Witness Name: Dr Katherine Henderson
Statement No.:1
Exhibits: 66
Dated: February 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR KATHERINE HENDERSON

I, DR KATHERINE HENDERSON, will say as follows: -

1. I am Dr Katherine Henderson MBE, President of the Royal College of Emergency Medicine, a post I held between October 2019 and October 2022. I have worked as a consultant in Emergency Medicine since 1998 and I currently practice at Guy's and St Thomas' NHS Trust in London. My professional qualifications include a Bachelor of Medicine and Bachelor of Surgery, Master of Science, Fellow of the Royal College of Physicians and Fellow of the Royal College of Emergency Medicine.
2. The statement is intended as an organisational response by The Royal College of Emergency Medicine and has been prepared with input from a number of key individuals. This statement has also been through a verification exercise to check the accuracy of the information contained herein. In providing this statement, I have received assurances from the key contributors and via the verification exercise that where information is not in my direct knowledge, it is accurate to the best of the knowledge and belief of the Royal College of Emergency Medicine, and in signing the statement of truth at the end of this statement I reasonably rely on those assurances.
3. In preparing this statement, and where appropriate, the following periods have been adopted as reference points against which to address the evidence:
    i. Start of the outbreak (March-May 2020)
    ii. First wave recovery (May-August 2020)
    iii. Second wave (August 2020-January 2021)
    iv. Vaccine rollout (January -June 2021)
    v. Delta outbreak (July -September 2021)
    vi. Omicron outbreak (October 2021-March 2022)
    vii. End of pandemic (March -June 2022).

4. The reason for adopting these periods is due to the relevance of the challenges faced by Emergency Medicine clinicians working in Accident and Emergency Departments (EDs). EDs were at the forefront of responding to rapidly changing situations and the impact of the pandemic on emergency care varied significantly during different phases. These time periods allow for a more targeted exploration of how the Royal College of Emergency Medicine and its members navigated and adapted to the changing circumstances of the pandemic.

The Royal College of Emergency Medicine's role, function and aims

5. The Royal College of Emergency Medicine (RCEM / the College) is a Charity registered with the Charity Commission for England & Wales. The registered Charity Number is 1122689. The College is also registered with the Office of the Scottish Charity Regulator. The registered Charity Number is SC044373.
6. The College is a membership organisation for doctors, nurses, and healthcare professionals working in the speciality of Emergency Medicine. The principal funding sources for the College are membership subscriptions and examinations income. These sources are in line with the main educational activities and charitable aims of the College.
7. The College aims to advance education and research in Emergency Medicine. It is responsible for setting standards of training and administering examinations in Emergency Medicine for the award of Fellowship and Membership of the College, as well as recommending trainees for Certification of Completion of Training in Emergency Medicine.
8. Educational standards, such as the RCEM curriculum and examinations, are regulated by the General Medical Council (GMC). Matters unrelated to examinations and training, such as quality standards and policy recommendations, do not possess legal status. The College produces research, campaigns, guidelines, advice, and recommendations to influence external bodies to ensure the NHS can provide high-quality patient care within Emergency Departments (EDs). The College is also accountable to the Charity Commission. As a result, the College only undertakes political campaigning when it relates to the College's charitable aims.
9. The College works to preserve and protect good health and to relieve sickness by improving standards of health care and providing expert guidance and advice on policy to appropriate bodies on matters relating to Emergency Medicine to relevant bodies such as NHS England and devolved equivalents, UK Governments, and healthcare regulators on matters relating to Emergency Medicine.
10. In February 2015 the College was granted the title Royal, having previously been known as The College of Emergency Medicine after a Royal Charter was gained in February 2008. The College has 10,792 UK members in total.

11. The College's mandate is given to us by our Royal Charter which sets our objectives as follows: (a) to advance education and research in Emergency Medicine and to publish the useful results of such research; and (b) to preserve and protect good health and to relieve sickness by improving standards of health care and providing expert guidance and advice on policy to appropriate bodies on matters relating to Emergency Medicine.
12. The College's Board of Trustees is its governing body, and its responsibilities include determining the policy and strategy for the College and responding to external developments. The President of the College is elected by its members and is the Chair of the Board of Trustees.
13. The Vice Presidents of Scotland, Wales, and Northern Ireland are elected by members living in those constituencies. The Vice Presidents and their respective National Boards are responsible for leading Emergency Medicine in that nation.
14. During the pandemic, the College worked to: (a) act as a point of contact for Emergency Medicine, facilitating communication between frontline healthcare professionals working in EDs and policymakers. This ensured timely dissemination of frontline insights to inform policymaking; (b) develop evidence-based guidelines to support the provision of high-quality patient care during unprecedented challenges; and (c) minimise disruptions to medical education and training by transitioning programmes to virtual platforms, allowing Emergency Medicine professionals to continue their education and training safely.

RCEM's working relationship with the named stakeholders

15. During the relevant period, as the President of the College, I had regular meetings with other College Presidents and the Chief Medical Officer in England, Sir Professor Chris Whitty. The purpose of these meetings was to share updates on the clinical experience of our members in managing patients with coronavirus, to be briefed on emerging epidemiology and to discuss challenges being faced by the members of each of the Royal Colleges, in our case Emergency Medicine. These meetings were held remotely and coordinated by the Academy of Medical Royal Colleges. These meetings were usually weekly although they reduced in frequency as the waves of infection settled. There were no formal agendas or minutes. The Vice Presidents of the College in Wales, Dr Jo Mower (Vice President from September 2018 to October 2020) and Dr Suresh Pillai (Vice President from October 2020-present) attended various meetings between the Academy of Medical Royal Colleges Wales and the Chief Medical Officer in Wales, Dr Frank Atherton. These were also organised by the Academy and were held remotely. To our knowledge, there were no minutes taken for these meetings. There were no meetings between the Vice President of Northern Ireland and the Chief Medical Officer of Northern Ireland and the Vice President of Scotland and the Chief Medical Officer of Scotland.

16. During the relevant period, the College participated in a number of meetings with Presidents of Royal Colleges and the Secretary of State for Health and Social Care in England, Mr Matthew Hancock. As there are no meeting minutes and because the College IT system only retains zoom invites for 12 months, it is difficult to be accurate of all the meetings and the dates of those meetings. However, I believe that there were meetings in 2020 on 15th May, 26th May, 12th June, 26th June, 17th July, 21st August, 15th September, 8th October, 20th October, 17th November and 15th December. In 2021 I believe that there were meetings on 9th March, 20th April, 11th May and 17th August. There was participation from the Royal College of Physicians, Royal College of Surgeons of England, Royal College of Psychiatrists, Academy of Medical Royal Colleges, Royal College of Anaesthetists and Royal College of General Practitioners. These meetings were coordinated by the Royal College of Physicians, who may be able to confirm the dates and times, and the purpose was to provide Mr Hancock with the relevant information about the frontline experiences of our members and the impact of the pandemic on our patients. The following topics were discussed in these meetings: (a) challenges with PPE in the early stages of the pandemic; (b) recovery of the NHS after each peak of the infection; (c) strategic planning for winter preparedness and anticipating a potential second wave of COVID-19; (d) impact of the pandemic on issues around equalities, homelessness, mental health: Deliberations encompassing matters of equality, homelessness, and mental health support; (e) staffing and workforce considerations including the impact of the pandemic on burnout; (f) vaccination programme; and (g) demand and capacity issues within the NHS and concerns around crowding. The College has identified only one meeting where a detailed note was prepared. This was for the meeting on 26th June 2020. It is not a formal minute approved by others in attendance. The notes confirm that at that meeting we discussed the timetable for NHS recovery and getting the getting back on an even keel; the constraints of getting back to normal including testing, PPE and a reduced workforce; space and safety; and winter preparation, including the flu vaccine [*KH/60* - INQ000409252]. I had provisionally arranged to meet on a 1:1 basis with the Secretary of State for Health and Social Care, Mr Hancock, on the 22nd April 2020 but that meeting was cancelled. I did meet with Mr Hancock's successor, Mr Sajid Javid in person on 3rd December 2021, the Director General of NHS Policy and Performance, Matthew Style, also attended this meeting. The College notes of the meeting (not approved minutes) show that the purpose of the meeting was to update the Secretary of State about the pressures facing the frontline services during the pandemic and the challenges of keeping patients flowing through emergency departments, including discharging patients from hospital to free up beds. We also discussed the Clinical Review of Standards (the NHS access standards set by NHS England to measure what matters most to patients and clinically).

They relate to Emergency Departments in England only and work on them pre-date the pandemic. The concerns of the college with this work were centered around the absence of a timeline for implementing the recommendations of the review (recommendations were published in December 2020 by NHS England). I was seeking to understand from the Secretary of State what his thinking was about the implementation of these standards. In the event they have not since be implemented and have been shelved. Additionally, I spoke to Mr Javid about vaccination and the impact of the new variant in my meeting with him in December 2021 [*KH/61* - INQ000409254].

17. In Scotland, the Vice President (Scotland) Dr David Chung, Vice President from September 2017 to October 2020, had meetings with the Health Minister Ms Jeane Freeman, on the 10th March 2020, and 26th June 2020.The purpose of the meetings was to discuss matters pertaining to the COVID-19 situation in Scotland and the plans of the Scottish Government to manage the virus and its impact on EDs. On 10th March the meeting discussed the COVID situation in Scotland and what the Scottish Government's plans were to manage the virus and demand on the health service. The College raised the potential need for quick expansion of capacity to be able to separate infected patients and to sort the undifferentiated patient. It was agreed to meet regularly to keep a close eye on what is happening on the ground and with the situation surrounding COVID in emergency departments. On 26th June the meeting discussed the COVID situation in Scotland and what the Scottish Government's plans were to manage the virus and demand on the health service. The College raised the potential need for quick expansion of capacity to be able to separate infected patients and to sort the undifferentiated patient. A further meeting took place between the newly appointed Vice President (Scotland) Dr John Thomson, who was Vice President from October 2020-June 2022, with Ms Freeman on the 18th December 2020 and 10th February 2021. The meeting on 18th December focused on preparing for the winter season, which was anticipated to present considerable challenges to the healthcare system. There was a discussion on the 4 and 12 hour performance data, ED capacity and the number of ambulance waits. On 10th February there was further discussion of these issues and discussions about the emergency workforce. My understanding is that beyond these summaries, there are no minutes.
18. There were no equivalent meetings in Wales or Northern Ireland.
19. Prior to the relevant period, the College had regular meetings with NHS England over winter pressures (the National Escalation Pressures Panel – NEPP) as well as for the Clinically-led Review of NHS Access Standards, which were attended by me (whilst in post) and Vice Presidents of the College. These meetings continued intermittently during the relevant period. These meetings were held remotely and organised by NHS England,

who scheduled the meetings. NEPP had a brief agenda and minutes were circulated by NHSE.

20. Additionally, I also attended another set of meetings set up by NHSE soon after the start of the pandemic with all the medical Royal Colleges but also other representative bodies such as the British Medical Association (BMA) and Public Health England (PHE). The meetings in question combined structured discussions and updates from NHS England to stakeholders. Key individuals from NHS England attended these meetings, including Steve Powis, the Medical Director of NHS England, who chaired the meetings, Jenny Harris and Susan Hopkins from PHE, and Jonathan Leech who attended once vaccines were introduced. The purpose of the meetings was for NHS England to provide insight on the epidemiology of the pandemic and upcoming guidelines. These meetings lacked consistent agendas and to our knowledge minutes were not taken.
21. I participated in regular meetings between NHS England and Improvement and the Academy of Medical Royal Colleges, chaired by Dr Edward Baker, the then CQC Chair, on behalf of NHS England. These meetings were held remotely on a regular basis: at first, they were held three times a month during the start of the outbreak and then reduced to when the meetings were required. The Academy of Medical Royal Colleges coordinated these meetings. The purpose of these meetings was for the respective presidents to advise NHS England on the impact of the decisions made during the pandemic on the emergency care pathway and the mitigation of any risks associated with those decisions. Other participants included: Professor Jonathan Benger, NR (Deputy Clinical Director, NHS Pathway & NHS Digital), Professor Anthony Marsh (Chief Executive, West Midlands Ambulance Service), and Dr Clifford Mann (the then National Clinical Director for Urgent and Emergency Care at NHS England), NR (Legal Adviser, NHS England) and Andrew Rawstron (Legal Adviser, NHS Improvement). There were minutes and agendas for these meetings produced by the organisers (NHSE) who may have retained copies. Examples of the issues impacting care pathways which were discussed are NHS pathways and 111 operations; ambulance triage relating to workload and reducing the variation in conveyance across England; concerns around the late presentation of some patient groups at hospital and routes to getting the public to call for help when required; the assessment of breathlessness remotely and limitations of telemed consultations; IPC and differing views on CPR risks.
22. As a response to a directive from NHS England, the Frontline Clinical Cell was established as a constituent subgroup of the National Clinical Cell. The College nominated Dr Adrian Boyle, then Vice President of Policy, in post from 2019-2022, to represent the College at these meetings. The Frontline Clinical Cell had its origins in a request made by NHS England, with the specific purpose of furnishing expert reference group insights originating

from 'frontline clinical areas'. The group's reporting structure was directed toward NHS England's Emergency Preparedness, Resilience and Response division. Dr Alison Walker, who concurrently held positions in the National Association of Ambulance Medical Directors and the College, undertook the role of chairperson for this group. Dr Walker's leadership encompassed her responsibilities within the National Association of Ambulance Medical Directors and her role as the lead for Emergency Preparedness, Resilience, and Response within the College. The assembly of the Frontline Clinical Cell consisted of representatives with varied professional affiliations, including: (a) NR representing the NHS England Emergency Preparedness, Resilience and Response (EPPR) office; (b) Dr Adrian Boyle, representing the College; (c) NR representing NHS England and serving as a representative of NHS 111; (d) Dr Peter Holden, representing the BMA General Practice; (e) Dr Jonathon Leech, acting as the National Medical Director for Vaccination under NHS England (NHSE); (f) Richard Weber, representing the College of Paramedics; and (g) Dr Fionna Moore, representing the National Association of Air Medical Directors (NASMeD). These meetings occurred on a fortnightly basis throughout the relevant period and were administered by the Association of Ambulance Chief Executives (AACE), which undertook the responsibility of documenting the minutes.

23. There were meetings organised by NHS Scotland that were attended by the Vice Presidents (Scotland), Dr David Chung and Dr John Thomson. These meetings were not a regular occurrence and were organised upon NHS Scotland's request as and when necessary for sharing information about the pandemic. To my knowledge, there were no minutes taken for these meetings.
24. The Chief Medical Officer's Directorate in Scotland organised the National Clinical Cell meetings with the Academy of Medical Royal Colleges Scotland which the then Vice President (Scotland), Dr David Chung, attended. This group was chaired by Professor Tom Evans and was convened remotely on a weekly basis throughout the relevant period and the agenda was set by NHS Scotland. Dr Chung provided feedback on what was happening on the frontline of NHS Scotland during the pandemic. The agenda and minutes were distributed by the Chief Medical Officer's Directorate who provided the secretariat for the National Clinical Cell in Scotland. The range of topics covered in these meetings included shielding considerations for vulnerable patients in hospital, issues with the guidelines around aerosol-generating procedures, changes to the testing regime, management of asymptomatic patients, guidelines on discharging patients to care homes,

Summary of RCEM's key submissions, representations and advice during the pandemic

25. The RCEM provided submissions, representations and advice to those bodies identified in paragraphs 15-24 throughout the relevant period. Our responses remained consistent across the nations of the UK; however, certain contextual variations necessitated adjustments in our messaging approach. In instances where such variations arose, I have tried to emphasise these in the following paragraphs. A summary of the key submissions, representations and advice is as follows. *[KH/1* - INQ000376144*], [KH/2* - INQ000376155*], [KH/3* - INQ000376166*].*

26. At the start of the pandemic outbreak, our submissions, representations, and advice focused on ensuring our members working in EDs had sufficient protective equipment.

    i. In response to the change in the classification of coronavirus as a high-consequence infectious disease (HICID) in March 2020, a significant shift occurred in Personal Protective Equipment (PPE) guidance for doctors working in EDs. This transition involved a change from utilising full protection to adopting basic protective measures. In the College's submission to the Health and Social Care Select Committee *Written evidence submitted by the Royal College of Emergency Medicine (COR0001) [KH/4* - INQ000376177*]*, a recommendation was made about the continued use of full PPE in areas where aerosol-generating procedures were performed. The College highlighted the discrepancies between PHE and World Health Organisation PPE guidance (World Health Organisation Interim Guidance 19 March 2020 "Infection prevention and control during health care when COVID-19 is suspected."). Staff working in the ED were understandably worried that PHE were recommending the use of a plastic apron and mask in all areas, rather than full POE including eye and face protection as recommended by the WHO. We were clear that "*Resuscitation rooms and red areas need to classify as high-risk areas, it is unacceptable that staff are expected to work in these areas with less protection than recommended. Guidance that does not mention Resuscitation rooms and the risk of the undifferentiated patient in the Emergency Department is unhelpful."* I should note that on 2 April 2020 PHE updated its PPE to expand the potential use of eye protection and fluid resistant surgical masks, including to doctors carrying out face to face assessments where a patient's risk of covid-19 is unknown ("Covid-19 personal protective equipment (PPE) 2 April 2020".) Our submission made the following recommendations: (1) ED resuscitation rooms and designated COVID-19 areas in EDs should be recognised as high-risk clinical areas; (2) staff should be encouraged to wear FFP3 masks at all times in high-risk clinical areas; (3) this protection should be upgraded to include a long-sleeved gown if staff are involved in aerosol-generating procedures. The College also raised concerns in meetings with NHS England, Sir Chris Whitty, and Mr Hancock and through submissions

about the impact of this change of PPE guidance on our members and the issues with the supply of adequate PPE as detailed below.

ii. The College co-authored a letter on 27 April 2020 with the other Royal Colleges to Lord Deighton who had been appointed as a government advisor on PPE *[KH/5 - INQ000376188]*. The purpose of the letter was to express continuing concerns over the availability of PPE in all settings. The Royal Colleges collectively raised concerns about: (1) PPE availability and stock; (2) too many clinicians still facing challenges in accessing PPE; (3) strain on global chain supplies; and (4) the need for open and frank messaging. I am not aware that a response was received.

iii. In April 2020 we provided written and oral evidence to the Health and Social Care Select Committee in England about emergency care during the first few weeks of the pandemic *[KH/6 - INQ000376199]*. In it, we detail how prior to the onset of the pandemic, EDs faced challenges such as overcrowding and long waiting times. In the early days of the pandemic, EDs reported that they found that they were not overwhelmed and there was a reduction in ED attendance. The reduction was clearly seen in the Emergency Department statistical data collated and published by NHSE. Concerns had however been expressed that seriously ill patients were not attending for care. The positive effects observed were detailed, including the opportunity to redefine the role of the ED, preventing overcrowding, and maximising clinical capabilities while ensuring patient safety. The College recommended building on these changes, maintaining infection control measures and addressing the challenges of managing those whose COVID status was not known, and looking further into the future, managing the backlog as NHS services resumed.

iv. In May 2020 we submitted further written evidence to the Health and Social Care Select Committee *[KH/7 - INQ000376200]*. This evidence focused on the operational changes that had taken place in EDs during the first few months of the pandemic and how normal delivery of care in the ED had been disrupted. We made a number of recommendations to support the following fundamental aims: (i) preventing overcrowding; (ii) minimising nosocomial infections; (iii) ensuring safe care for vulnerable patients; and (iv) creating safe workplaces for staff. We were clear in our written evidence that action must be taken to ensure that patient safety is never jeopardised again though poor infection control, design, physical crowding, inadequate staff protection, and corridor care. We stated that ill and injured people could not be treated in an environment that did not allow for social distancing. We raised the importance of consolidating alternative routes of access for lower acuity patients, whilst maintaining access to emergency departments for those who need

it which would ensure best outcomes and lower nosocomial infections. We highlighted the way that many specialities had transformed the way that care was delivered to the most vulnerable patients, including telemedicine and remote consultations, and called for that to continue. We concluded by stating *"Emergency departments should return to their original core purpose: the rapid assessment and emergency stabilisation of seriously ill and injured patients. They can no longer be used to pick up the pieces where community, "out of hours", or specialist care has struggled to cope. This will need leadership and active support at national, regional and local level, together with changes in behaviour from both the public, this will only be possible if patients have 24/7 access to high quality services they can trust."*

v. In May and June 2020, we issued a number of press releases to encourage the public to access emergency care where required due to ongoing concerns relating to the reduction in ED attendance compared to the same period in previous years [KH/8 - INQ000376201].

vi. In July 2020, the College issued a press release welcoming the announcement of an extra £3bn in NHS funding to help tackle coronavirus in the upcoming winter *[KH/9* - INQ000376202*]*. The College highlighted the impact of a spike in coronavirus infections if alongside a significant flu outbreak. Consistent with the message we were delivering to the named stakeholders in the meetings outlined in paragraphs 15-24, we emphasised the need for appropriate PPE for staff, extra beds to cope with admissions and money for the redevelopment and physical expansion of EDs to prevent further transmission.

vii. The RCEM in Wales wrote to the Welsh Health Minister, Mr Vaughan Gething, on 9 April 2020, recommending that the Welsh Government recommission the ED Wellbeing and Home Service run by the British Red Cross *[KH/10* - INQ000376145*]*. This scheme supported the flow of patients through the hospital through the presence of volunteers in the ED and supporting individuals to be safely discharged home. We emphasised the importance of ensuring that volunteers had access to PPE in line with PPE Guidance as recognition of the vital role that volunteers play across the healthcare service. I am advised that this service did re-start but the College does not know when and has no further information.

viii. In a meeting between the Vice President (Scotland) of the College and the Health Minister, Ms Jeane Freeman, on 10 March 2020, Ms Freeman discussed the Scottish Government's plans to manage the virus and demand on the health service. RCEM Scotland raised the potential need for quick expansion of capacity to be able to separate infected patients and to sort the undifferentiated patients.

We agreed to meet regularly to keep a close eye on what is happening on the ground and with the situation surrounding COVID in EDs. I am told by the then Vice President (Scotland), Dr David Chung, that further meetings did take place with him in June 2020 and with Dr Thomson in December 2020 and February 2021, as detailed in paragraph 17. I have no further information about those meetings.

27. When the NHS started entering the first wave recovery period in May 2020, our submissions, representations and advice focused on learning the lessons from the first wave and the actions that needed to be taken to ensure the NHS was well-equipped to manage future pandemics.

    i. In May 2020 the College made written submissions to Members of Parliament through email and made recommendations in our meetings with the Secretary of State for Health and Social Care to prevent further transmissions of coronavirus in Emergency Departments, including redesign to promote better patient flow *[KH/11 - INQ000376146] [KH/62 - INQ000409255]*. With regards to redesign, the recommendations were (1) UK Government to support structural rebuilding of Emergency Departments to promote good infection control. Emergency Departments must be able to provide isolation facilities for patients; (2) UK Government to support redesigning and rebuilding selected parts of acute hospitals to promote good flow and safe infection control; (3) UK Treasury should introduce a multi-year capital plan to redesign and rebuild Emergency Departments to promote good patient flow and safe infection control. The intent behind these recommendations was to expand the capacity of the NHS so it is better able to address future outbreaks of infectious diseases. Prior to the onset of the pandemic, infectious disease outbreaks within hospitals were exacerbated by overcrowded conditions that hindered the implementation of robust infection prevention measures. Notably, during the first wave of the pandemic, reduced attendance at EDs translated to decreased crowding, enabling healthcare facilities to maintain safer distances and implement stringent infection prevention and control. This resulted in a notable reduction in the occurrence of infectious disease outbreaks within hospital settings. I do not believe that a response to this letter was received.

    ii. In June 2020 we endorsed recommendations from the PHE report *[KH/12 - INQ000376147]* on the impact of COVID on Black, Asian and minority ethnic communities by issuing a press release recommending the Government to adopt the recommendations in full.

    iii. In June 2020 we issued a joint memorandum *[KH/13 -* **INQ000408887** *]* to the Health and Social Care Select Committee with the Royal College of Surgeons in

which we made recommendations on how to help the NHS recover from the impact of the pandemic. This work was a consequence of the direction to NHS Trusts from NHS England in June 2020 that Trusts take steps to commence recovery of routine services which had been stopped or significantly curtailed as a consequence of the onset of the pandemic. The Colleges voiced the concerns raised by our members that "business as usual" was still some way off, and limitations on PPE and testing capacity continued to limit how much the NHS could continue to do *[KH/14* - INQ000376149*]*.

iv. In July 2020 we issued press releases as social distancing restrictions were relaxed and bars, restaurants and pubs re-opened *[KH/15* - INQ000376150*]*. We encouraged the public to drink responsibly and highlighted the impact of requiring emergency care due to high levels of alcohol consumption.

v. In June 2020, The Vice President of RCEM (Wales) submitted evidence to the Welsh Parliament's *Health, Social Care and Sport Committee [KH/16* - INQ000376151*]*. The submission detailed the increase in attendance to EDs during this period, the increasing difficulty in complying with social distancing in waiting areas, and poor patient flow. The impact of the pandemic on EDs in Wales differed from what was occurring in England during this time period, with particular pressures around patient flow.

vi. In Scotland, as outlined in evidence submitted to the Scottish Parliament's *Health and Sport Committee,* in June 2020 the College highlighted existing issues of long waits and overcrowding in EDs and emphasised the need to increase capacity in emergency care to manage surges in demand effectively *[KH/17* - INQ000376152*]*. Testing capacity was identified as an area requiring improvement, particularly for inpatients, to reduce delays in EDs. RCEM Scotland advocated for regular testing of asymptomatic staff to prevent outbreaks.

vii. In a meeting between the Vice President (Scotland) of the College, Dr David Chung, and the Health Minister, Ms Freeman on 26 June 2020, the College provided an update on frontline matters, from the clinicians' perspective , discussing the coming winter and our views on what might be required to deal with an inevitably very tough winter for the health service, including the need for additional capacity and the cancellation of elective services to manage demand, as detailed in paragraph 17.

viii. The concerns of the RCEM (Scotland) are detailed in a letter dated 27 May 2020 from Dr Chung to Connaghan, Chief Executive of NHS Scotland *[KH/63* - INQ000409256*]*. In that letter, set out the principles that had been adopted that he wanted to become the new normal:

a. Ensuring delays and Exit Block do not occur and put vulnerable patients at risk of infection. Escalation plans must be whole system and embraced as such. Failure to implement an escalation plan, resulting in deterioration of safety must become a Never event.
b. Prevention of attendance, by ensuring resources and support to primary, social care and nursing homes to make Emergency Departments the last resort, not the first.
c. New ways of working and triage support to ensure Emergency Departments really is the best place for patients who contact NHS 24, Scottish Ambulance or out of hours services. Many can be seen with appointed care at a more appropriate place after discussion with top cover.
d. Ensuring all parts of healthcare ensure that they have a means to review patients under their care who develop issues, rather than advising them to go to the Emergency Department. Successful models of this during the coronavirus pandemic should be continued (for example, complications arising from chemotherapy, post-operatively or with renal dialysis).
e. Creating mental health assessment hubs, to where patients with urgent mental health crises can be directed from A&E triage or taken directly by ambulance or police. This group of patients are particularly disadvantaged by long waits for psychiatric assessment in Emergency Departments which, in the absence of physical self harm, add little to their care.
f. Creating sustained infection control models within Emergency Departments, to prevent cross infection from other patients and staff. The numbers of patients waiting need to be minimised by reducing demand as described as above and allowing constant, timely flow out of the Emergency Department. If these are done, then the reduced capacity of waiting rooms due distancing will matter less. Emergency Departments will need to create permanent means to isolate patients, including things such as negative pressure rooms.
g. Strong public messaging to explain that redirection from Emergency Department to more appropriate care is not denying patients access to care and might mean they get the right care. This needs to be backed up by central support for any complaints or litigation which ensues.

28. As we moved into another wave in August 2020, the peak of the second wave coincided with winter, placing significant pressure on the Urgent and Emergency Care system. The

College's submissions, representations and advice focused on preparedness for winter and mitigating typical seasonal spikes in demand for emergency care.

i. In August 2020, the College, charities, other medical royal colleges, and healthcare organisations issued a joint statement: *RCEM and homeless charities warn of the health impact of removing the eviction ban [KH/18* - INQ000376153*]*. In this, we addressed the risk of a 'wave of homelessness' that may occur if the eviction ban were to end. We cautioned that this would have a serious impact on ED attendance as we headed into the winter months with COVID-19 still present in the community. Furthermore, in August 2020, the College released a joint statement with Pathway and Crisis on the eviction ban, once again detailing concerns.

ii. In October 2020 the College relaunched its flagship campaign, RCEM CARES, in the light of the pandemic: *RCEM CARES during the Coronavirus pandemic [KH/19* - INQ000376154*], [KH/20* - INQ000376156*]*. The campaign sought to address the major issues facing emergency care, that were present long before COVID-19 but had been exacerbated by the pandemic. The iteration of the campaign outlined how the pandemic showed that our EDs do not have sufficient isolation capacity to manage patients with infectious diseases.

iii. In October 2020, the College issued a press release: *RCEM issues urgent warning as hospitals near capacity,* detailing that the College had concerns regarding capacity heading into the winter *[KH/21* - INQ000376157*]*. This was prompted by publication of NHSE data on A&E Attendances and Emergency Admissions.

iv. In November 2020, the College issued a press release: *RCEM A&Es remain open [KH/22* - INQ000376158*]*, which spoke for those working in EDs wishing to make clear that despite some reports, EDs remained open for all ill and injured patients and still had systems for safely looking after people with suspected COVID-19. The release was issued as we were experiencing fewer patient attendances at this time of year compared to what would be expected. NHSE collect data on A&E attendances, as detailed above.

v. On 19 November 2020, I wrote to the Chancellor, Mr Sunak *[KH/23* - INQ000376159*]*, calling for investment and an increase in funding which were needed in order to end corridor care and build a resilient healthcare system.

vi. On 30 November 2020, I wrote a letter: *Please Vote to Save Our Hospitals [KH/24* - INQ000376160*],* to Members of Parliament asking them, ahead of a parliamentary vote on coronavirus restrictions, to express the College's concern about the removal of the tiered system.

vii. In a meeting between the Vice President (Scotland) of the College, Dr John Thomson, and the Health Minister, Ms Jeane Freeman, taking place on 18

December 2020, the College highlighted pressures facing EDs during the COVID-19 coronavirus pandemic and winter. This included a discussion of the four-hour and 12-hour performance data, and discussions about capacity in EDs and the number of ambulance waits during the winter months.

29. Throughout the vaccine rollout period from early 2021, the NHS faced the dual challenge of the pandemic and managing persistent winter pressures. As outlined and evidenced in RCEM's publication *What's behind the increase in demand explainer – final version [KH/25 - INQ000376161]*, the impact of the winter pressures notably extended into the summer months, driven by unmet demand from patients who refrained from seeking healthcare during the first and second waves of the pandemic. These patients presented with more complex needs, adding additional pressures to the emergency care system. The College's submissions, representations, and advice focused on the record number of long waits, the unseasonably high demand, and the impact on patients.

    i. In January 2021, the College declared a "national emergency" through a press statement as there were record numbers of patients waiting 12 hours or more from the decision to admit, despite decreasing attendance *[KH/26 - INQ000376162]*. This was in response to NHSE data which demonstrated a deterioration in patient flow due to longer waits for inpatient beds.

    ii. In April 2021, the College launched the *Summer to Recover* campaign *[KH/27 - INQ000376163]*. This was an online campaign, aimed at policymakers, whereby the College emphasised the NHS faced significant challenges in tackling the elective backlog and managing the demand from easing coronavirus restrictions. We recommended that the summer months should be used effectively to prepare for the challenges ahead. The campaign outlined a series of recommendations to Governments and the NHS in all four UK nations, NHS Trusts and Boards, and Emergency Medicine Clinical Leaders.

    iii. In April 2021 the College issued a press statement: *RCEM calls for Emergency Medicine to be key part of any NHS Recovery Plan [KH/28 - INQ000376164]*, highlighting that the recovery of the emergency care system must be factored into any NHS recovery plan. In that document we made a number of recommendations at a national (4 nations) level, including recommending that that ahead of the winter there needs to be sufficient funding made available for urgent and emergency care to facilitate an expansion of capacity. We called for a commitment to using metrics that benefit patient care – with transparency of the data – and ensuring that patients have access to adequate, available, alternative care that is most appropriate for their needs. To achieve this, we recommended being transparent about the efficacy of the NHS 111 First and other equivalent phone-first services, and

committing to using the 12 hour data from time of arrival for all emergency departments to drive plans for winter. The College was concerned that there was a narrow vision of recovery focused on the elective backlog when in reality the system has to work as an integrated whole. We called therefore for embedding unscheduled care firmly into recovery plans, to ensure sufficient funding was allocated for the whole of the urgent and emergency care system. At NHS Trust and Board level we called for adequate urgent care alternatives to emergency departments, the use of 12 hour data proactively, and working with local health systems to meet local population needs. At a local level, we recommended teams had robust IPC measures in place, encouraged vaccine rollout, supported the health and well-being of staff, and supported ambulance handovers. In terms of the national recommendations there were no significant changes during the relevant period.

iv. In May 2021, we issued a press statement: *Rise in pressures across the health system must be met with urgent action [KH/29* - INQ000376165*],* which recommended to the Government and NHS that a frank discussion is required about how the health service can manage the current pressure and a plan to ensure that our health service can continue essential services across primary care, emergency care and elective care. We warned that with the threat of a further wave of COVID looming, effective action was needed now before it is too late.

30. With the outbreak of the Delta variant in the summer of 2021, there was an easing of restrictions across England. This period coincided with unusually high attendance at EDs. The College's submissions, representations, and advice focused on the impact of this on EDs and the unseasonably high pressures faced by the urgent and emergency care system.

i. In response to concerns raised by members experiencing abuse from visitors to EDs, we issued a press statement in July 2021 urging patients and visitors to continue wearing masks and adhering to social distancing guidelines to limit the spread of coronavirus in hospitals: *RCEM: It is absolutely essential that masks are worn by everyone in A&Es [KH/30* - INQ000376167*].*

ii. In June 2021 we issued a press statement in response to NHS England's performance figures which showed the highest attendances ever recorded. We highlighted the impact of crowded corridors to both COVID and non-COVID patients: *RCEM: We have a serious problem in Urgent & Emergency Care [KH/31* - INQ000376168*].* In that statement I said *"We are facing record breaking attendances with a tired workforce and fewer beds; it is seriously challenging. Busy departments are a threat to patient safety, it increases the chance of crowding and*

corridor care, this risk is significantly increased if covid and non-covid patients are sharing the space for long periods of time."

iii. The College issued a response welcoming the Government's announcements of extra funding available for the NHS in September 2021 *[KH/32* - INQ000376169*]*. The College emphasised the funding comes at a crucial time when the health service enters what will likely be its most challenging winter ever, as it exits the pandemic, seeks to recover the elective backlog and faces the worst-ever levels of performance in the summer. The College particularly welcomed the investment in improving infection prevention control measures in hospitals: *RCEM welcomes Government funding but warns it won't be enough*.

31. The period running up to the Omicron outbreak coincided with mounting pressures on the urgent and emergency care system. The College's submissions, representations, and advice focused on the impact of the omicron outbreak on the emergency care system, the poor performance of the NHS, and the subsequent impact on patients.

    i. In November 2021 College launched *RCEM CARES: The Next Phase*, our system-wide plan to improve patient care *[KH/33* - INQ000376170*]*. We outlined the need to examine the reasons why the Urgent and Emergency Care system was ill-equipped to meet demand during the pandemic in order to enable lessons to be learned for future pandemics. We made written recommendations to the Government and NHS England on restoring staffed bed capacity to the levels that existed before the pandemic in order to achieve a desirable ratio of emergency admissions to beds. In the medium term, we estimated that over 7,000 beds are required across the UK, as we set out in a parliamentary briefing: *RCEM Explains: hospital beds [KH/65* – INQ000409258]. From Q1 2010/11 to Q1 2019/2020, there was a loss of 9,000 general and acute overnight beds in NHS hospitals across England. In this same timeframe, bed occupancy percentages rose from 86% to 90%, considerably higher than the recommended limit of 85%. Moreover, during Q1 of 2020/21, which coincided with the first wave of the pandemic, the number of available beds decreased drastically by 10,000 in order to comply with Infection Prevention and Control measures. High levels of bed occupancy are an important indication that the health system is under pressure. Maintaining bed occupancy rates of 85% ensures that there's additional capacity in the system to meet surges in demand and to enable patients to receive the care they need in a timely manner. Insufficient bed availability can lead to increased waiting times for patients, crowding and consequently corridor care in EDs, and it can increase the rate of hospital-acquired infections, which has become even more dangerous due to the pandemic. For winter 2021/2022, rather than calculating the probable number of

beds each trust would need to achieve the 85% occupancy threshold, we instead elected to look at the ratio of beds to emergency admissions across the NHS. This method allows us to capture the complexity of the hospital system as it directly accounts for the link between demand (admissions) and capacity (beds).

ii. The College continued to highlight the impact of the Omicron variant and extreme delays to emergency care on patients. In November 2021 we issued a press statement responding to a report by the Association of Ambulance Chief Executives, on the harmful effects of delayed care on patients*: RCEM calls for system-wide action, as shocking report shows extent of harm to patients [KH/34 -* INQ000376171*]*. The College also published a report, *Acute Insight Series: Crowding and its Consequences [KH/35 -* INQ000376172*]*, which applied modelling carried out by NHS England to show that in 2021 of those who waited 8-12 hours in an ED, there were 303 excess deaths in Scotland and 709 excess deaths in Wales. In England and Northern Ireland, 4519 excess deaths occurred in England and 566 excess deaths occurred in Northern Ireland in 2020-21 associated with long waiting times in EDs.

iii. In January 2021, we issued press statements on the growing number of staff absences as a result of the pressures experienced by the NHS *[KH/36 -* INQ000376173*]*. We issued a response to the winter situation reports which highlighted instances of COVID-related absence have tripled since the beginning of December: *Crisis deepens amid relentless pressures and high numbers of staff absences.* During this time, the army was deployed to assist the health service in London.

32. During the period identified as the end of the pandemic from March 2022, the College continued to raise awareness of the pressures facing the urgent and emergency care system as the NHS recovered from the pandemic. By this point, there were no meetings focusing on the pandemic with the stakeholders identified in paragraphs 15-24 of this statement.

Staffing

33. Hospital buildings and ED staff facilities are generally inadequate for the number of staff involved and the nascent phase of the pandemic caused unease among the staff due to the uncertainty associated with the impact of the COVID-19 virus.

34. At the start of the outbreak, EDs were reconfigured into streams or zones to segregate patients likely to have COVID-19. Staff changing and 'donning and doffing' facilities were very difficult to manage adequately. In terms of the physical environment and segregation, EDs were not built to enable this segregation. The physical space is constrained and there

are very few isolation cubicles. The space in emergency departments for example for major trauma often meant that there was no alternative other than to co-locate covid and non-covid patients. During the pandemic it was common for clinicians from other parts of the hospital to help or be re-deployed to the ED. However those who were not emergency physicians did not have the broad advanced generalist skill sets needed to deal with the undifferentiated patient. Whilst they could therefore help with specific conditions that suited their skills set and training, they were unfamiliar with the ED environment, case mix and the clinical management of the undifferentiated patient. In relation to the donning and doffing of PPE, one of the key limitations was that ED changing rooms were not designed for this regime, they often had a single access/exit door which meant that you could not enter, change and leave through a separate exit which made infection control more difficult. As outlined in our position statement published in May 2020, *COVID-19: Resetting Emergency Department Care*, we emphasized the importance of ensuring a safe workplace in EDs for staff *[KH/37* - INQ000376174*]*.

35. The College supported the efforts of NHS England and Trusts to keep staff safe during the pandemic. The College used its communications with members, such as emails and meetings to adopt measures such as shielding, redeployment to other parts of the health system, and risk assessments to protect vulnerable staff.
36. The capability of staff testing at the beginning of the pandemic was insufficient and resulted in wide variation across the country both in terms of the speed of getting results and where staff could be tested as outlined below. In meetings, members reported difficulty in staffing EDs due to staff absence due to sickness or quarantine. The ability of workers to stay in hotel accommodation if a household contact became symptomatic was helpful in reducing the quarantine time from 14 to 7 days but members reported this as being difficult for staff with families.
37. During the relevant period, the College carried out two surveys (also referred to in paragraphs 53 and 54 below) of its members which elucidated both the issues with delivering healthcare during the relevant period and the impact on our members as staff. The first member survey, which took place in May-June 2020 *[KH/38* – INQ000376175*]*, asked members whether they faced any problems accessing testing. The survey found that:
    i. 19.3% of respondents reported problems accessing testing.
    ii. Participants were experiencing long delays or struggling to get testing, forcing participants to continue working without knowing their status. Furthermore, hospitals and trusts lacked clear guidelines on testing staff, leading to confusion and inconsistent practices. Whilst the survey is only a snapshot, 70.90% of those

responding reported, when asked if they had been tested, said no. Of those who had been tested, 80.66% reported problems accessing testing.

38. In 2021, College members reported an increase in incidences of the NHS Test and Trace app notifying staff to self-isolate. Staffing challenges were observed as clinicians were required to take time off after being notified by the Test and Trace system. High levels of staff sickness were reported throughout 2021, and in the winter in particular, as evidenced by *NHS England Acute Trust Staff Absences* available in winter situation reports.
39. While no specific geographic areas were highlighted to the College for workforce shortages, the regions affected by larger waves of the pandemic inevitably experienced higher cases of staff absences as discussed in Council meetings.

Examination and training

40. At the outbreak of the pandemic in 2020, all face-to-face events and examinations were cancelled.
41. On the 6th March 2020, the College decided to cancel the Spring Continuing Professional Development conference in Bournemouth, which was due to take place on the 24-26th March 2020.
    i. The purpose of this conference was to focus on areas of clinical practice that are rapidly changing, pose frequent clinical dilemmas or occur with a rarity that warrants regular review, and cover a range of clinical areas.
    ii. We decided to cancel the event as a precautionary measure, at the time it was in the best interests of the NHS and the wider public to cancel this event to contain the spread of coronavirus and ensure Emergency Medicine professionals were available for duty if needed rather than attend a conference.
    iii. Cancelling the conference had the following impact: (a) loss of learning for members; and (b) loss of staff time and resources as the College had planned most of the conference at the time of cancellation. The financial impact was minimal as the venue allowed the College to postpone the contract.
42. The College saw it as essential to support the ongoing career progression of emergency medicine clinicians despite the difficulties of COVID-19. It had no wish to see career progression through training being slowed down because of a shortage or absence of examination places if it could be avoided. In January 2020 its theory examinations were paper-based examinations sat in examination halls and its clinical practical examinations were undertaken in person in simulated clinical environments. The Fellowship examination (FRCEM) consisted of:
    i. FRCEM primary (a three-hour multiple-choice question paper of 180, single best answer questions) examination

ii. FRCEM intermediate short answer question paper examination
iii. FRCEM intermediate Situational Judgement Paper examination
iv. FRCEM Final Critical Appraisal examination
v. FRCEM Final Quality Improvement Programme examination
vi. FRCEM Final short answer question (SAQ) Theory Paper
vii. FRCEM Final Objective Structured Clinical Examination

43. In March 2020 when it became clear that we were moving towards the first national lockdown, the College worked to shift its examinations from in-person paper-based formats to online delivery. This remarkable effort was completed within eight weeks, making the College one of the first Royal Colleges to offer its examinations online, this meant complex work to establish contracts with IT suppliers and build, test and implement systems to support the theory and clinical practice examinations online. The FRCEM Primary examination in June 2020 was cancelled, but efforts were made to conduct the August 2020 sitting online, after approval from the General Medical Council (GMC). The FRCEM Final SAQ examination scheduled for March 2020 was cancelled, and an online sitting for registered candidates was planned for July 2020. The College ensured that exam cancellations were treated as "no-fault" outcomes, allowing for extensions and alternative arrangements to be provided.
44. Despite challenges posed by the pandemic, the College successfully managed to resume face-to-face OSCEs as restrictions eased in 2021 and throughout 2021, a total of 9,034 candidates sat for RCEM examinations, showing a significant increase of 1,547 candidates compared to the previous year and a return to pre-pandemic activity levels.
45. During the relevant period, there was no significant impact on awarding Emergency Medicine qualifications to new members. Although the diploma ceremony was held remotely until restrictions eased in 2021, qualifications continued to be awarded as planned.
46. Training faced challenges during the pandemic, including redeployments, course cancellations, and reduced supervision opportunities. Medical personnel redeployments impacted the completion of competencies in Paediatric Emergency Medicine (PEM). Nevertheless, efforts focused on COVID-19-related training within Trusts continued. Regional-based classroom teaching stopped during the peak of the first COVID wave but resumed in August 2020 with a different format, providing more blended learning opportunities combining online, eLearning and in person training. This is delivered through NHS Health Education England (HEE), who can provide further information on this matter. However, the College provided additional resources to members to support their training requirements. *Coronavirus Tips and Resources* were made available on our E-Learning website, which linked to information and advice from the College as well as other medical

institutes around the country and the world. A number of 'member only' content on the E-Learning platform was also made available more widely. Reconfigured guidance was made available to members, making COVID-19-related resources easily accessible.

47. As COVID-19 restrictions eased in 2021, trainee redeployments were reduced, and training and study leave recommenced. Examinations continued in a virtual format until October 2021.

Infection prevention and control

48. During the initial outbreak of the COVID-19 pandemic, the College issued the following infection prevention control clinical guidance:
    i. *Salbutamol, peak flow and nebulisation advice during Covid-19* (April 2020) *[KH/39 - INQ000376176]*: the College issued a safety flash to raise awareness of PHE's position that nebulisation is not an aerosol-generating procedure.
    ii. *Airway management in COVID-19 Pandemic* (May 2020) *[KH/40 -* INQ000376178*]*: This guidance focused on safe airway management procedures for COVID-19 patients to minimise the risk of transmission to staff. Airway management and ventilation can generate aerosols, putting staff at risk of exposure. The College recommended the use of full PPE for airway management, specifically: a full gown, FFP3 mask, gloves and eye protection.
    iii. *Buddy System* (April 2020) *[KH/41 -* INQ000376179*]*: In response to concerns raised by Clinical Leads about difficulty donning and doffing PPE, the College issued a safety flash to encourage members to 'buddy up' during the process.
    iv. *Best Practice Guideline for Infection Prevention and Control during the first wave of the pandemic* (June 2020) *[KH42 -* **INQ000353469** *]*: The College issued this guidance to provide staff with essential information on IPC measures during the first wave of the pandemic. The overall aims of this document were to provide guidance to prevent the spread of infectious diseases between patients, prevent patients from acquiring infection from clinical staff, and prevent staff from acquiring infection in their workplace.

49. As the pandemic progressed into the second wave, the College continued to provide vital clinical guidance related to IPC measures and PPE, including:
    i. *RCEM and NASMeD Position Statement: The management of ADULT cardiac arrest patients taken to Emergency Departments (EDs) during the Covid-19 Pandemic (June 2020)* [KH/43 - INQ000376181]: The purpose of this document was to provide a shared framework for ambulance clinicians and ED senior clinicians to provide the most appropriate care in the most appropriate place for

adult patients in cardiac arrest on arrival at an ED. The recommendations are intended to cover the communication and co-operation between ambulance and ED clinicians, pre-alerts, management of the cardiac arrest in the ambulance; PPE and resource. They stress and highlight the need for dignity and respect, and that family should continue to be supported.

ii. *PPE Fatigue* (November 2020): The College issued a safety flash highlighting the importance of wearing PPE after receiving reports of 'PPE fatigue' *[KH/44* - INQ000376182*]*. This information was received through the Clinical Leaders Zoom meetings, of which the agendas outline the discussion topics.

iii. *Appropriate PPE and risk assessment* (December 2020) *[KH/45* - INQ000376183*]*: The College issued a safety flash to remind members to ensure they are accessing the right forms of PPE and to remind them to ask their Trusts to risk assess them after carrying out a survey of members that showed that members from ethnic minority backgrounds faced barriers in access to appropriate PPE and occupational risk assessment. More information on this survey can be found in paragraph 54.

iv. *Best Practice Guideline for Infection Prevention and Control during the Coronavirus Pandemic* (February 2021) *[KH/46* - INQ000376184*]*: The College issued an updated version of its IPC guidance. This publication included: (a) guidance on communicating with patients when wearing PPE, ensuring staff consider strategies to reduce the risk of patients feeling frightened, especially in paediatric areas; (b) guidance on the use of technology to facilitate communication between relatives and patients as access to visitors in hospitals was restricted during this period; (c) vaccination and ensuring staff are encouraged to take up vaccination, especially those who are pregnant or from an ethnic minority background; (d) engaging with staff who are hesitant to take the vaccine and encouraging dialogue with sensitivity; and (e) the need for mandatory and regular training in IPC and how to use PPE optimally.

v. *Communication errors with PPE* (Update March 2021) *[KH/47* - INQ000376185*]*:

The College issued a safety flash to raise awareness of communication errors when wearing PPE. The concerns raised were related to muffled speech which also had an impact on telephone communication, difficulty in lip reading for members and patients living with impaired hearing, loss of non-verbal cues making empathy difficult to convey, and misunderstanding of verbal requests which may lead to errors.

50. At the start of the outbreak, members raised concerns about the difficulty in maintaining IPC measures in hospitals. This was because patients could not be separated accurately without definitive test results.
51. Throughout the relevant period, the College held regular calls with Clinical Leads from EDs across the UK. These meetings were held remotely on a regular basis. Their purpose was primarily to provide support to members and disseminate guidance and best practices during the pandemic. At times they were also helpful for gathering intelligence on the impact of the pandemic on EDs. They were largely presentational in style. Whilst many were recorded, the meetings were not minuted. Where recorded, the themes discussed at each meeting have however been noted up by the College [*KH 66* – INQ000409259]. On a *Clinical Leaders Zoom Call* taking place on 20 August 2020, I raised with members the issue of hospitals and wards that had to be shut down to new admissions due to outbreaks of COVID-19, therefore disrupting the emergency care system which had been highlighted, including in the press. I reiterated to those present that we have to work very hard to stop local outbreaks where the hospital is at the epicentre of the outbreak. I reminded members of IPC guidance and the importance of not disrupting the emergency care system. From recollection there had been a couple of incidents, even if the ED had not been the epicentre of the outbreak. I re-iterated the need to adhere to local systems and the use of PPE.
52. It was discussed in the College's Council meeting on 18th March 2021 that by this stage in the pandemic, many EDs were able to establish and maintain good infection prevention and control (IPC) practices which minimised risk to staff, but that the return of crowding and corridor medicine has certainly increased patient risk as flow into hospital beds has slowed significantly.
53. The College ran a survey, *RCEM COVID Survey Results June 2020 [KH/38 - INQ000376175]* during the first wave of recovery to gather information about the experiences of its members regarding various issues related to staff testing, infection prevention and control, risk assessments, availability of appropriate PPE, and its impact on patient care. The survey was responded to by 1,356 people, which represents a little over 10% of our members. The survey took place between May to June 2020 and the key findings of that survey are:
    i. During the outbreak, 19.34% of respondents expressed encountering problems accessing testing for staff members in hospitals. A concerning 11.5% of respondents reported not receiving any training in the use of PPE. Additionally, 33.8% of respondents stated that they had to reuse disposable PPE items, and 17.8% mentioned they had to improvise or create their own PPE items, indicating a lack of adequate risk assessments.

ii. Respondents were asked if they thought their ED layout was safe enough for adequate infection prevention and control so that staff and patients respectively, could be protected. 48.6% of respondents said that their department layout was not safe enough to keep staff protected, and 44.3% said their department layout was not safe enough to keep patients protected.

iii. The survey revealed that 70% of respondents reported not having a designated PPE buddy, indicating potential challenges in accessing appropriate PPE in emergency departments. Around 20% of respondents expressed that they did not have the necessary PPE to adequately manage patients with COVID-19, suggesting a potential negative impact on patient care. The survey findings highlighted that 14% of respondents were not confident in fit-checking their PPE before entering patient-facing areas. Moreover, 48.6% of respondents expressed concerns that their emergency department layout did not provide adequate infection control measures to protect staff, and 44% felt the same for patient protection.

54. During the second wave, the College published a report, titled *RCEM PPE, ethnic minorities and risk during the pandemic [KH/48* - INQ000376186*]*, this contained the findings of the College's second membership survey. The survey took place in December 2020, and the report was published on 21st January 2021 *[KH/49* - INQ000376187*]*. The survey was responded to by 699 members, representing less than 10% of our membership at the time. A summary of the findings is as follows:

i. The survey results showed that a significant proportion (29%) of respondents disclosed that they had not been risk-assessed by their respective Trusts, raising concerns about the level and availability of staff testing in hospitals.

ii. Despite the Cabinet Office Race Disparity Unit's assertion that almost all ethnic minorities had received a risk assessment by 31 July 2020, 19% of ethnic minority respondents reported not receiving any risk assessment. Dissatisfaction with risk assessments was commonly attributed to their inadequacy and the lack of consideration for ethnic differences.

iii. Both white and ethnic minority respondents reported similar rates of receiving PPE training. However, a slightly higher percentage of ethnic minority respondents revealed that they had not received any PPE training. Additionally, a significant number of BAME respondents (48%) reported failing fit testing for PPE, compared to 37% of white respondents.

iv. The survey revealed that a higher percentage of ethnic minority respondents (31%) lacked access to adequate PPE and were more likely to come into clinical contact

with suspected or confirmed COVID-19 cases without adequate PPE, compared to white respondents (19%).

v. The survey indicated that most respondents would feel either supported or neutral if they were to raise concerns about PPE shortages. However, the percentage of BAME respondents who felt supported or neutral (88%) was slightly lower than white respondents (90%). Notably, ethnic minority respondents were more likely to fail fit testing for PPE, which may be linked to structural biases in the manufacturing of respiratory PPE designed to be worn on white men.

Healthcare provision and treatment

55. The College issued guidance on a range of issues during the relevant period. With regards to safe ways to provide patients with oxygen in EDs, including those with co-morbidities and additional needs, this included:

i. *People with diabetes and COVID-19* (April 2020) *[KH/50* - INQ000376189*]*: Members of the College identified early in the pandemic that COVID-19 precipitates atypical presentations of diabetes emergencies. The College issued a safety flash to raise awareness of changing guidance issued by the Association of British Clinical Diabetologists on managing patients with diabetes and COVID-19. The College recommended that every patient requiring admission has a blood glucose level check along with a blood ketone check in those with known diabetes and everyone with glucose over 12mmol/l. Additionally, the College recommended when admitting people with diabetes with suspected or confirmed COVID-19 to hospital, to stop the use of metformin and SGLT2 inhibitors (flozins) and review the safety of continuing other oral hypoglycaemic agents.

ii. *All that glitters… Things to remember during the COVID pandemic* (May 2020) *[KH/51* - INQ000376190*]*: The College issued a 'safety flash' during the first wave of recovery to alert its membership to the impact of the recovery on patient diagnosis along with the evidence that points to patients experiencing cardiac symptoms, stroke and trauma delaying attendance to ED. The guidance recommended that members take into account (a) alternative diagnoses during the COVID-19 pandemic and consider alternative diagnoses; (b) patients may present to EDs with multiple issues, including COVID-19; and (c) patients may present late in the clinical course of the disease, which may affect clinical signs and care needs.

iii. *Children & COVID-19 Clinical Brief* (June 2020) *[KH/52* - INQ000376191*]*: The College issued guidance in response to the emergence of Paediatric Multisystem Inflammatory Syndrome (PMIS) which was associated with COVID-19 infection; a rare syndrome sharing common features with other paediatric inflammatory

conditions: sepsis, Kawasaki disease & toxic shock syndromes. The College provided guidance on how to recognize and manage PMIS, which included (a) Consider in children with fever, inflammation evidence of organ dysfunction; (b) Respiratory failure not as common as a symptom; (c) Shock is the commonest presenting feature; (c) Acute abdominal and gastroenteritis symptoms may be seen; (d) Early referral to Paediatric Intensive Care using local pathways.

iv. *NEWS2 and oxygen requirement* (December 2020) *[KH/53* - INQ000376192*]*: The College issued a safety flash to raise awareness. That need for awareness being that because the NEWS2 system is simply a binary measure of whether a patient is on oxygen therapy or not, it does not measure the effectiveness of that. The nature of Covid-19 was that if patient oxygen saturation levels dropped then the patient would need a rapid increase in oxygen. However, this may not result in any additional increase in NEWS2 score.

56. The Emergency Care Data Set (ECDS) collects information about why people attend EDs and the treatment they receive to (a) improve patient care through better and more consistent information; (b) allow better planning of healthcare services; and (c) improve communication between health professionals. The College and NHSE had been contacted by various trusts and individuals asking what code should be used in emergency care settings (ECDS) to record patient deaths due to Covid-19. It was recognised that a new code was needed and in the absence of any official guidance from what was then NHS Digital, the internationally agreed SNOMED (structured clinical vocabulary) code for Covid-19 was adopted, and guidance was that if that was not available as a code, to use the code for SARS. Ultimately the NHS Digital guidance was not to use the international SNOMED code for Covid but instead to use a UK specific covid-19 code. This collaboration supported the collation of data and meant that data could be submitted as part of ECDS, either as the normal diagnosis list (suspected/confirmed) and/or using the ECDS 'DISEASE OUTBREAK NOTIFICATION' field. The data is not accessible to the College but instead it informs NHSE ED data.

57. A summary of the College's members' concerns about medicines and therapeutics, or other equipment used to provide care of COVID-19 patients during the relevant period, are summarised is as follows:

    i. The College's members raised concerns in Clinical Leaders Zoom meetings over oxygen delivery during the first wave the pandemic. Although the College does not have direct responsibility for this matter, the College provided advice and guidance to address the challenges related to oxygen therapy during the pandemic (as detailed in paragraph 55.iv. of this statement: *[KH/53* - INQ000376192*])* .

ii. At the beginning of the pandemic, members highlighted difficulties in creating safe areas, specifically red/green areas, to manage and segregate COVID-19 patients effectively. The College used Clinical Leaders Zoom meetings to draft speakers to share pragmatic solutions to practical problems encountered by Emergency Medicine staff. Clinical area poor ventilation and the ability to isolate patients was a constant theme.

58. In April 2021 announcements about the rare complication of vaccine-induced thrombosis after the AstraZeneca COVID-19 vaccine resulted in a surge of worried patients attending EDs. Members were voicing concerns which demonstrated the need for rapid guidance. Because this was an emerging concern, there was no guidance (later published by NICE in July 2021), the College rapidly collaborated with the Expert Haematology Panel (EHP), British Society of Neuroradiologists (BSNR), Royal College of Radiologists, Society for Acute Medicine and the Royal College of Physicians to create guidelines for the management of the affected patients titled: *Management of patients presenting to the Emergency Department or Acute Medicine with symptoms 5-42 days post AstraZeneca vaccine [KH/54 -* INQ000376193*].* This guidance was updated as new information became available but in summary, it advised clinicians on how to proceed with a patient presenting with new onset headache or abdominal pain that are severe in nature. The college raised concerns regarding the ability to provide safe and appropriate care to patients suffering from COVID-19 within EDs during the relevant period, which are summarized as follows:

i. At the start of the outbreak, members reported communication challenges through the regular Clinical Leaders Zoom meetings, committee meetings, and the first membership survey while wearing PPE; both situations challenged communication skills because the subtleties of facial expression and body language were lost.

ii. In the RCEM COVID Survey May – June 2020, members raised concerns regarding PPE and aerosol-generating procedures. Some members felt that coughing should be labelled an aerosol-generating procedure with others reporting caring for COVID patients for over 4 hours in ED wearing a surgical mask, apron and gloves while testing staff carrying out COVID swabs had better protection.

iii. At the start of the pandemic, resuscitation rooms, where the sickest patients in ED were seen, were not designated as 'red zones'. In response to concerns by members, the College raised awareness of this with relevant stakeholders.

iv. Via the RCEM COVID Survey May – June 2020, members anonymously reported that they "did not have adequate PPE for aerosol-generating procedures", with one respondent sharing that they felt that their "Trust tried to convince them that they didn't need to use them in Resus" and that there was a "need to save PPE for more 'complicated cases'". Other members were unconvinced about the scientific basis

of government recommendations of the type of PPE to use in non-aerosol generating areas of the department. As the survey is a snapshot, we have no further analysis.

v. Members raised concerns that the rules regarding PPE were changing regularly, despite the patient subset and ED ventilation systems not changing. They reported receiving confusing differing advice regarding aerosol-generating procedures and droplet precautions as mentioned previously in this document.

59. During the relevant period, members of the College played a crucial role in providing care and treatment in the ED to patients with various conditions other than COVID-19.

60. As clinicians working in Emergency Medicine, their primary responsibility was the immediate assessment and treatment of patients with serious and life-threatening illnesses and injuries. During the relevant period, EDs remained open for those accessing emergency care. However, one of the main challenges observed during the relevant period was a decrease in ED attendance, especially at the beginning of the pandemic, as detailed earlier in this statement. The College's Council Minutes from January 2021 evidence that the London Regional Chair highlighted a higher incidence of cardiac arrests within the community during this time *[KH/64* - INQ000409257*]*. This supported the view of members that some individuals with serious conditions, such as heart disease, were delaying seeking emergency care and therefore suffering heart attacks at home due to hesitancy in visiting EDs for fear of exposure to COVID-19.

61. In August 2021, as evidenced in the file *APPG Prep,* which outlines the College's preparation for the All-Party Parliamentary Group *[KH/55* - INQ000376194*]*, demand for emergency care peaked and at least 14 hospitals declared 'black alerts' which is the highest level of escalation for local health and care systems and means that there is more demand than capacity to meet it.

62. College members expressed concerns about a notable reduction in patient attendance at EDs during the early stages of the pandemic. This reduction was observed, particularly among patients with heart conditions. In response to this, the College published a number of press releases as detailed in paragraphs 25-28 early in the pandemic to raise awareness about the importance of seeking emergency healthcare when necessary. The objective was to ensure that patients understood the significance of seeking urgent medical care for conditions that required immediate attention, irrespective of the pandemic situation.

63. The availability of ventilators was not an ED concern during the relevant period. Whilst we understand that oxygen pressure in hospital systems was an issue in some locations the College has no information on which locations nor data to support this.

64. The use of Do Not Attempt Cardio-Pulmonary Resuscitation ("DNACPR") notices was not raised as a concern for ED personnel because normal clinical practice was followed whereby clinicians assessed and treated patients based on their clinical presentation and acted accordingly, and where appropriate admitted to hospital for ongoing management and treatment.
65. In relation to the ischemic heart disease; colorectal cancer; children and young people with mental health disorders; and pregnant women during childbirth and labour, patients presenting with these conditions were managed as normal in the ED setting and no specific concerns were raised.

The impact on the RCEM's members

66. From March 2020, the College took proactive steps to monitor the mental health and well-being of its members during the relevant period. These measures included:

    i. *Regular virtual meetings*

    The College offered Clinical Leads across all four UK nations a weekly virtual meeting to provide a forum for dissemination. Clinical Leads are typically responsible for overseeing the delivery of high-quality patient care and implementing best practices and guidelines to ensure that clinical standards are maintained. The College would update Clinical Leads on any relevant intelligence from meetings with policymakers, as well as collate helpful information from Clinical Leads on the frontline experience. These meetings served as another way to support members through unprecedented times. Active regional chairs and Devolved Vice Presidents also offered regular virtual meetings to identify and share best practices, centrally collate experiences, and provide assistance during the pandemic.

    ii. *Wellbeing App*

    In April 2020 the College collaborated with the employee well-being platform, 87%, and offered this to members and the wider Emergency Medicine community. The app helps measure, understand, and improve mental well-being. The app provided COVID and non-COVID-related resources to support individuals' well-being, curated and provided by 87%, mostly written articles. The app also signposts to other support services including the BMA counselling support line, charity helplines such as Mind and Samaritans as well as Health Assured assistance programme as provided by RCEM to its members. The app also allows users to monitor and track their well-being and provides the College with data twice a year which is reviewed by the President, Regional Chairs and College Committees. During the

pandemic. Some of the key findings of the RCEM Wellbeing Report *[KH/56 - INQ000376195]* include:

i. *80% increase in anxiety and work stress within the last 12 months*
ii. 62% of participating members said they feel tired most of the time.
iii. 51% said that sometimes their job made them "feel ill."

iii. *Membership surveys*

Three membership surveys were conducted during the relevant period to better understand the impact of the pandemic on the College's membership.

67. Throughout the relevant period the College provided support to its members, recognising the challenges they faced. The support the College provided included:

i. *Support for Emergency Medicine Trainees*

In response to concerns raised by Emergency Medicine Trainees regarding exams, the College revised requirements for ARCP and assessments, working closely with the Emergency Medicine Trainee Association. A revised version of the Faculty Governance was made available in the college's ePortfolio system. It was a requirement for trainers to fill out for all trainees of ST3 and above. In particular, the revised wording catered for those trainees who had not been able to complete the Advance Trauma Life Support/Advanced Paediatric Life Support courses due to COVID-19. In May 2021 the College's Training Standards Committee published guidance for ensuring Training Recovery for those EM trainees *[KH/57 - INQ000376196]* who had been affected by the COVID-19 Pandemic which recommended enhanced supervision for Trainees.

ii. Publication of *Position Statement on Sustainable Senior Doctor Working Patterns* in response to requests from Clinical Leads *[KH/58 - INQ000376197]*. These were unprecedented times, and members of all grades were being asked to work exceptional working patterns to meet the needs of our patients. In April 2020, the College published a position statement on *Sustainable Senior Doctor Working Patterns* which outlined sustainability principles and sensible job planning to ensure that staff were able to fit in adequate rest and recuperation.

iii. *Guidance on When a Colleague Dies [KH/59 - INQ000376198]*

The College issued guidance to address the emotional and practical aspects of dealing with the loss of a colleague during the pandemic.

68. The College has limited information on the transmission rates of COVID-19 among its members, specifically within the ED environment. While doctors in the ED will have been affected, the numbers are unclear. Regrettably, there were deaths among these

individuals, primarily occurring early in the pandemic and affecting those from an ethnic minority background. The College does not have specific information on how these members contracted the virus. It is not our role to judge the cause of their infection or attribute their deaths solely to occupational exposure. The College remains committed to supporting its members and providing guidance on infection control to support the safety of our patients and healthcare professionals.

Other concerns or issues

69. EDs had been under considerable strain for some time prior to 2020. For example, in 2019, 18 million people attended EDs across the UK and that winter over 100,000 patients waited 12 hours or more from arrival to departure (relying on NHSE ED statistical data). The pandemic shone a light on the preexisting issues within emergency care and the healthcare system at large; the first wave of the pandemic demonstrated that when capacity can match demand patient flow drastically improves.
70. Prior to the pandemic, corridor care was commonplace as most EDs were stretched beyond the capacity they were designed and resourced to manage at any time. EDs were poorly equipped, lacking essential facilities like negative pressure rooms. Operating in this way is not conducive to creating a resilient healthcare system that can adequately manage an outbreak. It is evident that lessons from previous outbreaks such as SARS were not effectively learned and implemented in these settings.
71. Unfortunately, the cumulative effect of over a decade of mismatch between demand and capacity followed by a pandemic has exacerbated these challenges. As resilience was not built into the healthcare system prior to the outbreak of COVID-19, it is now having to recover from directing all resources to addressing the pandemic. The already limited resources have been stretched even thinner, making it increasingly difficult for Emergency Medicine clinicians' workers to deliver timely and adequate care to patients.

Recommendations

72. To build resilience in the emergency care system to improve conditions in the event of a future pandemic, the UK Government must:
    i. End overcrowding in hospitals by improving patient flow through the health and social care system. This requires an expansion of hospital capacity by increasing the number of staffed hospital beds and ensuring hospital occupancy levels do not exceed 85%.
    ii. Provide more resources to improve community and social care services, so that when a patient's medical treatment is complete, they are able to leave the hospital quickly and safely.

iii. Rebuild and redesign hospitals so they are able to meet changing population needs and support infection prevention and control measures. The growing backlog of NHS maintenance repairs must be eradicated to support safer conditions and better care for patients and staff.

iv. Recruit additional UK Emergency Medicine staff across all professions and ensure that they stay in their jobs, so that there are enough clinicians to take care of patients safely as well as enough to train the workforce for the future.

v. Retain existing staff by working with the NHS to make sure it can meet the needs of its employees such as providing clinicians with more freedom to set their working.

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: 8 February 2024