likely occupational exposure. The letter was co-signed by a significant number of other organisations (representing professional bodies, unions and other Royal Colleges) that had come together in an informal alliance to seek to influence the UK government on these issues. In the letter we highlighted the fact that we felt it necessary to escalate our concerns to the Prime Minister because of a lack of sufficient engagement from UK government departments and agencies in addressing our concerns. We also reiterated our previous calls to adopt a more collaborative multidisciplinary approach to producing and coordinating IPC guidance. A response to this letter was not received until 7 May 2021 **[RG/59 – INQ000114417]**.

90. The lack of UK government response to the issues raised in the RCN and the BMA's letter of 23 December 2020, and the disappointing response from PHE, prompted the RCN to commission the Independent Review of the UK IPC Guidance (the "**Independent Review**") **[RG/60 – INQ000114357]**. This was not a measure I would have expected the RCN ever to have to take, but the organisation felt forced into a corner by the inaction of the UK IPC cell, PHE and the UK government. The Independent Review was published in March 2021 and, in my recollection, it received significant push back from senior health leaders in the four countries.

91. On 12 March 2021, the RCN co-signed a letter (with Royal Colleges, professional bodies and trade unions) to the CMOs in each of the four nations calling for an urgent review of PPE and ventilation guidelines **[RG/61 – INQ000114413]**. In that letter, we requested a meeting due to the length of delay, and in some cases entire absence, in communications with senior leaders. In that letter, we pointed out that the lack of response to many of our letters asking for changes to current guidance was not only professionally discourteous but also unacceptable. We received a very dissatisfactory response to this letter from Dr Gregor Smith (CMO Scotland) on 25 March 2021 **[RG/62 – INQ000114412]** – the response was no more than a brief acknowledgement of receipt. Further to our letter, Chris Whitty (CMO England) agreed to a meeting to take place on 22 April 2021, but this was postponed by the DHSC on 20 April 2021 **[RG/63 – INQ000114426]**.

92. On 29 March 2021, Kamini Gadhok, CEO of the Royal College of Speech and Language Therapists wrote to Sir Robert Francis in his role as Chair of Healthwatch England **[RG/64 – INQ000114294]**. Whilst the RCN was not a signatory to this letter, I was aware, at the time, of it being sent and the letter explicitly mentioned the RCN as working with the AGP Alliance and other bodies to lobby government to update guidance on ventilation in healthcare settings and PPE for health care workers. The letter was seeking the advice and guidance of Sir Robert as to potential next steps given the lack of engagement the AGP Alliance and others were experiencing from UK government and senior health leaders. The letter states: "*This reflects an ongoing pattern whereby our concerns are dismissed or ignored, which has meant we have never been given the opportunity to directly present our evidence to decision makers as stakeholders. We are perplexed and very concerned, particularly with the time that has lapsed and the seriousness of our concerns*".

93. On 27 April 2021, I attended a meeting with the then Deputy Branch Head PPE Policy at DHSC, along with Tom Embury (from the British Dietetic Association), Ms Gadhok and Robert Wilson (from the BMA). This meeting was arranged in lieu of the original stakeholder meeting, due to take place on 22 April, which was postponed at very short notice. I recall that, at that meeting, we spoke about the evidence-based approach we wanted the government to take to the IPC guidance, we reinforced the centrality of the protection of health care workers, and how our respective organisations could support the UK government in amending the IPC guidance.

94. On 5 May 2021, Ms Gadhok and I wrote to the then Deputy Branch Head PPE Policy at DHSC on behalf of the alliance of organisations that had written to the Prime Minister on 18 February **[RG/65 – INQ000114258]**. This was in lieu of the meeting with the CMO that had been postponed. In this email, we raised our concerns in relation to PPE guidance, drawing attention to the fact that the current UK IPC Guidance did not align with guidance from the ECDC or the Centers for Disease Control and Prevention in the United States. We also expressed our ongoing concern that professional bodies and other representative organisations

had not been offered opportunities for communication and consultation on guidance that affected their members.

95. As mentioned above at paragraph 89, we received a letter from 10 Downing Street on 7 May 2021, in response to our letter of 18 February. The letter was dismissive of our calls for the IPC guidance to be amended and for a multidisciplinary approach to developing, reviewing and updating guidance for health care workers. The letter stated that the IPC Cell within NHS England had "*recently reviewed evidence in relation to the transmission route of Covid-19 and the precautions required, and agreed that no changes to the current PPE requirements were needed*" and that "*there is also a consensus among the Chief Medical Officers in the four nations of the UK that existing guidance regarding the use of face masks and FFP3 masks by health care workers is correct*".

96. In light of this very disappointing response, I coordinated a press release that was published by members of the informal alliance on 14 May 2021 **[RG/66 – INQ000114427] [RG/67 – INQ000114429]**. As mentioned in the press release, the response from the Prime Minister's office failed to recognise the growing evidence that Covid-19 could be spread by aerosols.

97. On 3 June 2021, the DHSC held a PPE IPC Guidance Stakeholder Engagement meeting (which was in place of the meeting with the CMO which was initially scheduled for 22 April 2021, but which now had a much larger cast of invitees). I attended this meeting with my colleague Matthew Barker, Deputy Director of Nursing **[RG/68 – INQ000114332] [RG/69 – INQ000114333]**. We prepared well for this meeting – the alliance prepared a presentation on protective solutions for airborne Covid-19 **[RG/70 – INQ000114414]** that we delivered at the beginning of the meeting and, in the spirit of transparency and collaboration, we also sent in a number of questions prior to the meeting to be addressed in the scheduled Q&A session **[RG/71 – INQ000114261]**. These questions highlighted our concerns around:

    a. the IPC Guidance not being consistent with the latest evidence on airborne transmission and being defective in terms of not reinforcing the need for

healthcare employers to undertake effective local risk assessments that reflect the needs for flexibility in infection control;

b. what measures were being taken to secure sufficient and sustainable provision of the correct PPE (i.e. FFP3 masks or equivalent) to protect frontline health and care staff from airborne transmission;

c. the design and ventilation of healthcare environments and the interim/alternative measures that were being considered where close proximity/ventilation was unpredictable;

d. what was being done to ensure that national IPC Guidance was coordinated with the Health and Safety Executive to ensure infection control and workplace health and safety regulation was consistent; and

e. how to secure greater future collaboration between policy makers and stakeholders in the development of policy and guidance.

98. As far as I was concerned, our concerns were not taken seriously by the UK government and its agencies. Whilst our approaches to the CMO and DHSC on these matters were professional and transparent, in terms of us being clear about why we were seeking to engage, the concerns we had on behalf of the professions we represented, and what our desired outcomes were, the questions we asked were not answered and our concerns were dismissed almost out of hand. This was a really important meeting and huge opportunity for the RCN, and the broader alliance of organisations, to have our voices heard to influence changes in policy to improve the safety of health and care workers and the adoption of a precautionary approach to the use of RPE where evidence was not felt to meet the 'gold standard' expected by the UK IPC cell. It did not deliver and we came away feeling belittled and patronised.

99. On 23 June 2021, Michael Dynan-Oakley (Deputy Director, PPE Policy, Briefing and Engagement at DHSC) wrote to the attendees of the IPC Guidance stakeholder meeting **[RG/72 – INQ000114267]**. The letter purported to answer the

questions that we posed in the Q&A section of the meeting but was again rather dismissive of our key concerns and did not provide any tangible means by which a wider range of stakeholders could support the revision of future guidance and resources.

100. On 8 July 2021, the RCN wrote to Mr Dynan-Oakley expressing disappointment with regards to his letter of 23 June **[RG/73 – INQ000114265]**. The questions the RCN and the broader alliance had posed were not answered adequately at the meeting or in the follow-up letter from Mr Dynan-Oakley. We felt that the DHSE had failed to recognise the critical issue of short-range aerosol transmission of Covid-19. The RCN's letter stated that "*our members continue to report a loss of confidence in the UK IPC guidance, dissatisfied with a lack of consultation with stakeholders, in particular those represented at the meeting on 3 June*". I was disappointed and surprised not to be offered a follow-up meeting (which is something that was requested by the alliance at the time). Also on 8 July, the RCN wrote to Dr Jenny Harries **[RG/84 - INQ000148342]**, Chief Executive of the UK Health Security Agency, attaching the correspondence between the RCN and Mr Dynan-Oakley, expressing our disappointment at the responses to our questions to date and offering our assistance with the review of the UK IPC Guidance that Dr Harries had been commissioned to lead.

101. On 14 July 2021, the RCN co-signed a further letter to the Prime Minister **[RG/74 – INQ000114256]**. This called for the continued use of RPE for staff in health and care settings, alongside improvements in ventilation, in the context of continuing concerns around health care staff becoming infected with Covid-19 in the workplace. We continued to call for the use of FFP3 masks for staff in all settings of care who may come into close contact with known or suspected Covid-19 patients.

102. On 19 July 2021, I raised concerns with the National Covid-19 Response Centre ("**NCRC**") in relation to inconsistencies between PHE's guidance document '*COVID-19: management of staff and exposed patients and residents in health and social care settings*' and the PHE Briefing Note 2021/050 issued on 19 July 2021 **[RG/75 – INQ000114274] [RG/76 – INQ000114275] [RG/77 – INQ000114276]**.

This was another example of where poor guidance was being published without the necessary stakeholder consultation and engagement taking place in its development and communication. Having to retrospectively and publicly critique key guidance put out by PHE was something I never thought I would have to do in my professional life.

103. On 30 July 2021, Jude Diggins (Director of Nursing, RCN) and I met with Dame Ruth May, CNO for England, and Sue Tranka, Deputy CNO at the time **[RG/78 – INQ000114273]**. We proactively reached out to arrange this meeting in order to offer support for a review of the IPC Guidance, to explain the work the RCN were planning on doing to support frontline health care workers with risk assessments, and to raise concerns about health care worker infection data and the need for greater detail on inequalities. I came away from that meeting feeling like we had got very little traction with the CNO and Deputy CNO on the important issues we raised.

104. In light of the lack of traction with DHSC and PHE on the issue of risk assessment for health care workers working in close proximity to patients who have or are suspected to have Covid-19, the RCN worked on developing its own risk assessment resource for its members to plug the gap between IPC and Health and Safety requirements. Developed with a range of stakeholder organisations, the RCN's Covid-19 workplace risk assessment toolkit was launched on 23 December 2021 **[RG/79 – INQ000114284] [RG/80 – INQ000114307]**. The toolkit highlights the legal duties of employers to protect their staff and reflects UK legislation on risk assessment, such as COSHH. It allows health care staff and employers to make evidence-based decisions about the correct level of PPE, including RPE, needed to keep staff safe. The toolkit underwent extensive review by specialists prior to launch, and was well-received by stakeholders.

<u>The RCN's reflections on the extent of engagement from UK government</u>

105. It was a serious failure of the UK government in relation to the handling of the Covid-19 pandemic that the lessons of EVD regarding the importance of engaging key stakeholders were not learnt. The EVD outbreak highlighted the

critical importance of information sharing and transparency among stakeholders, particularly given the fact that in a pandemic situation fear spreads much faster than the actual infection. My experience was that, during the EVD outbreak, the RCN was able to meaningfully feed in its expertise and knowledge, speaking to the concerns of the frontline professionals it represents, and that this intelligence and input was taken seriously at a national level. The information we were able to provide, in relation to issues such as the psycho-social impact of the outbreak on certain communities and the training needs of nurses around the use of PPE, meant that interventions could be properly targeted and key messages could be adapted and communicated in ways that nurses could interpret and apply to their practice on the ground. Conversely, with the Covid-19 pandemic, I experienced a much more "top-down" dogmatic style of information dissemination (rather than two-way information sharing which I experienced during the EVD outbreak). The culture was more aligned to hierarchy than an open table for collaboration to deliver the same objective. There were, and continue to be, very few opportunities for the RCN to feed in its intelligence and expertise to the key-decision makers at national level in a proactive and timely way.

106. Likewise, the level of engagement that the UK government has had with the RCN throughout the Covid-19 pandemic (and as it continues) has been woefully inadequate. By way of example, the RCN was not invited to the CMO's weekly meetings with the Academy of Medical Royal Colleges ("**AoMRC**") that took place during the height of the pandemic. Whilst the RCN is not a member of the AoMRC, the two organisations have a close working relationship and, in my experience, the RCN was often included in key meetings that involved the other medical Royal Colleges. The fact that the CMO overlooked the RCN in this case to my mind demonstrates that the UK government did not consider that nursing was an equal partner to the medical Royal Colleges in managing the response to Covid-19, despite the fact that the RCN represents the largest number of healthcare workers of any Royal College. The RCN, instead of being around the table with its medical and clinical counterparts, was forced to receive the information imparted by the CMO secondhand via the Royal College of General Practitioners. Not only was this state of affairs highly disrespectful to the nursing profession, it caused unnecessary delays in the dissemination of vital information

and created tensions that absorbed energy that could have been much better used elsewhere.

107. In summary, prior to January 2020, the RCN had limited engagement with the UK government and its agencies in relation to pandemic preparedness – and this engagement was mostly through formalised advisory groups and one-off table-top planning exercises. From January 2020 onwards, despite multiple attempts made by the RCN, both on its own and in collaboration with other professional stakeholder organisations, to engage with the UK government and its agencies on serious issues largely relating to the IPC Guidance, no significant changes to guidance, and therefore the management of risk to our members, had occurred. This included attempts to redress this through letters to the Prime Minister, PHE and CMO and the IPC Guidance stakeholder meeting on 3 June 2021. Our attempts to influence meaningful stakeholder inclusion and engagement in guidance development were met by the UK government and its agencies with disinterest.

Key articles and reports the RCN has published or contributed to, and/or evidence it has given regarding the UK's emergency and pandemic planning, preparedness and resilience

108. The following is a list of the key articles and reports the RCN has published regarding the UK's emergency and pandemic planning, preparedness and resilience:

a. RCN Parliamentary Briefing - Coronavirus Bill 2020 [24 March 2020] **[RG/81 – INQ000114407]**

b. Personal Protective Equipment: Use and availability during the COVID-19 pandemic [18 April 2020] **[RG/40 – INQ000114401]**

c. Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the COVID-19 pandemic [28 May 2020] **[RG/41 – INQ000114402]**

d. Written submission to the Scottish Parliament's Health and Sport Committee's Call for Views in relation to resilience and emergency planning and the lessons that can be learned from the Covid-19 pandemic [June 2020] **[RG/3 – INQ000114371]**

e. RCN Submission - HM Treasury Comprehensive Spending Review (CSR) written representation [September 2020] **[RG/19 – INQ000114252]**

f. RCN Response: COVID-19: Supply of Personal Protective Equipment [15 December 2020] **[RG/6 – INQ000114408]**

g. RCN Submission: HM Treasury Budget 2021 written representation [January 2021] **[RG/24 – INQ000114341]**

h. RCN Submission to the NHS Pay Review Body: 2021/22 Pay Round [January 2021] **[RG/26 – INQ000114340]**

i. RCN Northern Ireland Supplementary evidence to the NHS Pay Review Body 2021-2022 [January 2021] **[RG/25 – INQ000114328]**

j. RCN Independent review of guidelines for the prevention and control of Covid-19 in health care settings in the United Kingdom: evaluation and messages for future infection-related emergency planning [28 February 2021] **[RG/60 – INQ000114357]**

k. RCN response to the Public Accounts Committee consultation on Government preparedness for the Covid-19 pandemic: Lessons for Government on risk [December 2021] **[RG/2 – INQ000114416]**

l. RCN Covid-19 workplace risk assessment toolkit [December 2021] **[RG/80 – INQ000114307]**

109. The following is a list of the key articles and reports the RCN has contributed to:

a. Centre for Workforce Intelligence – *Review of the infection prevention and control nurse workforce* [July 2015] **[RG/39 – IN000114403]**

b. National Audit Office - *Readying the NHS and adult social care in England for COVID-19* [12 June 2020] **[RG/33 – INQ000114319]**

c. National Audit Office - *The supply of personal protective equipment (PPE) during the COVID-19 pandemic* [25 November 2020] **[RG/82 – INQ000114373]**

The RCN's view on what lessons can be learned for future pandemics and other whole-system civil emergencies

110. This is a unique moment in time for the UK government, and the health system in general, to learn lessons from the Covid-19 pandemic and apply these now to strengthen pandemic planning for the future. The Covid-19 pandemic is not yet over, and the UK remains at high risk of a zoonotic pandemic outbreak. It is vital that the opportunity to learn from the UK's experience of the Covid-19 pandemic is capitalised on.

111. The RCN considers that the key lesson learned is the crucial importance of the UK government working proactively and collaboratively with key stakeholders, including professional organisations, trade unions and other organisations that represent clinicians on the ground, as part of a multi-professional team to plan for, manage and respond to pandemics and whole-system civil emergencies. This includes professional and scientific stakeholder involvement in the development, implementation and evaluation of guidance. The Covid-19 pandemic has shone a spotlight on the critical role undertaken by nursing in our health and care system. As such, the role of professional nursing (as opposed to specialists in IPC) in the design, development and implementation of

national protocols, policy decisions and guidance at the local and national level should be strengthened.

112. The Covid-19 pandemic taught us that the experiences of those on the frontline of health and social care was often dangerously overlooked. There were inadequate opportunities for those representing frontline workers to feed into the development and delivery of guidance (particularly IPC guidance); this resulted in guidance that was not fit for purpose and 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. The shortcomings of the IPC Guidance, the way it was put together and reviewed and the impact of this on the decisions and views of managers, and implications for healthcare workers is something that the RCN will speak to in more detail in Module 3 of the Inquiry, in respect of which it is a designated Core Participant. It was a recommendation of the Independent Review **[RG/60 – INQ000114357 pp.8]** that the team responsible for issuing and updating the interim IPC Guidance should form a post-pandemic group to inform the input of post-Covid strategy into the Five-Year Antimicrobial Action Plan requirement to implement national infection prevention and control guidelines in England.

113. As a profession, nurses have led the way in reducing the transmission of infection by prioritising infection prevention and control measures. These measures are fundamental to nursing, meaning the profession is uniquely able to understand the importance and methods to reduce infection rates. Prior to, and during the Covid-19 pandemic, nursing leaders were not fully involved in the design of national guidance on PPE and infection control. In future, full and proper engagement with the nursing profession on infection control will help to ensure national guidance is robust, fully informed and evidence based.

114. A pandemic will impact all parts of society not just the NHS, therefore greater consideration of the needs of individuals affected by infection or its impact, or who would require health services from non-hospital settings (eg GPs, out of hours), should have been as central to pandemic planning as the reactive management of the NHS.

115. During the Covid-19 pandemic a vital opportunity was missed by UK government and its agencies to recognise the value of the contribution the RCN could have made due to its access to clinical expertise and strategic oversight/intelligence on nursing issues impacting on delivery of health and care services especially to the most vulnerable in all settings.

116. The Covid-19 pandemic has shown that there was too much of a focus on preparing for a flu pandemic and not enough consideration was given to how such plans would need to be adapted to deal with a respiratory infection pandemic, where the primary mode of transmission was not necessarily via 'traditional' droplet transmission. This emphasis on dealing with a flu pandemic seemed to limit the ability of the UK government to adapt its approach and be flexible in the face of mounting evidence from the frontline experience of the pandemic, especially in relation to the new variants of SARS-Cov-2, that airborne transmission needed to be properly factored into IPC Guidance concerning the level of PPE required for health and care workers exposed to patients with Covid-19. Development of the IPC Guidance should have involved the inclusion of a broader range of experts, drawing on expertise in sectors and disciplines outside of medicine and health care (i.e. engineers, ventilation experts and aerosol scientists). The RCN definitely benefitted from the expertise of a wide range of specialists when producing its workplace risk assessment toolkit. This is a key lesson which should be implemented in the development and production of future IPC guidance.

117. The Covid-19 pandemic has also shown that the social care sector had been, and in many ways continues to be, severely overlooked and underappreciated. It is clear that previous resilience planning, both nationally and locally, had not adequately incorporated the community and care home sectors. Those working in care homes were particularly impacted by stock availability and the slow distribution of PPE, illustrating that the sector was not sufficiently considered in resilience plans. The pandemic has highlighted the need for health and social care partnerships to consider and include all health and care facilities in their area, including independent sector care homes, in resilience and emergency planning.

118. The UK government and its relevant agencies need to review and carefully consider how to build better isolation facilities now so that they will be fit for the future. The UK government needs to learn from the Covid-19 pandemic and specifically consider the role of ventilation in the transmission of infection and how care can be delivered safely to large numbers of people whilst also focusing on staff safety considering that, in a pandemic, it is unlikely there will ever be enough single rooms in which to isolate infected patients.

119. The failure of the UK government to tackle the issues facing the nursing workforce, including in recruitment, retention and burnout, remains a serious risk to the country's ability to robustly tackle future pandemics. Currently, in England, there is not yet a shared credible system understanding of workforce shortages and of the increasing demand in both population and service. Persistent, systemic workforce issues put nursing staff and patients at risk – this was even more in evidence during the Covid-19 pandemic when many frontline staff had to self-isolate and nurse-to-patient ratios were challenging, unsustainable and frequently compromising to patient safety. The RCN is clear that in England the Government must take action to develop a sustainable nursing workforce supply to meet the needs of the population now and in the longer term, and to ensure staffing for safe and effective care in all health and care settings. This includes a fully funded health and care workforce strategy, an assessment of workforce requirements in health and social care and accountability for provision of the workforce in legislation. The RCN campaigned extensively for an amendment to the Health and Care Act 2022 (when it was the Health and Care Bill) to create legal accountability for safe and effective staffing with the Secretary of State for Health and Social Care. Unfortunately, politicians did not take this amendment forward and a key opportunity was missed.

120. Similarly, safe staffing legislation, as exists in Scotland and Wales, needs to be brought forward without delay in Northern Ireland to ensure that the need to provide enough nursing staff to deliver safe and effective care to the people of Northern Ireland is never again subject to the vagaries of ad hoc workforce planning and budget constraints.

121. It is also vital that new structures in health and care systems in England have dedicated registered nurse leadership roles, including within Integrated Care Boards, and national bodies, as well as within the UK government.

122. The shortages of PPE in the early stages of the pandemic revealed serious concerns with how the UK procures essential safety equipment. The government must adopt a longer-term approach to sustainably procuring and maintaining stockpiles of PPE as well as other medical equipment essential for staff and patient safety. Procurement should be harmonised between government departments, and additional resource should be factored in to enable the expertise of clinical procurement staff to be part of the decision-making processes.

123. The pandemic exacerbated the health inequalities in the UK's population (including health care workers) and exposed the fact that the historic underfunding of public health had undermined the capacity of local public health teams to effectively improve health and reduce inequalities and respond to the Covid-19 pandemic. In terms of moving forward, the RCN has called on the Government to deliver a long term, increased, sustainable funding settlement for public health services commissioned and delivered by local authorities in England **[RG/2 – INQ000114416 pp.8]**. This will enable local authorities to plan and deliver safe and effective services that improve and protect the health of their population and reduce inequalities. At minimum, the public health grant should be immediately restored to its 2015 level. The most deprived areas of England where health needs are greatest, which have been disproportionately affected by the Covid-19 pandemic, should receive additional public health investment to level up health across the country and support an equitable recovery from the pandemic.

124. The government's decision, in August 2020, to disband PHE was taken at a time when public health and health protection had never been so vital and requiring of stability. The early plans for the new National Institute for Health Protection ("**NIHP**") excluded vital public health functions including health improvement and prevention. There was a lack of assurance that services including sexual health, smoking cessation, health visiting and school nursing for

example, would remain and continue to be a priority. To disband a key public health agency in the middle of a pandemic seemed to me to be completely misguided. This put efforts and resource in entirely the wrong places. It also necessarily meant that decision-making was delayed, and key relationships built up over time were lost at a crucial moment.

Closing remarks

I would like to thank the Inquiry Chair, on behalf of the RCN, for the opportunity to provide evidence in relation to Module 1 of the UK Covid-19 Inquiry. We recognise that this Inquiry presents a unique opportunity to identify and put in place actions to ensure that learning from the UK's experiences of the Covid-19 pandemic is implemented. This is crucial to ensure that the UK is properly prepared, as well as it can be, for future pandemics (where the only question is when, not if, the next pandemic will hit). Nurses and health care workers will be on the frontline of the next pandemic and the RCN has a responsibility to ensure anything that went wrong or things that could be improved are reported on and acted upon in the interests of nurses, our wider health care colleagues, and the patients to whom they provide care.

The RCN is committed to working with the Inquiry throughout its investigations and we are happy to assist with any further requests.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 20 April 2023

Witness Name: Rosemary Gallagher
Statement No.:1
Exhibits: 84
Dated: 20 April 2023

UK COVID-19 INQUIRY

INDEX OF EXHIBITS OF ROSEMARY GALLAGHER MBE

RG/1- INQ000114384	Global Outbreak Alert and Response Network (GOARN) Request for assistance regarding MERS-CoV infections, dated 12/11/2013
RG/2 – INQ000114416	Document titled "Royal College of Nursing response to Public Accounts Committee consultation on Government preparedness for the Covid-19 Pandemic: Sessions for Government risk", dated 01/12/2021
RG/3 – INQ000114371	Submission by the Royal College of Nursing Scotland, titled "Health and Sport Committee - Resilience and emergency planning", undated
RG/4 – INQ000114285	Report from Dame Deirdre Hine, titled "The 2009 Influenza Pandemic An independent review of the UK response to the 2009 influenza pandemic", dated 01/07/2010
RG/5 – INQ000114290	Report from Public Health England, titled "Report: Exercise Alice Middle East Respiratory Syndrome Coronavirus (MERS-CoV)", dated 15/02/2016

RG/6 – INQ000114408	Submission from the Royal College of Nursing, titled "Royal College of Nursing (RCN) submission: Public Accounts Committee inquiry COVID-19: Supply of Personal Protective Equipment (PPE), December 2020", dated 01/12/2020
RG/7 – INQ000114366	Emails between Royal College of Nursing colleague's accounts, with subject "evd", attaching draft summary feedback from Ebola summit, dated 10/08/2020
RG/8 – INQ000114368	Draft document from the Royal College of Nursing, titled "Royal College of Nursing summary feedback from Ebola summit Madrid, 27/28 October 2014", dated 29/10/2014
RG/9 – INQ000114387	Document titled "Department of Health Ebola Key Stakeholder Group - Key Discussion Points and Actions", dated 31/10/2014
RG/10 – INQ000114388	Royal College of Nursing presentation handout, titled "Initial feedback from Ebola summit for nurses - Madrid 27/28 October 2014"
RG/11 – INQ000114389	Agenda for Control of Infection Network (CoIN) meeting and Cross Organisational Working and Learning Programme (COWL) seminar, dated 13/11/2014
RG/12 – INQ000114406	Royal College of Nursing document titled "Nursing priorities for the United Kingdom's withdrawal from the European Union", dated 01/11/2016
RG/13 – INQ00114410	Spreadsheet of NHS Core Standards for Emergency Preparedness, Resilience and Response, undated

RG/14 – INQ000114392	Emails between Unison and NHS England colleagues, with subject "Ebola", dated 05/11/2014
RG/15 – INQ000114292	Report from National Guard Health Affairs, titled "Infection Prevention & Control Manual 2nd Edition", undated
RG/16 – INQ000114394	Programme from NHS England and Public Health England, for Exercise PICA, dated 05/09/2018
RG/17 – INQ000114395	Delegate list from Public Health England and NHS England, for Exercise PICA, dated 05/09/2018
RG/18 – INQ000114397	Questions for participants of Exercise PICA, undated
RG/19 – INQ000114252	Submission from the Royal College of Nursing, titled "Royal College of Nursing Submission: HM Treasury Comprehensive Spending Review (CSR) written representation", dated 01/09/2020
RG/20 – INQ000114302	Report published by the Royal College of Nursing, titled "Safe and Effective Staffing: the Real Picture", dated 01/05/2017
RG/21 – INQ000114303	Report published by the Royal College of Nursing, titled "Safe and Effective Staffing: Nursing Against the Odds", dated 01/09/2017
RG/22 – INQ000114304	Report published by the Royal College of Nursing, titled "Nursing education policy and funding in England", dated 01/12/2019

RG/23 – INQ000114306	Report published by the Royal College of Nursing, titled "Staffing for Staff and Effective Care - Nursing on the Brink", dated 01/05/2018
RG/24 – INQ000114341	Submission from the Royal College of Nursing, titled "Royal College of Nursing (RCN) Submission: HM Treasury Budget 2021 written representation, January 2021", dated 01/01/2021
RG/25 – INQ000114328	Submission from the Royal College of Nursing Northern Ireland, titled "Supplementary evidence to the NHS Pay Review Body 2021-2022", dated 01/01/2021
RG/26 – INQ000114340	Submission from the Royal College of Nursing, titled "Royal College of Nursing Submission to the NHS Pay Review Body: 2021/22 Pay Round", dated January 2021
RG/27 – INQ000114398	Article published by the Royal College of Nursing, titled "Safe nurse staffing in Wales", dated 06/12/2022
RG/28 – INQ000114399	Article published by the Royal College of Nursing, titled Safe staffing Scotland, dated 15/02/2023
RG/29 – INQ000114411	Guidance published by Public Health England, titled "Guidance for social or community care and residential settings on COVID-19", dated 25/02/2020
RG/30 – INQ000114287	Scottish Government COVID-19 Guidance, titled "National Clinical Guidance for Nursing and AHP Community Health Staff during Covid-19 Pandemic", dated 17/04/2020

RG/31 – INQ000114400	Department of Health document, titled "The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance", dated 01/01/2015
RG/32 – INQ000114286	Health Protection Agency document, titled "Health Care Associated Infection Operation Guidance and Standards for Health Protection Units", dated 22/05/2012
RG/33 – INQ000114319	Report published by the National Audit Office, titled "Readying the NHS and adult social care in England for COVID-19", dated 12/06/2020
RG/34 – INQ000114291	Report published by the Royal College of Nursing, titled "Brexit: Royal College of Nursing priorities overview", dated 17/10/2019
RG/35 – INQ000114281	Email from Royal College of Nursing colleague to NHS colleague, with subject "Question for CRG members", dated 22/01/2020
RG/36 – INQ000114393	Draft document from NHS England, titled "Primary Care and Potential Roles and Responsibilities during an Influenza Pandemic", dated 21/09/2016
RG/37 – INQ000114288	Public Health England document, titled "Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings", dated 01/10/2016
RG/38 – INQ000114289	Report published by the House of Commons Health Committee, titled "Public Health England Eighth Report of Session 2013-14", dated 04/02/2014

RG/39 – IN000114403	Report published by Centre for Workforce Intelligence (CFWI), titled "Review of the infection prevention and control nurse workforce", dated 01/07/2015
RG/40 – INQ000114401	Report published by the Royal College of Nursing, titled "Personal Protective Equipment: Use and availability during the COVID-19 pandemic", dated 01/01/2020
RG/41 – INQ000114402	Report published by the Royal College of Nursing, titled "Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the COVID-19 pandemic", dated 01/05/2020
RG/42 – INQ000114404	Document titled "Royal College of Nursing response to Professional Standards Authority review into the learning from Covid-19", dated 01/01/2021
RG/43 – INQ000114405	Article published by the Royal College of Nursing, titled "RCN position on plans to expand the COVID-19 temporary register", dated 22/12/2021
RG/44 – INQ000114377	Emails between Royal College of Nursing colleagues, with subject "Meeting for briefing on involvement with the NHS PHE EPPCRG", dated 09/02/2023
RG/45 – INQ000114379	Terms of Reference, published by NHS England, titled "Emergency Preparedness, Resilience and Response (EPRR) Clinical Reference Group", dated 01/09/2017
RG/46 – INQ000114380	Emails between Royal College of Nursing colleagues, with subject "Meeting for briefing on involvement with the NHS PHE EPPCRG", dated 09/02/2023

RG/47 – INQ000114253	Emails, with subject "Stakeholder Consultation High Consequence Infectious Diseases (Airborne) Interim" dated 22/03/2017
RG/48 – INQ000114312	Form completed by the Royal College of Nursing, titled "Stakeholder Response Form CRG Product Testing", dated 27/03/2017
RG/49 – INQ000114418	Emails, with subject "Draft High Consequence Infectious Diseases Assessment PPE Guidance - request for feedback", dated 16/05/2019
RG/50 – INQ000130263	Emails between the National Infection Service and the Royal College of Nursing, with subject "Draft High Consequence Infectious Diseases Assessment PPE Guidance - request for feedback" dated 04/06/2019
RG/50a – INQ000130264	Draft report from Public Health England, titled "High Consequence Infectious Diseases Personal protective equipment for assessing suspected cases", with comments from the Royal College of Nursing, dated 29/05/2019
RG/52 – INQ000114353	Emails between the Royal College of Nursing and NHS England and NHS Improvement, with subject "EPRR CRG Agenda and Papers", dated 29/01/2020
RG/53 – INQ000114354	Emails between the Royal College of Nursing and NHS England and NHS Improvement, with subject "EPRR CRG Agenda and Papers", dated 29/01/2020
RG/54 – INQ000114338	Letter to Sir Patrick Vallance from the Royal College of Nursing and British Medical Association, regarding

clarification about transmission of Covid-19, dated 23/12/2020

RG/55 – INQ000114315 Letter to Public Health England from Royal College of Nursing, regarding risk of aerosol/airborne infection and review of current NHS IPC guidance, dated 15/01/2021

RG/56 – INQ000114314 Letter to Royal College of Nursing from Public Health England, regarding risk of aerosol/airborne infection and review of current NHS IPC guidance, dated 17/02/2021

RG/57 – INQ000114330 Emails between the Royal College of Nursing and the AGP Alliance, with subject "AGPs and PPE", dated 10/02/2021

RG/58 – INQ000114283 Letter to Prime Minister Boris Johnson, from various medical organisations, with subject "Protecting health care workers - better ventilation, PPE, awareness and research", dated 18/02/2021

RG/59 – INQ000114417 Letter to the Royal College of Nursing from the Prime Minister, regarding response to letter about protecting healthcare workers against Covid-19, dated 07/05/2021

RG/60 – INQ000114357 Report from the Royal College of Nursing, titled "RCN Independent review of guidelines for the prevention and control of Covid-19 in health care settings in the United Kingdom: evaluation and messages for future infection-related emergency planning", dated 28/02/2021

RG/61 – INQ000114413 Letter to the Chief Medical Officers, from various medical organisations, regarding urgent review of PPE and ventilation guidance consistent with airborne transmission of Covid-19, dated 12/03/2021

RG/62 – INQ000114412 Letter from Dr Gregor Smith, Chief Medical Officer Scotland, to the Association of UK Dietitians, dated 25/03/2021

RG/63 – INQ000114426 Email from BDA to various recipients, regarding the postponement of an AGP alliance meeting, dated 20/04/2021

RG/64 – INQ000114294 Letter to Chair of Healthwatch England from the Royal College of Speech and Language, regarding request for update on ventilation in healthcare settings and health care workers, dated 29/03/2021

RG/65 – INQ000114258 Email from Kamini Gadhok to Department of Health and Social Care, regarding rearranging 22nd April meeting, dated 05/05/2021

RG/66 – INQ000114427 Email between Royal College of Nursing colleagues, regarding update on actions and press release to be sent at 4pm, dated 15/05/2021

RG/67 – INQ000114429 Press release, titled Global recognition that Covid-19 is airborne shows UK is lagging behind, undated

RG/68 – INQ000114332 Email from Royal College of Speech and Language Therapy colleague to various recipients, with subject "PPE Infection Prevention Control Guidance Stakeholder Engagement Agenda & question sent in prior to meeting", dated 03/06/2021

RG/69 – INQ000114333	Department of Health & Social Care agenda, for the PPE Infection Prevention Control Guidance Stakeholder Engagement meeting, dated 03/06/2021
RG/70 – INQ000114414	Presentation, titled "Protective solutions for airbone Covid-19", undated
RG/71 – INQ000114261	List of questions, titled "Meeting 3 June 2021", dated 03/06/2021
RG/72 – INQ000114267	Letter from Michael Dynan-Oakley to attendees of IPC Guidance Stakeholder Meeting, with subject "PPE IPC Stakeholder Engagement", dated 23/06/2021
RG/73 – INQ000114265	Letter to Michael Dynan-Oakley from the Royal College of Nursing, in response to his letter of 23/06/2021, dated 08/07/2021
RG/74 – INQ000114256	Joint letter to the Prime Minister from various orgnisations including the Royal College of Nursing, with subject "Protecting the public and healthcare staff", dated 14/07/2021
RG/75 – INQ000114274	Emails between National Covid-19 Response Centre and the Royal College of Nursing, with subject "Inconsistencies in guidance issues today on management of exposed health workers and patients in health care settings", dated 26/07/2021
RG/76 – INQ000114275	Emails between National Covid-19 Response Centre and the Royal College of Nursing, with subject "Inconsistencies in guidance issues today on

	management of exposed health workers and patients in health care settings", dated 20/07/2021
RG/77 – INQ000114276	Letter from National Covid-19 Response Centre, in response to Royal College of Nursing concerns due to inconsistencies, undated
RG/78 – INQ000114273	Emails, with subject "HSE v PHE/IPC", dated 10/08/2021
RG/79 – INQ000114284	Article published by Royal College of Nursing, titled "RCN launches new COVID-19 risk assessment tool", dated 23/12/2021
RG/80 – INQ000114307	Document from Royal College of Nursing, titled "COVID-19 workplace risk assessment toolkit", undated
RG/81 – INQ000114407	Briefing from Royal College of Nursing, titled "RCN Coronavirus Bill 2020", undated
RG/82 – INQ000114373	Report published by National Audit Office, titled "The supply of personal protective equipment (PPE) during the COVID-19 pandemic2, dated 25/11/2020
RG/83 – INQ000114313	Guidance titled "Novel coronavirus (2019-nCoV): interim guidance for primary care", dated 31/01/2020
RG/84 - INQ000148342	Letter to Dr Jenny Harries, Chief Executive of the UK Health Security Agency from the Royal College of Nursing and Chair of the AGP Alliance, dated 08/07/2021