Monday, 4 November 2024

(10.31 am)

LADY HALLETT: Mr Fireman.

MR FIREMAN: Good morning. May I please call Patricia Temple, who will be sworn.

MS PATRICIA ANN TEMPLE (sworn)

Questions from COUNSEL TO THE INQUIRY

MR FIREMAN: Could you please give your full name.

A. Patricia Ann Temple.

Q. Ms Temple, you have given a witness statement dated 14 June 2024, that's INQ000486012.

Ms Temple, you have been a qualified registered nurse working in various countries since 1972; is that correct?

A. That's correct.

Q. Is it correct that from March to November 2020 you worked as a band 5 nurse in a cardiac care unit of an NHS trust?

A. That's correct.

Q. Could you tell the Inquiry, first, what a band 5 nurse and what your role in the cardiac care unit involved?

A. A band 5 nurse is a registered nurse at the first level, and I worked providing bedside care to patients, both Covid patients and non-Covid patients, and primarily those with cardiac problems.

Q. Going back to March 2020, what was your daily working pattern like?

A. I worked full-time night duty at weekends.

Q. You mentioned that you cared for both Covid and non-Covid patients. While working in the cardiac care unit, were you always aware of whether or not you were caring for Covid or non-Covid patients?

A. Not always. Sometimes patients had not evidenced symptoms of Covid when they were admitted. Some patients were admitted as suspect Covid patients and only proved to be Covid-positive at a later stage once their test results were back. So at various stages we were not aware that the patients were Covid-positive or not.

Q. Was there a specific Covid-19-positive ward in your hospital?

A. There was, yes.

Q. Were staff from your ward ever called upon to care for patients in the Covid-19-positive ward?

A. Yes, it depended on whether staffing levels in the Covid-positive ward were actually at appropriate levels or not, and if not then, if our ward had what they considered to be sufficient staff they would float, is the word that we used, to another ward to supplement staffing levels in that ward.

Q. When that took place would those staff who had floated, to use your word, ever return to -- return relatively quickly to your ward, the cardiac care unit?

A. We would be floated for a shift.

Q. And return the next shift?

A. Yes, return to your ward the next shift. So it would only be for a shift.

Q. So there was no break time in terms of no time off after having spent time within a Covid-19 ward to account for the fact that the nurse had spent time in that ward and may well have potentially been exposed to Covid-19?

A. No.

Q. With respect to infection prevention and control, you say in your statement at paragraph 5 that "policies seemed to change daily and, at times, did not seem to adhere to the normally accepted Infection Prevention and Control Guidelines". What do you mean by this?

A. I think that the one particular incident that I said was we were told on a Friday that we were to wear a mask starting on Monday, which seemed to me a strange thing to do.

Q. Why?

A. Because if we're going to be wearing masks from Monday surely we should be wearing them now. It seemed to make no sense at all.

Q. Did you feel as though the management and those in charges charge of infection prevention and control within the hospital were forthcoming with information about the level of risk that --

A. I don't think so, no. Initially I think that we got the impression that we weren't being told everything. I have no idea whether that was deliberate or not but it appeared that we weren't being told about everything that was going on, particularly as it related to Covid-positive patients and how many there were and potential issues with Covid-positive patients.

Q. What gave you that impression, that information was being withheld?

A. Just that it was very difficult to extract information about anything, if you asked questions about how many Covid-positive patients there were and what was happening, pandemic-wise in the trust that I worked with.

Q. Did you feel that there was sufficient clarity around what protective equipment, PPE you should be wearing?

A. No, there was confusion, I feel.

Q. Was confusion related to the type of PPE that you should wear?

A. Yes, definitely. There was confusion as to whether surgical masks were adequate as opposed to FFP masks,

and whether -- initially we were told that surgical masks were fine for everything except for patients who were having aerosol-generating procedures, and in the early stages of the pandemic the unit that I was in was declared a white unit so that we weren't supposed to be admitting Covid-positive patients but as the beds in the remainder of the hospital became scarce then we did start admitting Covid-positive patients and we were told then that only with aerosol-generating procedures were we to wear FFP masks for the added protection, but otherwise surgical masks were adequate.

Q. You make clear in your witness statement that you had been fit tested for one type of FFP3 mask in 2019. Were you able to wear this type of mask in those circumstances in which it would have been advised that you wear an FFP3?

A. Yes. Yes, except that during -- I found that out in retrospect after I contracted Covid and when I investigated a little bit further I found out in retrospect that in actual fact the mask for which I had been fit tested was actually withdrawn from the trust and put back into general stocks in the NHS, I believe in July of that year, but that was just -- I have no evidence of that, that was just hearsay from someone who was actually organising the mask fitting for me, told me

that that mask had been removed. We were not advised of that.

Q. So do you actually know whether or not the mask that you were wearing, the FFP3 that you were wearing, was one you had been fit tested for?

A. It wasn't. It was initially until those became unavailable and then FFP masks that were available I used, but later on in the November shortly before I acquired Covid I discovered that in actual fact the masks for -- the masks that were available in the unit, they fit tested me -- they came around with a new computerised testing system for fit testing masks and we found that all the masks, other than one which I had never seen before on the unit, that none of the masks were actually suitable for purpose in relation to me.

So, it became clear to me that obviously I was not adequately protected during the time.

Q. You were wearing an FFP3 mask but not one --

A. Yes.

Q. -- which adequately --

A. Protected you.

Q. -- fit your face?

A. Yes. But we did, in terms of aerosol-generating procedures, shortly before I became ill I actually was caring for a patient on aerosol-generating procedures

whom I remember really clearly and in that instance we took all our protections we, put FFP masks, we put visors and we took full precautions as we were advised to do. But it was difficult.

LADY HALLETT: What was it about the masks, when you weren't having a visor and everything else, what was it about the masks that meant they weren't giving you sufficient protection? Why were they found unsuitable?

A. There's leakage I believe, so they tested it on the computer to see whether it actually -- in previous tests what they did was they put the mask on and then they injected a smell, you know, some sort of -- so that you could smell it and see, and if you could then it meant that the mask wasn't effective, but in this instance the computer told us that it actually didn't provide adequate protection. It gave you percentage protection, I believe, some of them gave minimal percentage protections, and the last one that they tested on me which was I believe called the Stealth mask was the one that gave adequate protection.

But in actual fact I never tested that again because I went -- I was ill shortly thereafter and when I came back from my sick leave I actually didn't nurse Covid patients again, simply because I felt that it was not possible for me to do so.

MR FIREMAN: To be clear, you found out this detail about the accuracy after you had been nursing patients wearing FFP3 masks --

A. Yes.

Q. -- which turned out not to be sufficiently protective for you, is that right?

A. That's correct.

Q. Is it right that in your hospital there was an infection prevention and control team?

A. There was.

Q. Did your working pattern which you mentioned earlier working consistently night duties impact your ability to engage with that team?

A. It did. I was fortunate in as much as the education and training department came round to those of us on night duty during November 2020 and actually provided us with mask fitting tests and that's how I established that in actual fact the masks that I had been using were not fit for purpose.

Q. What was your experience like of infection prevention and control measures in staff areas? Did people tend to keep their masks on in staff areas or did they take them off, what was the general impression that you got from working --

A. I think we tried to keep them on. It was difficult in

staff areas like when you went for your breaks to actually keep your masks on while you ate and drank and it was difficult as well to keep masks on if you were at the nurses station, for instance. That was the most difficult area, I think, to remain infection aware because there were so many of us coming and going.

Q. Was this the case for both the surgical fluid-resistant masks and FFP3 masks or particularly the case when you'd been wearing an FFP3 mask?

A. I think we wore the surgical masks routinely and the FFP3 masks only when indicated.

Q. So there wasn't any particular issue in relation to FFP3 masks having to be taken off; it was in fact the case even with the surgical masks people were taking them off in staff areas?

A. Yes.

Q. Was there anything that you think could have been done to improve compliance with infection prevention and control, particularly in staff areas?

A. I think if issues had been explained better, if people had actually made themselves available for those of us on night duty. I felt that there was general confusion surrounding infection control practices and what the best things to do were. It was relating as well to how many people would be in one area at a time. You know,

there was -- no one explained the sort of science behind it, like there could only be three people there or there could only be two people there or four people there and it didn't seem to be based on anything scientific. So it was difficult to adhere to principles that were, I suppose, questionable.

But I have been nursing for a long period of time so I have infection control principles sort of imprinted in my brain and some of them really didn't seem to make sense and were difficult to adhere to because of that, I feel.

Q. Regardless of what the guidance was, would you have then appreciated some more explanation as to how --

A. Yes, yes.

Q. -- the guidance had been reached?

Did you feel that you had adequate access to testing for Covid-19?

A. I think so, yes. I can't remember that there was any problem with that, although people were reluctant to be tested because of the implications, if you went off sick, particularly, I think, financial implications if you went off sick and you didn't have sick leave available there was, you know, a reluctance perhaps to go off sick so there might have been a reluctance to be tested just for that reason.

Q. Did you encounter staff avoiding testing?

A. I don't think anyone actually refused to be tested but they did try and avoid it as much as -- as was possible I think, because of the -- having to go off sick and the financial implications thereof.

Q. One aspect of infection prevention and control which the Inquiry has heard a lot about is the visiting restrictions that were imposed. From your perspective as a nurse, someone who's been nursing for many years, what was the impact of having to impose visiting restrictions on patients and their families?

A. That was really sad. I found it really, really sad. I remember well one patient that we heard talking to his mum on the phone, a learning disabled man who couldn't understand why she couldn't come and see him and he was dying and you could hear him speaking on the phone to his mum and asking her to come and that was devastating for all of us because we have an obligation as nurses to care for our patients, to empathise with them and to be there with them and it was very, very difficult to see them suffering without their loved ones there. It was difficult for us as well to see them dying alone.

Q. Did you feel you had the flexibility to adjust the rules to individual circumstances?

A. No.

Q. You note at paragraph 10 of your witness statement that staff who did test positive were advised to return to work as soon as possible and made to feel guilty if they did not. Where did this pressure to return to work come from?

A. I'm not sure whether it actually came from management or whether it came from nurses ourselves. You know, we ourselves are really obligated to our team members and our colleagues and we sometimes I think we probably put an inordinate amount of pressure on ourselves to actually get back and not let our team down. So I think it possibly came from management because of staff shortages and we were well aware how short staffing was so we were reluctant to let our team down and let our patients down.

Q. You say at paragraph 19 of your witness statement this:

"We expected the NHS and management would look after us as required. I fear they failed to do so."

Can you elaborate a little on your concerns there?

A. I think there was systemic failures. I think that's the big thing is -- I'm very much a quality improvement people and in quality improvement you look at the systems and I think that if you looked at the system that was put in place to deal with Covid there were failures and failures and failures. And I think they

let us down as nurses about many things.
Q. Anything in particular?
A. I think infection prevention and control, particularly. I think with myself in terms of Long Covid and looking after me when I developed Long Covid, that was really difficult. I had to fight really, really hard to get any support from management in terms of Long Covid. I had to try -- I tried redeployment on a number of occasions and that failed. But there could have been far more support I feel and far more adjustments made and I feel very strongly for the Long Covid nurses that are out there now that are having to take ill health dismissal. It was less difficult for me I think because I had come nearer the end of my career than the beginning but there are still -- there are a lot of nurses out there that are beginning their careers and have had to take dismissal due to ill health and that makes me feel that they consider nurses disposable and I think that's where they let us down particularly.
Q. Did there ever come a point whilst you were working when the vaccine became available?
A. It did, yes.
Q. Did there come a point at your hospital -- it may not have -- but did there come a point where it was proposed that taking the vaccine was a condition of deployment?

A. It was, yes, although that didn't affect me particularly at that time. My main decision was -- to take the vaccine was after I had been put on sick leave due to Long Covid, and I lived alone in the UK, my family are in Israel and South Africa, and I desperately needed to go somewhere to be looked after and the only reason I took the vaccine, I think, was so that I could travel. And that's an honest opinion.
Q. From the perspective of you and other staff, from your perspective and other staff's perspective, the opposition of having a policy that required staff to take the vaccine in order to be deployed as nurses, did that have any impact on staff morale?
A. It didn't, I think, but I think that, if I remember, I remember two nurses particularly that they were very certain that they were not prepared to have the vaccine and as far as I'm aware were still allowed to continue to work. I think it possibly became a condition of employment but possibly that was by the time I had Long Covid and was no longer at work, it might well have done. But we were still able to refuse.
Q. You touched on your experiences briefly in relation to contracting Covid and developing Long Covid. Am I right that you understand or you believe that you contracted Covid at work?

A. Yes.
Q. Do you know when you contracted Covid or how?
A. From that patient that I was talking about that I nursed in the 7 to 10 days prior to becoming ill. And I remember him well because it became such that we were unable to continue to nurse him on the ward that he was on and we moved him to the respiratory unit where he subsequently died, much to my regret because I knew that he, too, would die alone.
Q. After you contracted Covid did you have some time at home isolating alone?
A. Until it became such that I had phone calls from everybody to tell me that I had to go to hospital but I was of the firm belief that we were told that you had to isolate at home for 10 days, that whatever you did, please not to go to hospital because it would further confound the problems that they were having at the hospital. So I stayed at home for an exceptionally long time. I actually stayed at home for 10 days until I was actually ambulanced to hospital because I was seriously ill.
Q. How long were you admitted to hospital for?
A. 11 days.
Q. Were you then discharged home?
A. Yes.

Q. And were you able to then return to work?
A. I tried to return to work -- I did try to return to work in January 2021 and then had to leave in March of 2021 simply because I couldn't maintain my oxygen saturation levels at an appropriate level to function and to breathe, and I also had an inappropriate tachycardia that I couldn't manage a full day's work.
Q. What was that period of time working, trying to work as a nurse, something you'd done for many, many years but simply being unable to do it to the standard that you previously had been able to, what was that like?
A. It was six very difficult weeks, because I tried my best to manage and not let my team down, as that's very important to me that one doesn't let one's colleagues down.
Q. When did you recognise that you had in fact developed Long Covid?
A. Well, I felt that I had developed something a long time before I got the diagnosis because a lot of people poo-poo'd the idea of Long Covid, and I believe still do, but I knew that there was something wrong with me in as much as I couldn't breathe and I had difficulty with extremely serious fatigue and was just not able to function on a daily basis. To even get around and do my shopping was very difficult. I just found difficulty

with normal, everyday tasks.
Q. Did you eventually manage to access a Long Covid clinic?
A. I did but after -- yes, I went to -- yes, there was a Long Covid hub and I managed to get hold of a respiratory physiotherapist who came and visited me at home and they established that I had ongoing symptoms of Covid and that I had respiratory issues and I eventually travelled to South Africa where my daughter was and consulted other physicians there and discovered that I had permanent lung damage from Covid.
Q. You say in your statement that you feel more should have been done from your employer's perspective to create a supportive environment for nurses while they recover from Covid-19 or, indeed, Long Covid if they've developed it. What do you feel could have been done to support you?
A. I think people could have kept in touch more. As it were, I lived alone and -- I did have friends obviously that kept in touch with me but in terms of work they didn't keep in touch with me as much as I think they might have. I think there are standards that are set when you're on sick leave but I think it caught them unawares the fact that Long Covid would go on for quite so long, so people found it difficult from a management perspective I think to keep on touching base with you to

see how you were, and I think there should be a much more robust system of looking after people at home when they have Long Covid.
Q. You ultimately were required, were you not, to take ill health dismissal?
A. I was.
Q. When was that?
A. September 2023.
Q. After everything you've experienced have you been able in any form resume nursing?
A. Not bedside nursing at all but I'm a nurse and always will be a nurse and so I am now working with one-to-one nursing students online to help them with their academic work, and also preparing an online programme for nurses who are compassion fatigued, as I think many of us are, particularly in post pandemic.
Q. You finish your statement with these words:
"Nurses should not be viewed as disposable and every attempt should be made to retain this valuable resource."
Are there any recommendations beyond which you've already touched on that you think ought to be borne in mind by the Inquiry to ensure that nurses are better protected in the event of a future pandemic?
A. I think we have to learn the lessons from this pandemic,

what has happened from this pandemic and why so many people actually -- why so many nurses actually contracted Covid and then Long Covid, so that lessons should be learnt and I hope what this Inquiry does is to learn those lessons and put them into place in the future. But I also would like, in terms of Long Covid nurses, is, they are still willing to nurse and they still could nurse in many, many different capacities, so can we not make reasonable adjustments and allow them to continue in their nursing capacity?
I have a lot of nurses that I know who are trying very, very hard to stay in the workplace and are unable to do so and that's something that I think should be seriously looked at and learnt from so -- they are a valuable resource, they are not disposable. Having Covid and Long Covid, you can't be clapped for one minute and declared disposable the next.
MR FIREMAN: Thank you very much, Ms Temple.
My Lady, those are all my questions.
LADY HALLETT: Ms Temple, thank you very much indeed. I don't have any questions for you. You and I qualified in the same year --
A. Oh, did we?
LADY HALLETT: -- 1972, so to see your dedication to your profession after so many years is inspiring, and I'm

really sorry that you've had to suffer the impact of Long Covid, it's obviously been a great blow to you to give up nursing in the wards. But you are obviously doing a huge amount of work supporting other nurses online and we're really grateful for what you did during the pandemic and that you continue to do in supporting nurses. Thank you very much for your help.
THE WITNESS: Thank you very much, my Lady. Thank you.
(The witness withdrew)
LADY HALLETT: Ms Carey.
MS CAREY: My Lady, the next witness, please, is Mrs Rosemary Gallagher.
MS ROSEMARY GALLAGHER (sworn)
Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3
MS CAREY: Ms Gallagher, your full name, please.
A. Rosemary Gallagher.
Q. I think you are known as "Rose" at work, and indeed we look at some emails and we will see you signing off as such.
Mrs Gallagher, you're coming to give evidence today as the professional lead for infection prevention and control at the Royal College of Nursing?
A. That's right.
Q. I hope you have in front of you your witness statement dated 25 April, INQ000475580.

A. I do.
Q. May we start with a little background, please. Firstly, to you. Just help us, what does the professional lead for IPC at the RCN do?
A. I'm a registered nurse, and I'm a specialist nurse working in infection prevention and control. My role essentially is to advise the college and its members on matters relating to infection prevention and control but specifically in the context of nursing practice.
Q. And presumably, therefore, were rather busy during the relevant period --
A. Yes.
Q. -- dealing with the IPC guidance. We're going to come on and look at some of the guidance and indeed some of the RCN's concerns --
A. Yes.
Q. -- about the IPC guidance during the course of your evidence. May I just ask you, please, though, to give us an overview of the role of the RCN?
A. Yes. So the RCN, the Royal College of Nursing has a dual function. It was established first as a Royal College in 1929 and therefore acts as a professional body for nursing focusing on professional nursing standards, health policy, and advice and support for its members.

It's also a trade union and therefore has the additional role and ability to support its members in relation to employment relations, queries or issues.
Q. Can we start, then, with one of the major concerns from -- of the RCN as set out in your statement, which is that relating to lack of engagement with the RCN and indeed other stakeholders, particularly, you say, in reviewing, updating and indeed developing the IPC guidance.
Just help us, please, if you're able: which bodies did the RCN want to engage with?
A. In the early days of the pandemic, the development of guidance would have been led by Public Health England in collaboration with the other countries and main stakeholders, and our experience in previous incidents had been that royal colleges and nursing was around the table in terms of considering the impact of that guidance on those that would implement it.
Q. Why do you say on behalf of the RCN that it's so important for the RCN to be engaged with when IPC guidance is being developed?
A. Well, there are a number of reasons that support our position. First of all, we had learnt, as I said, through a number of prior incidents that it was absolutely critical for people that needed to use the

evidence and practice and to implement it were actually involved in its development, and that was a key outcome from the Ebola incident and review.
Our members also work across a variety of health and care settings, both in the NHS, adult social care and independent settings, but they're also present in prisons they work in mental health settings, so it's really important that there isn't a one-size-fits-all guidance. Certainly it can be based on principles, but it has to be implemented the context of where those nurses are working.
So for us to be around the table, whilst I might not wear my specialist infection prevention and control hat, I would bring with me that experience of nurses and look at how it could be implemented in the various settings.
Q. I think you said a moment ago that there was difficulty certainly with engagement in the early days by which I mean March/April, that kind of time of 2020.
A. Yes.
Q. How did it improve, if indeed it did, after the initial months of the pandemic?
A. In the early stages we didn't have specific concerns around the Covid-19 guidance or the Wuhan guidance, as it was known at that point, because it was being treated

as a high consequence infectious disease, and therefore it followed the high consequence disease management. It wasn't after SARS-CoV-2 was downgraded from a high consequence infectious disease that our concerns really started to actually be raised. Or to come to the forefront.
Q. Was there better engagement in wave 2? Or 3?
A. The level of engagement really varied. We tried to be very proactive in terms of offering our support as a royal college. This was very much about a one-team approach to managing the profession -- the pandemic and ensuring that all healthcare professionals, because our responsibility as nurses is clearly to our patients. But we have responsibility for the colleagues that work alongside us as well, so we wanted to make sure that that professional voice was there and heard, both to enable us to be confident that it could be implemented, but also to support communication and to feed in any intelligence from the frontline that could shape it.
LADY HALLETT: When you say there was a level of engagement varied, level of engagement with whom?
A. The majority of my contact, my personal contact, was with the leads in NHS England who were leading the NHS IPC cell. The countries -- because the RCN is a UK-wide organisation and we have four regions, the four

countries, they would also have had relationships with their respective devolved partners and potentially their IPC leads as well in individual conversations.

MS CAREY: We've heard evidence from Lisa Ritchie who was at one stage the chair of the UK IPC cells. Was it people like her and those that made up the IPC cell that you were engaging with?

A. Yes, I would have gone to Lisa directly and although there was an email address for the UK IPC cell where a lot of the inquiries went, but I would also contact Lisa directly as a contemporary and national leader in IPC.

Q. Can I ask, what's the impact or the downside, whichever word you prefer, of a lack of engagement with the nurses when reviewing and developing IPC guidance?

A. What became very clear in this incident, which was different from previous incidents, was that not only in its scale, but also our members were able to watch on the television and see what was happening in Europe before it came to the United Kingdom. So our members were very aware of seeing other nurses in other countries wearing respiratory protective equipment whilst, here, after SARS-CoV-2 was downgraded, they were offered primarily surgical face masks. So it was a matter of confusion, and also there was a sense of

a lack of confidence around the focus on their protection and a lack of understanding on why the UK appeared to be taking a different approach to other countries dealing with the same science and the same organism.

Q. How did that lack of understanding or the confusion that the nurses felt actually play out on the ground? Are you able to speak to that at all?

A. So we had many, many enquiries from nurses across health and adult social care settings asking us to explain or to rationalise the difference in levels of PPE. Nurses are expert in their practice and their patients, and when they started to raise real concerns, particularly around specific procedures such as nasogastric tube insertion or when they're very close-up to patients, they started to express doubt about the predominance of the droplet or -- mode of transmission. So they came to us, they contacted us through RCN direct, they contacted various people individually, and they wrote to us as well, raising their concerns.

Q. I suppose it may be said that in the early days of the pandemic there simply wasn't time for the level of engagement that the RCN would have wished for, but making such allowances as you feel able, do you think, in the event of a future pandemic, there needs to be

engagement from the get-go, if I can put it like that?

A. Absolutely. I mean we all understand that in a pandemic situation which is very fast moving and big, that there is a requirement to act fast. What I would say is that there was professional engagement with the swine flu pandemic in 2009. We all understood we had to turn documents around very quickly and attend meetings, and indeed everybody did that, and we achieved multi-professional collaboration.

We simply didn't understand why that engagement did not happen in this situation, given it was another pandemic albeit a different organism.

Q. On this topic I'm asked to ask you this. Do you think that any future guidance issued by the IPC cell would be more accurate or better received if there had been not just engagement with the RCN but perhaps with independent health providers like the independence ambulance sector, do you think that would have been of benefit?

A. Certainly I mean the College of Paramedics and other organisations would have been incredibly valuable to have because the context of risk to them is very different than it is to a nurse on the ward, and they would have provided a different perspective. But I would also just add that what was really needed was

some form of implementation plan, given that time was short, and a communication plan, and because we weren't involved, we weren't able to pursue those asks. And I think communication was a real issue in terms of the frontline health workers understanding why they needed to do what they needed to do.

Q. And who do you think should be responsible for an implementation plan and/or a communication plan?

A. I'm not certain. It should be part of that whole management of writing guidance. There was an incredible amount of guidance written both IPC and non-IPC, so having a governance and risk cell that could support identify issues around implementation and communication plans would have been very helpful.

Q. One other matter you mention in relation to engagement is you say that the RCN is not a member of the Academy of Medical Royal Colleges --

A. That's correct.

Q. -- and therefore was often excluded from key meetings when, previously, you have been involved in the meetings. Do you know why the RCN was excluded from various meetings in the pandemic?

A. I don't. Certainly we have a good relationship with the Academy of Royal Colleges, and we have attended meetings at their request, but during the pandemic it appeared

that it was only the medical royal colleges around the table. It's absolutely critical that nursing as the largest part of the professional workforce is there, and we are as able to provide insight and intelligence and critical thinking to those situations as our medical colleagues are as well.

Q. Now, you've touched on concerns about RPE already.

A. Yes.

Q. And I think you say at your paragraph 12 that it was the RCN's wish that RPE for healthcare workers, including nurses obviously, and for what you call the adoption of the precautionary approach rather than just saying there was no evidence to justify why IPC not changed. Can you expand on that in a nutshell, please, and encapsulate the RCN's concerns?

A. The guidance was predicated on influenza guidance which had continued how we had practised at the time, which was a predominance of surgical face masks. We knew that SARS-CoV-2 was a Coronavirus and that previous coronaviruses of high significance such as SARS and MERS-CoV were both classified as airborne infections.

Now, without getting into the semantics, when you talk about something as airborne, healthcare professionals are able to visualise what that means and are therefore able to easily understand why they need to

do what they need to do, ventilation, open windows, respiratory protective equipment, whatever.

Sorry, I've lost my train of thought.

Q. I was asking you about the RCN's concerns about the RPE or the lack thereof?

A. Yes. So to have this dominance of surgical face masks when we were dealing with what was an airborne high consequence infectious disease, other Coronavirus infections classified as airborne, the two did not meet and we also knew that surgical face masks did not protect adequately against airborne particles, aerosols, from the Health and Safety Executive themselves.

So we were really concerned about the level of protection that was being advised. We were equally mindful that actually wearing RPE for long periods of time is not good to work in those situations, so we needed clarity and we needed discussion and debate on how best to protect healthcare workers given those various tensions.

Q. Can I ask you then how does the RCN think that that tension should be resolved? You want it but you don't want to wear it all the time, I understand that, but is there a middle ground?

A. The middle ground, we have to look at the level of risk and we are legally bound to look at the level of risk

and manage that through existing legislation which primarily comes under Health and Safety and COSHH. So that was the driving force at that time and COSHH remained in place throughout the pandemic and therefore was a natural place to go to in terms of how to protect healthcare workers. The equipment that we had to manage that risk was what we had at the time, which was single use, predominantly, respiratory protective equipment or FFP3s.

Q. Now, I think in your statement you go on to make observations about PPE being reused, out-of-date PPE, there are problems that her Ladyship is already familiar with in terms of fit testing --

A. Yes.

Q. -- and the sheer number of masks that need -- or FFP3 that needs to be fit tested. So I just wanted to put all of those into the round because I would like to ask you, please, Mrs Gallagher, about two of the surveys that the RCN conducted.

A. Yes.

Q. One in April and then another one in May 2020 which really bring to the fore the concerns of your members in relation to PPE.

So can we start with the April 2021, and could we have up on screen, please, INQ000114401.

The survey was conducted over the Easter bank holiday weekend in April 2020, as I understand it?

A. That's correct.

Q. And there were 13,605 replies. I ought to have asked you, it's my fault, how many members are there of the RCN?

A. At the time we had just under 500,000.

Q. All right, okay. So it's a large number of responders but actually not a huge number of your members?

A. It's a proportion of our membership.

Q. All right. But it was a UK-wide survey as we can see there. The majority of respondents worked in England, 11% in Scotland, 4% in Northern Ireland and Wales, 5% identified as having a disability, predominantly females who replied and we can see the ethnicity breakdown of those 13,500-odd that responded.

Can, please, we go to page 6 of the survey, and set out there really is a number of the concerns of the majority of respondents, 11,300 of them, who worked in environments with patients with confirmed or possible Covid but does not involve undertaking high-risk procedures -- do you mean AGPs by that or is that --

A. Yes, we didn't have major concerns around nurses working in, say, intensive care facilities because the ventilation tended to be quite good and they were well

used to using RPE.

Q. And you can see there what PPE was required to be worn and then in the section below saying "Access to enough supplies of PPE" 30% of respondents said there was not enough eye/face protection for them for the during of their shift. 28% said they have enough now but are concerned for the supply for their next shift.

One in four said there was not enough fluid-resistant surgical face masks for the during of the shift. And, again, a quarter of those were concerned about the next shift.

And 14% said they were lacking surgical masks. 32% said they had enough surgery masks for the duration of the shift but are concerned, again, about the next shift.

The least shortage was with aprons and gloves.

So over the course of that weekend there's still a fair proportion of the responders concerned about face and eye protection, and FRSMs and that was fairly early on in the pandemic, Easter?

A. That was April --

Q. April 2020.

And if we go to page 14 of the survey, I think there's -- some more general concerns were outlined. You see:

"Anecdotal evidence from our members revealed that they were concerned with being pressured by their employers to care for confirmed or possible COVID-19 patients without suitable PPE."

You received calls about that from the members. The purpose of the survey was to understand how far nursing professionals had access to materials and facilities to help address infection control. We asked about the extent to which nurses were able to raise concerns, how they did that and whether those concerns had been addressed.

We can see there half of the respondents said that during Covid pandemic they felt pressure to care for a patient without adequate protection as outlined in the current PPE guidance.

And one in five of the respondents, almost one in five, has had issues with PPE due to specific individual needs such as disabilities, religious and cultural practices, having facial hair or wearing glasses.

The overriding issue related to PPE was for those wearing spectacles?

A. Yes.

Q. And what was the problem with -- if you're a glass-wearer?

A. So if you were provided with a visor it may not have

been so much of a problem, but certainly with the protective goggles and wearing spectacles underneath there were practical issues and the goggles didn't fit properly over the spectacles. So for a nurse, for example, that could have impacted on their ability to read prescriptions for example, dispensing medications, and also the fact that the goggles potentially, the members felt weren't actually protecting them appropriately.

Q. Can I ask you this, it doesn't sound like a new problem. Is there any kind of goggle that does work over glass wearers?

A. We don't tend to wear goggles in general practice. If we need eye protection it tends to be either a visor that goes over our faces with a mask or an integral surgical face mask with a visor as part of it.

Q. And we're familiar, I'm afraid, with the issue of fit testing for FFP2 and FFP3 masks and indeed those that had failed the fit test due to having too small a face, wearing a hijab or a head scarf or having a beard, we've heard about those, I'm afraid, from a number of other witnesses, Mrs Gallagher.

Can I ask you, what did the RCN do with the results of the survey?

A. So the survey was really a snapshot survey to help us

understand the sort of experiences of our members at that time and in early April 2020 this was at a time when we were told there weren't any shortages of PPE, so it allowed to us feed into conversations from a four-nations perspective to lobby and put pressure on the governments to ensure that the supply of PPE was kept going to keep healthcare workers safe.

Q. I think you said in due course you sent these findings and indeed the May survey, which we'll come on to, to Department of Health, the UK Prime Minister, the equivalents in the devolved nations, NHS England, and the HSE?

A. It was widely disseminated, yes.

Q. Did you have any response from any of those organisations to the findings?

A. So the four country responses would have gone back to the respective four country directors. My recollection is that there was a limited response, an acknowledgement of the situation but that would be about it.

Q. Did you find that there was any improvement in the supply of PPE as the months wore on?

A. As the months wore on we didn't really see any particular issues with aprons or gloves although there were moments when certainly I remember the issues with the quality of aprons being an issue. Most of the

concerns tended to be around masks and eye protection on an ongoing basis.

Q. Let's look, please, if we may, at the May 2020 survey and it's INQ000328873, and could I have on screen page 4 where there's a very helpful summary of the findings.

Now, this was conducted over 7-11 May 2020.

A. Yes.

Q. This time 5,023 replies and some positive news:

"The situation has improved across the board in terms of access to standard and high-risk items of PPE ..."

When you say high-risk items, what was being referred to there?

A. So that would have been respiratory protective equipment FFP3s.

Q. Right.

A. And potentially, but forgive me, I can't quite remember, but long-sleeve gowns.

Q. 28% of respondents were very confident their employer was doing enough to adequately protect them from Covid. 40% moderately confident. You hadn't asked that the first time around.

A. No.

Q. No criticism but just making the position clear:

"However, more standard and high-risk PPE are

being donated, home-made or self-bought, especially eye/face protection compared to our previous survey."

So still by May of 2020 there are concerns about the supplies. And what was the position where people donated or made PPE? Was that an acceptable form of PPE to be worn?

A. So if I just explain some of the issues that could have potentially resulted in that response.

Q. Yes.

A. The surveys were open to health and adult social care settings. So without having the data in front of me I couldn't say, but certainly we know that a lot of donations were made to adult social care at the time by the general public and by family members that were concerned about their loved ones going to work.

Our position was very clear and we added this to our frequently asked questions on our website that whilst we really appreciated donated and home-made items, it was absolutely critical when wearing them in the workplace that they met the right standards of protection.

Q. Over one-third of respondents said they felt pressure to care for a patient with possible or confirmed Covid. That had improved since the April survey.

Clearly there were some general concerns about

infection control supplies.

And this, then, over half of respondents had raised concerns about PPE and over a quarter of these were not addressed at all.

"However, there had been improvements in the concerns that had been addressed fully compared to the previous survey ..."

May I ask you about that, please, Mrs Gallagher. If you are a nurse on the frontline to whom is it that you should raise concerns initially?

A. Initially you should go to your manager in the first place.

Q. And what's the sort of brief trajectory of an escalation of concerns from the manager up?

A. So depending on where you work, it would go to a manager, then a senior manager, then go up through the organisation from there in line with the various governance arrangements. Members did report that they had a general lack of confidence in concerns being listened to and acted upon and in fact many members admitted to not raising concerns based on that.

Q. That can come down.

But one of the things you do say in your statement is that the first PPE survey revealed that staff from ethnic minority groups were more likely to report they

did not have access to adequate PPE compared to their colleagues from British, white British groups. Are you able to help at all as to why there is this apparent disparity?

A. I can't based -- without having the data in front of me. So for example, I don't know how many of our respondents were working in adult social care or working in the NHS. Also we do know that some of our colleagues from black and ethnic minority groups are very reluctant to challenge or have a complete lack of confidence in their concerns being raised and that may well have had an effect on their ability to ask for PPE, whether or not that would have been provided.

Q. I think you set out in your statement and you say:

"Staff members from ethnic minority groups reported feeling less confident in their employer's ability to protect them from exposure to Covid in comparison [with] their white British counterparts: Almost a quarter of ethnic minority staff did not feel confident at all compared to around 1 in 10 white British."

And you said:

"Staff from ethnic minorities reported they were less likely to have had their concerns addressed in comparison to their white British counterparts."

A. Yes.
Q. Can I ask you, what did the RCN do, and I'm not suggesting it's solely your responsibility, but is there anything the RCN did to try and ameliorate those concerns or improve the position for ethnic minority staff to help them feel confident?
A. So working through the regions, the organisation, the Royal College of Nursing has its regional structure and then work through our branches, our health and safety and well-being representatives and learning representatives, so a huge amount of energy went in to try and reach our black and ethnic minority colleagues through the various communities and where they worked.

We also knew that based on where the majority where -- or the roles that the majority of our colleagues had were in sort of band 5, band 6 roles where they would have had significant patient contact. So some of this may also have been around the demand that they need, the demand to use PPE that simply wasn't being met on the frontline as well. So it's a really complex issue and it's one that we really want to understand in order to build in the experiences of our black and ethnic minority colleagues into future pandemic planning because it's absolutely critical.
Q. You may have answered my question in part there because

I was going to ask what additional steps could have been taken to try and address some of those disparities. Clearly planning?
A. Yes.
Q. But is there anything else that you can perhaps suggest that would make a real practical difference here?
A. The greater use of collecting data on protective characteristics is something that we're really keen is implemented both in terms of data on infections or deaths but also in day-to-day issues to help us understand where some of these challenges are and why they're actually arising.

That is counterbalanced slightly by some people not wanting to disclose their ethnicity and we have to respect that but it would be really helpful for us to understand that -- that real lived experience of them in the workplace.
Q. Whilst we're dealing with PPE, I think the RCN, is this right, advised its members on its dedicated PPE webpage to not use PPE which was not fit for purpose --
A. Correct.
Q. -- if it didn't fit correctly; is that correct?
A. Yes.
Q. Didn't meet the correct standards, had degraded, was donated as we've just looked at, or was dirty or unable

to be adequately decontaminated?
A. Yes.
Q. Now, I think the RCN, is this right, received reports of PPE being removed and staff being challenged when they wore PPE. It's at your paragraph 45 onwards, Mrs Gallagher, but there's an email that may bring this to light.

Could we have a look, please, at INQ000328902. And could we go to the final page of the document, page 3.

This is an email from Dave Carr at Unite and it is dated, forgive me, 21 January 2021. And if we could just go to -- it actually just starts on the bottom of page 2, I'm so sorry. Thank you very much.

The recipient had been "contacted by several members of staff yesterday, last night and this morning about PPE provision on a ward.

"Staff have been told at morning handover that they were not allowed to wear FFP3 masks (These masks have been physically removed from PPE stations in the areas discussed)

"Staff have been told that they will be challenged if 'caught' wearing them.

"[The] ward had their FFP3 stock removed to the do I was may of the staff working there."

I understand -- is it the head of nursing, "HON"?
A. I would say that's probably what it refers to.
Q. Yes.

"... in this area has supported the decision to remove FFP3 from non-AGP areas."

Then it sets out the trust is following the guidance. The author makes a point:

"We are not asking for FFP universally, although we would be happy with that! We are asking that staff to have the choice to wear the PPE they feel safe with."
A. Yes.
Q. "Incidentally medical staff in the same environment as nurses wearing full FFP3 and long sleeve gowns, this adds even further [to] distress and alarm to our nurses discouraged from doing likewise."

And so this -- Mr Carr is raising this with the RCN. Perhaps then if we could scroll up, please, to follow the thread, there we can see -- you're asked whether you can support this with the RCN's backing, they can't find an easy answer on the PPE pages, just that the RCN has asked for a review of guidance generally.

"... not sure of the evidence base but what I would say from experience that you can't guarantee the Covid status of anyone you're dealing with so not having

FFP3 does seem to be an extreme measure ..."

And if we go up again, you're copied in.

A. Yes.

Q. And up again, please. We can see your response.

"... Mark -- thanks this is really timely. [It's] very disappointing to hear staff being responded to in the way described below. I've copied Jude [another colleague at the RCN] in for some advice as I also had a conversation today where I discussed with a member barriers to a staff requesting FFP3's. The new IPC guidance (NHS not [Public Health] ...) does allow for employers/Trusts to implement a move to the use of FFP's in areas or across the board. If this happens though staff must be fit tested ..."

And if we go up again I think there is an update to what was going on at the hospital concerned:

"... by way of ... update we gather [the] hospital removed ... FFP3 as staff were wearing it without being fit tested appropriately. They may bring it back with fit testing in place. That said there is disparity across London with some trusts voluntarily providing [a] higher grade PPE because they recognise it makes staff feel safer -- all links in to the postcode lottery press release that's been prepared."

So a number of issues in there.

A. Yes.

Q. It sounds like it was removed, but perhaps not necessarily for the reasons people thought, and it was being removed because there wasn't proper fit testing going on. Is that how you read that chain?

A. So that's certainly a possibility. As I say, this incident was reported to us. What we know is that there was certainly a lot of misunderstanding around the application of the IPC guidance in practice. There was huge confusion over the hierarchy of controls. And, of course, what a lot of people didn't appreciate was that actually the IPC guidance in effect was the minimum level of guidance, and that actually organisations were quite within their rights to go beyond that in areas in line with the employer's overarching risk assessment where there were higher risks to staff. So certain areas such as Accident & Emergency departments, for example, where lots of people would have been coming in to the organisation, you wouldn't have known what status they had with Covid or whatever. That would be different perhaps to an outpatients setting.

What this email did really was to highlight the confusion that was in place, and at this time, of course, we had the new variant starting to circulate,

which was much more transmissible. So staff were highly anxious around their status and their protection. They knew that FFP3 masks offered a higher degree of protection. They clearly identified they needed to use them in that area in line with their dynamic risk assessment, which sounds complicated but in fact it's not if the employer has done their risk assessment appropriately, and actually their confidence would have been decimated to have those masks removed or fit testing not provided.

Q. Can I just ask you about the risk assessments, because I think in your statement you say that the RCN subsequently worked on developing its own --

A. Yes.

Q. -- Covid-19 risk assessment. Why did the RCN do its own?

A. We came to the decision to create a toolkit, so not guidance but a toolkit, after we had tried for some time to influence the IPC guidance and how it described the level of protection that could be used in different situations.

We wrote the guidance with stakeholders rather than it just being a nursing document, because this clearly was -- should have been available to all, and was not available to all. What we wanted to do --

because we had realised by the end of June 2021 that there was no way we were going to be successful in influencing any changes in the IPC guidance -- so our thinking and our decision-making turned to improving education and awareness on how to actually implement risk assessment, and think about COSHH in the workplace.

COSHH in particular is something that many nurses haven't historically thought about on a day-to-day basis and where they would have considered COSHH it would have been in specific instances such as working in endoscopy with disinfectants or when cleaning up spillages of blood and body fluids and using chemicals for those.

The use of COSHH is applied to a biological hazard, so a virus in this situation, is something that very, very few people outside of laboratory settings would have had to consider. So their knowledge, their confidence in this and then to put it into practice with a risk assessment was minimal. So that's why we did our risk assessment toolkit.

Q. Thank you.

LADY HALLETT: I can't remember if you did explain earlier, but for those who don't know, COSHH is the Control of Substances --

A. Control of Substances Hazardous to Health. That's correct.

MS CAREY: May we after the break, please, come on just to look at some of that IPC guidance and some of the problems you've just alluded to.

LADY HALLETT: Very well. I shall return at midday.

(11.43 am)

(A short break)

(12.00 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Mrs Gallagher, can I ask you, please, about the IPC guidance you've hinted at some of the RCN's concerns already, which I hope I may do justice by saying it was a major concern of the RCN's that the IPC guidance did not make sufficient or limited reference to HSE requirements. And I just want to try and understand why does the RCN say it's so important, for example, to refer to Health and Safety Executive requirements or COSHH, as we were just talking about before the break?

A. Our position was and remains that IPC guidance does not exist in isolation. So IPC guidance not only has to be implemented in the context of where a healthcare worker is working, but it also has to align and reflect the needs of other legislation or regulations.

Given that many healthcare workers were not familiar in the way that they needed to become familiar

with COSHH and health and safety legislation we felt that just having a single reference to refer to health and safety was not helpful.

So our expectation would have been that there either would have been an appendix or there would have been signposting, not to a website but to practical or to guidance in a practical way that healthcare workers can relate to, to help them relate the IPC guidance to the implementation of COSHH.

Q. May I ask you about that, though, because one of the things we've heard obviously is the guidance changed a lot throughout the pandemic and the difficulties of keeping up with the guidance --

A. Yes.

Q. -- is something that's been raised. How practically helpful is it to give yet more information to the healthcare workers by way of an appendix, perhaps, as you have just suggested?

A. I would have liked to have seen that at the beginning. So when SARS-CoV-2 was downgraded from a high consequence infectious disease, which would have happened at some point in the pandemic, we all accept that's a natural part of the process, that first iteration of guidance was absolutely critical because it sets the bar for what would follow given that learning

would take place and guidance would inevitably be adapted over time.

So March 2020 would have been the time to really put additional resources, FAQs, guidance, tips for whatever it was, in, that then would have guided employers, managers and healthcare workers through the rest of the pandemic.

Q. Would it have been too late to have done it later in the pandemic or perhaps between wave 1 and wave 2?

A. Well, providing information is always helpful but that first iteration, because everything falls from the IPC guidance, you know, assumptions around demand fall from the IPC guidance.

So, for example, being able to understand the demand for PPE, taking into account that individual healthcare workers would at times need to consider the risk to them and perhaps use an FFP3 mask instead of a surgical face mask, for example, that could have had a profound impact on the modelling for PPE supply, rather than just referring people to the IPC guidance which felt very flat in a one-size-fits-all.

Q. May I ask you about one particular piece of guidance. We know that there was in April 2020 the acute shortages guidance that came out.

A. Yes.

Q. Particularly at that time we've heard there was a real shortage of gowns at that time, and that guidance in short advised sessional use of some PPE or reuse of some PPE, and I think the guidance said that HSE had approved that where it was safe to do so, where there were acute shortages.

You make the point in your statement, Mrs Gallagher, that that guidance was developed without full and formal consultation with the RCN and that the RCN did not support that guidance.

A. That's correct.

Q. And why did the RCN take that position?

A. The RCN, I mean, this is after the fact but we were really surprised at the speed at which this guidance was developed, and also surprised that shortages of PPE hadn't really been considered and built in at an early stage, so it would be completely understandable and expected, given the global supply chain demands, that we would run short of PPE. It was never going to be perfect all the time.

If this had been -- if this guidance, this concern had been addressed earlier, with multi-professional stakeholders including nurses, because it wasn't just us that were facing risks, our other colleagues were as well, then that would have given us an opportunity to

think about the types of messages we might need to give to our members, what sort of questions, you know, to prepare answers for when they were concerned. But given that we had had shortages of PPE, as identified in our survey, and then members were asked to reuse PPE potentially, it just added to the concern and added to the confusion and further eroded that confidence around: am I really protected when I'm going to work to do my job, which I want to do, to look after my patients but I am at huge risk from getting an infection.

Q. It might be said by those that brought it in that they needed to do it at speed because there was such a shortage and so they had to do something to try and bridge the gap.

A. Yes.

Q. But when it came out how did it go down with the RCN's members?

A. So RCN members were really concerned and our country directors in particular were really concerned, and in fact the other nations, so Wales, Northern Ireland and Scotland chose not to accept the acute shortages guidance and relied instead on their supply of PPE. So this was predominantly an England-only issue, for want of a better word.

Although the technical aspects of reusing or

decontaminating PPE were considered, and indeed some of my decontamination colleagues, actually, what didn't really follow was good communication and explanations around that and that was the main concern of our members.

Q. I think you say in your statement that Dame Donna Kinnair who was the chief executive of the RCN at the time wrote to the Secretary of State for Health and Social Care who was in fact cited on the acute shortages guidance, as I understand it, and indeed the chief executive of Public Health England raising concerns about the lack of consultation with the RCN and advising both the Secretary of State and the chief executive that the RCN did not endorse the guidance?

A. Yes.

Q. Do you know whether there was any response from the Secretary of State and/or the chief executive of PHE?

A. I don't, I'm sorry.

Q. So it's not to say there wasn't one but you don't know?

A. I can't recall, I can't recall one.

LADY HALLETT: Had the RCN and other interested parties been consulted, Mrs Gallagher, what difference would it have made to the guidance as it went out?

A. So we would not have had -- well, I may have had some

views on how PPE could be reused and what was safe to do and what wasn't safe to do, but this was around helping our healthcare workers say confident. I, to this day, don't understand how considering shortages of PPE wasn't taken into account at a far earlier stage and then thinking and engagement around how we might broach this really difficult subject would have been started to think -- thought about a lot earlier because to do it in what was in effect, I think, about 48 hours is incredibly fast and people are working at pace with other demands at the same time.

So, you know, it was just incredible that, you know, as the largest part of the workforce and that nurses were using predominantly the most PPE, we weren't engaged in that discussion.

LADY HALLETT: That I understand as a principle, that obviously as the people who were the most affected you should have been consulted. I understand that. But my question really is, what difference would there have been to the guidance if you had been consulted?

A. There probably wouldn't have been any difference in terms of the technical aspects of the guidance, we may have had some comments around how healthcare workers could have stored their masks safely, knowing how people can put things in pockets, you know, what to do, what

not to do, things like that, and looking at what might happen in different care settings rather than just in an NHS hospital, but the technical aspects probably would not have changed but we would have been able to support potentially, given the situation, if we had been able to look at communication and things like that.

I do feel, though, that the position of the RCN would have remained reflective of the position of the other countries in that we needed to keep the PPE supplies coming in rather than potentially rely on reusing PPE as a stop gap or to keep the PPE going.

LADY HALLETT: I've got one other question that I was going ask anyway but has arisen. You say the other countries, Wales, Northern Ireland and Scotland didn't accept the guidance, so what happened? What happened?

A. They chose not to implement the shortages guidance. So they maintained their efforts, as I understand it, on having the PPE supplies continuing to come through, so there wasn't a need for them to implement it. And in fact they didn't advise that that's what healthcare workers did.

LADY HALLETT: One more question. But surely in England they carried on trying to get supplies?

A. They did. So the acute shortages guidance was written, I -- forgive me, but I'm not aware that it was ever

really implemented, it was, it was -- they were getting really, really close to running out of PPE so they had to have something in place to do that.

MS CAREY: My Lady may recall that when the Chief Nursing Officer gave evidence Northern Ireland sent 25,000 gowns over to England to try and stem the problem, and as I understand it, the shortages were not so acute in the other nations that they required the guidance.

A. There was an issue of mutual aid between the countries as well as between NHS organisations and somehow they managed to keep things going.

Q. Thank you. Mrs Gallagher, it is my fault, I asked you a bad question but I think in fact in your statement you do go on to set out that PHE did in fact respond to Dame Donna's concerns.

A. Right.

Q. Dame Donna had asked them for the evidence base on which the acute shortages guidance was issued and although PHE indicated that they were worried about the concerns that the RCN had raised, they did not provide the evidence base that Dame Donna had requested.

Now, can I ask you, though, about some guidance that did come from the RCN which was that I think given that there were concerns about availability of PPE, RCN published guidance to the members about refusal to

treat?

A. Yes.

Q. Can we have a look, please, on screen, at INQ000328905.

May I, perhaps before we descend to some of the detail there, why was it necessary for the RCN to publish a guidance which might be telling the nurses you don't have to treat people in certain circumstances?

A. We had been having an increasing number of concerns raised by members and had actually published guidance on PPE, am I safe in the wake of the shortages guidance, and also given the ongoing flux, I suppose, in terms of supply of PPE.

This really came to a head, and in particular Northern Ireland had a specific concern around the supply of PPE in discussions with the First Minister in Northern Ireland. So my recollection is that we brought this issue back because it was starting to be raised, and rather than wait for members to potentially refuse to treat patients, we would issue guidance on what needed to be considered, given this huge tension around protecting the patient and protecting the healthcare worker and what this actually meant in practice.

Our professional code takes precedence, so this is not about somebody just walking into work and suddenly refusing to treat patients; there is a process to go

through and there are implications for healthcare workers should they actually find themselves in that situation. But, given that, what I would say and what our members were also aware of in some settings was that a precedent already existed in terms of what healthcare workers should consider and could do if they found themselves in danger. So an example would be a community nurse, for example, going into a patient's home where weapons were present. If the healthcare worker felt themselves to be in danger, she could withdraw, and then there was a process to follow.

So this was really an extension of that, and also the precedent that exists in other professions when faced with danger.

Q. Now this came, I think, about on 9 April 2020. Can we just go to page 2 because at box 6 there's various steps that the RCN urging the member to consider before getting to this stage. Box 6 says:

"Ultimately, if you have exhausted all other measures to reduce the risk and you have not been given appropriate PPE in line with the UK [IPC] guidance, you are entitled to refuse work. This will be a last resort and the RCN recognises what a difficult step this would be for nursing staff."

And they advise them to talk to local reps or

indeed phone a telephone number to take advice.

A. Yes.

Q. Do you know if any nurses did in fact refuse to treat?

A. To the best of my knowledge, no nurses did.

Q. And was there any criticism of perhaps those who were talking about refusing to treat or thinking about potentially following and implementing this guidance?

A. It was an incredibly difficult subject to have conversations with people about, clearly even when considering the potential to not provide care to patients, that is incredibly difficult for nurses to do, and obviously the other issues were around how their colleagues may feel in the same areas and things like that, as well as the implications from a managerial perspective. But by writing this guidance, it was available as a resource for people to read and think through in a structured way, rather than going to the workplace, and perhaps make a rash decision which is not what we wanted our members to do.

Q. In fact, if we just scroll down on the guidance, you can see there that the implications of a lack of PPE and if you refused to treat there were potentially legal consequences of dismissal, action taken by the regulators --

A. Yes.

Q. -- clinical negligence, inquests or indeed -- it may well be rare, but potential criminal charges upon it.
A. That's correct. Yes.
Q. So it was setting out fairly and squarely, if I may put it like that --
A. Yes.
Q. -- that these are difficult steps you have to consider, but there are also potentially ramifications if you do in fact refuse to treat?
A. And it was our responsibility to make our members very clear that whilst you may be in an untenable position actually there is a process and there are implications if you go down that line. This is a really important point for me in terms of learning and future planning for the pandemic is how we start to consider these issues for the next incident that occurs, and how we broach these really difficult conversations and this tension because if our healthcare workers are getting infected and are unable to work on one level, obviously there's the more serious harm that can occur, then how do we manage the public's expectations and have that conversation around this really difficult ethical issue.
Q. That document can come down, please. Can I turn to a slightly different topic and that is of fit testing.
A. Yes.

Q. I think in your statement you make the observation obviously that we are aware there needs to be a fit test for FFP3. There were reports, is this right, of up to sometimes 17 different types of mask within one trust?
A. That's correct, yes.
Q. Each of which has to be fit tested?
A. Yes.
Q. And you say in your statement that some brands of FFP3 do not appropriately fit female faces?
A. That's correct.
Q. And that's been raised with the British Safety Industry Federation. Can you help now, is there any working with done to try and broaden the numbers of types of FFP3 to fit female faces, those wearing beards, all the other different problems that we've heard of?
A. So there is an issue, in that the use of respiratory protective equipment in healthcare is -- historically it's not been something that's been widespread, it's something that we've used when nursing particular patients with, for example, TB, or other infections, but generally it's not widely used. And we lost an opportunity after the swine flu pandemic to actually build that into our planning.

The FFP3 masks that we have are built on something called the Sheffield man face so a white man, about

age 50, with a certain face shape and of course we all don't fit that shape. So what we need, I'm not aware of any specific work that is going on in a structured way around looking at this, but certainly from our perspective in terms of recommendations and learning, we need personal protective equipment, respiratory protective equipment that will enable to us do our job safely. At the moment we have only what is provided, which is predominantly single use FFP3, that apart from the fact that it doesn't fit everyone and there are huge practical problems with fit testing, it's not sustainable and the wastage is huge.

So reusable respiratory protective equipment, our members are suggesting is the way forward should we need it. We need innovation at pace to find and test designs that are not only acceptable to nurses but are acceptable to our patients and can enable lip-reading and some of the practical care provision. And also, that we involve the public because they will be the recipients of healthcare workers wearing these masks.

So it's a huge piece of work but one I think that the UK would really benefit from in terms of preparing us in the future, whatever that design looks like.
Q. And I presume, from what you've said, that that answer would apply equally to some of the problems we've heard

with ethnic minority healthcare workers not having --
A. Absolutely.
Q. -- sufficient supplies of PPE that fit them.
A. And we would clearly need to take their views and their input into the design and everything alongside both for ethnicity to meet ethnicity needs but also religious needs, as you've said.
Q. I think you're aware that we have heard from Professor Dinah Gould in relation to the independent review --
A. Yes.
Q. -- that the RCN commissioned her to undertake so I don't need to ask you about that, Mrs Gallagher, and also we've heard from the Resuscitation Council --
A. Right.
Q. -- in relation to AGPs and what was or wasn't deemed to be an AGP, and so I don't need to ask you that, but I just say that so that if anyone who is following wants to look when the statement is published, there are various sections in your statement dealing with that.
A. Yes.
Q. Can I just ask you this. In your statement you set out over 25 or so pages a chronology of the RCN's concerns that were raised with government, with the IPC cell and with other bodies, other stakeholders, and I'm not going

to go through all of it but there are some topics I'd like to ask you about, please.

Clearly you say -- have told us already that certainly in the beginning of the pandemic there was concerns raised across all four nations about the lack of PPE in March 2020, going into April 2020. And I think, is this right, that Dame Donna wrote to the Prime Minister on 23 March raising concerns? There was a similar letter sent to the First Minister of Scotland --

A. Yes.

Q. -- and indeed one to the Welsh minister.

Indeed, in relation to the Welsh minister there was concerns about PPE being of poor quality, so not just the lack of it but the quality of it once it was available.

Perhaps we could just put up on screen the letter to Vaughan Gething. It's at INQ000417538.

It's from the Royal College of Nursing's branch in Wales. 27 March. We've just gone into lockdown. The author, Helen Whyley, who is the director of RCN Wales --

A. That's correct.

Q. -- wrote to the minister and said that there was concerns. Firstly:

"The guidance is not clear and is causing confusion.

"The changes in approaches has made staff confused and not trusting of the ... guidance."

As I think you've already alluded to in your evidence.

"What has been extremely challenging is the constant change in advice/guidelines, particularly in relation to PPE. When we are sending out updated advice this is causing anxiety with people, as whilst we are being totally transparent, people's confidence in the system is being eroded."

May I just ask you about that because there is a tension. The guidance needs to be updated --

A. Absolutely, yeah.

Q. -- as and when there are, perhaps, acute shortages as we've just been discussing, or change in the routes of transmission in due course. How do you balance the need to keep people updated without overburdening them with ever-changing guidelines?

A. What I found in my experience is that nurses understand that the guidance will need to change over time. Their real concern in phase 1 of the pandemic was that the guidance changes always came out on a Friday afternoon and there was a massive scramble to try and get the

guidance changed and implemented locally by the Monday, and the communication around why the guidance was changing, so the rationale for that -- to aid the communication and reassure people's anxiety, they felt was lacking. So that was a major concern there that -- of course the guidance will change. Our members, I feel, would have been reassured if they felt we were around the table. Now, that may have resulted in criticism for us if they didn't agree with what the guidance said, but there was -- by that time their confidence was, as the letter says, really being -- becoming eroded.

Q. Can I just ask you about something you said there. You mentioned the guidance coming out on a Friday afternoon and we heard from a witness from the RCN just before you gave evidence who said, "It seemed ridiculous that I needed to wear a mask on Monday and I was given a weekend of not wearing a mask and therefore being at risk."

A. Yes.

Q. How practically possible would it have been for a guidance to come out on a Friday afternoon saying: from now masks have got to be worn?

Is that realistic for the trusts and all of the other settings to be able to bring in mask wearing

forthwith?

A. It was incredibly difficult. So some of that may have been something around making sure the supplies were in place, I don't know. What I do know is that infection prevention and control specialist nurses found themselves really stuck in the middle of trying to implement the guidance that was coming down from the UK infection prevention and control guidance and then implementing it in practice to meet the needs of the board and senior managers so they could say they were complying with the guidance whilst dealing with healthcare workers on the ground who were asking them many, many questions about why that was, and asking for explanations and those infection prevention and control nurses often didn't have the answers.

So there was a huge amount of pressure within the system at all levels to implement the guidance quickly and at pace.

Q. I think just to finish off with this letter. Can we go to the second page, please and the section beginning:

"PPE is of poor quality and unsuitable.

"... very poorly produced, is one size, so for example the visors fall off and does not instill confidence.

"Staff fit test one mask and then get issued

with a different type of mask so have to fit test everyone again -- no one has capacity to keep doing [that].

"We fit test with one mask and then get issued with a different type ...

"FFP3 ... only to be used in certain procedures. [There are] only 30 masks given for a team of 30 ... [so] we have to wear basic fluid repellent masks.

"Basically our PPE is Apron, short gloves, fluid repellent theatre masks and [what are described as] Christmas cracker glasses."

So fairly clearly telling the Welsh minister --

A. I think this was a draft letter. There's a "draft" water print through so you will have to forgive me, I don't know if this letter actually went but what it's doing is really describing the reality on the ground of the challenges that were being faced in relation to PPE provision and many of the issues that are mentioned here are actually reflective of what happened in the other countries as well.

Q. The statement doesn't say it's draft but perhaps you can clarify if we need to. Certainly Mr Gething --

A. Sorry, I saw the watermark on the previous page.

Q. No, not at all. If it is a draft we'll deal with that

by way of correction, but the statement says that was the letter that was sent and he responded a couple of weeks later --

A. Oh, all right, thank you.

Q. -- noting the Welsh Government were working hard to have extra supplies of PPE.

You say that the Prime Minister didn't respond to Dame Donna's letter.

The Scottish minister did respond to -- it went to Scotland.

And in relation to Northern Ireland, letters were sent to the First Minister and Deputy First Minister, I think, is this correct, about a lack of PPE? There was a holding response that the department was not in a position to respond due to volume of work --

A. That's correct.

Q. -- but the letter had been sent to what was described as the lead policy official?

A. Yes.

Q. Thank you, that document can be taken off the screen.

And may I ask you, please, about one aspect of the chronology that you mention in your statement. It is at paragraph 176, Mrs Gallagher. We are in November 2020 and the RCN wrote that month to NHS England asking for clarification about the IPC guidance.

"We reiterated our concerns that while the recent publication of guidance for domestic settings implied airborne transmission, IPC guidance and policy did not seem to align with this in a clinical setting."

Which had caused confusion and questions to be asked about the risk in healthcare settings?

A. Yes.

Q. Can you just summarise, please, why it was that the RCN wanted the IPC guidance to make clear whether there was airborne transmission or implied airborne transmission? Why was it so important for your members?

A. Our members, nurses, healthcare support workers, cadet nurses, students, are members of the public that happen to be nursing professionals. So when they saw the Cabinet Office video talking about the need to open windows, have good ventilation because Covid was airborne, that led them to reflect on that in their own domestic settings or perhaps if they were going to patients' own homes, and then to consider the stark difference in hospital settings, where actually we have no particular ventilation unless you're in specific areas like operating theatres, bone marrow transplant ITUs for example, so nurses knew that there was no ventilation in hospitals, our ability to open windows generally is extremely restricted so these are stuffy,

hot environments so when they looked at the video and reflected on what that meant where they worked, they noted the difference there.

So if Covid-19 was in fact airborne, which was the challenge that they put to us, then that meant that it had implications for the infection prevention and control guidance on one hand, but also what was the NHS estate going to do to make it safe by improving the ventilation or looking at other technologies that could support it to let Covid out, which was what the public were being advised to do.

Q. I think those concerns remained extant in January of 2021 when Dame Donna wrote to, I think the chair of Public Health England cautioning them against group think.

A. Yes.

Q. And indeed continued until, I think, May 2021, when the RCN issued a press release.

And can I have up on screen, please, INQ000114429.

The concern in the press release was a global recognition that Covid is airborne shows the UK is lagging behind, and there is reference in there to the alliance members, which includes the RCN, AGP Alliance, the Fresh Air NHS writing to the Prime Minister to express their concerns.

"They say the response they received from Number 10 failed to recognise the growing evidence that the virus could be spread in tiny particles known as aerosols."

And there was reference to SAGE, the WHO, and I think the CDC in the States beginning to recognise airborne transmission, yet UK guidance only recommends the use of higher grade FFP3 respiratory masks for a limited range of procedures.

Why did the RCN take such steps as to make a press release like this, which is fairly critical, I think it's fair to say?

A. It is. I mean, the concerns were -- because we had seen at least two new variants by that time, each one increasing in transmissibility, and a healthcare worker or nursing workforce that was really starting to become affected by Long Covid and also the rates of healthcare-acquired Covid-19 along with our patients.

So we had been really trying to influence behind the scenes since November/December 2020 to have the IPC guidance changed and really it was a case of a last-ditch attempt to try and get the issue discussed in the open and to try and influence change but we weren't able to do that, despite the fact that, as you said, the UK guidance was contrary to other guidance

including within Europe by ECDC.

Q. Thank you, that document can be taken down.

May I ask you about one thing you do say in your statement was that at times, certainly at the end of December 2020, there were obviously enormous pressures on IPC staff and there was concern that there was some non-adherence to IPC guidance?

A. Yes.

Q. How did that get reported back to the RCN, the non-adherence?

A. We didn't actually hear much about the non-adherence to IPC measures until we received the communications from NHS England. What we did know was that there were many nurses and other healthcare workers off sick. We knew that staff were by now extremely tired and all the existing literature, not about Covid but about the state of the workforce points to how missed episodes of care or mistakes or errors can be made if you are short-staffed or are looking after too many patients.

So when we received that information from NHS England I wasn't surprised that there was concerns being raised around a lack of adherence to infection prevention and control guidelines, which are clearly the gold standard that you would expect, but actually what hadn't been taken into account was the state of the

workforce and how it was really struggling to do the right thing at that time.

So what our members subsequently told us was that they felt blamed for increasing rates of healthcare-acquired infection of Covid-19 but in fact they were decimated as a workforce and didn't have the time or capacity to do the right thing.

Q. Did the RCN take any steps itself to try and reinforce the need for compliance?

A. We were invited to review -- to go to a meeting and to review a survey that was planned to go out in early January. We reviewed the survey, but actually the questioning, the way that the questions were posed we felt wasn't helpful to members, and in fact it could result in healthcare workers being blamed even more for increasing rates of healthcare associated infections.

Q. May I change topic, please, Mrs Gallagher, and ask you about the reporting of data relating to the deaths of healthcare workers and nurses in particular.

If it helps you, I'm at around paragraph 130 onwards in your report. But in short, we've already heard there are difficulties with ascertaining a precise number of deaths of healthcare workers. Why did the RCN say it's so important that this data should be collected?

A. Despite the fact that you're in a pandemic which is clearly a chaotic and very busy situation, data is absolutely critical to give you an indication over time on what the situation is, but also to be able to adapt and change practices if needed. So the data that was provided on healthcare worker infections, although it was reported as initial data a bit more frequently than it was published, it was extremely lagging, so it was published monthly but reported quarterly.

So that meant that if organisations were trying to adapt and put in place interventions, so for example some organisations moved their healthcare workers to wearing FFP3s for all suspected or known patients with Covid-19. Then actually understanding the impact of that on healthcare worker infections, that data is absolutely critical.

And, likewise, to support learning after the event, we need good data so we can build that into future planning and our future understanding of what worked well and what didn't work well.

Q. I think you say in your statement that you think data ought to be collected as well from non-NHS organisations. Who did you have in mind?

A. So our membership, includes as I said before, nurses working in independent healthcare settings and adult

social care, so I would include all the data from those settings as well.

Q. And can I ask you, Mrs Gallagher, who do you think should be the body or the organisation to actually collate this data?

A. That's a really important question, and the honest answer is I don't know given the current organisations we have and their roles and remits. I would not suggest -- and this is my personal view -- that it is not the role of UKHSA -- because we are not talking about surveillance data per se -- they may disagree -- I don't believe it's the role of the Health and Safety Executive. Our suggestion would be that we need to consider how we can collect data from a UK perspective and a standardised way as a minimum data set. Perhaps it needs an independent organisation, but something where we can all feed in digitally, in realtime, and then look to clarify the data afterwards.

Q. And presumably make it comparable across all four nations --

A. Yes.

Q. -- so we are comparing like with like?

A. Yes, we understood that the data was collected and reported in slightly different ways across the four nations, and that wasn't always helpful in trying to get

a sense of what was going on from a UK perspective. So, yes, a standardised minimum set across the UK that everybody feeds into, but then everyone can use that data to suit their needs.

Q. That brings me to recommendations, please, and I'd like to ask you about a number of them that you've set out in your statement. Clearly, data for those healthcare workers that died is one of them. I think you advocate for nursing input into the IPC guidance, including early on in a pandemic?

A. Yes.

Q. And we've looked at that. Can I ask you about this, though. You recommend that there is input from non-IPC specialists --

A. Yes.

Q. -- when producing future IPC guidance, including health experts, occupational hygienists, aerosol scientists, occupational health and wider professional stakeholders such as paramedics, speech and language therapists. A number of people there that you would advocate for being involved in the guidance. Can I ask you this though, might that be actually a danger of too many people being involved in it so that you don't turn it around as quickly as one needs to do particularly at the beginning of a pandemic?

A. We may need to look at how we write guidance in a slightly different way, but I absolutely believe that these non-IP specialists are critical in terms of shaping guidance. Their input would I imagine be different in different ways but certainly my -- from my experience in clinical practice I heavily relied on my authorised engineers for decontamination, my health and safety leads, parties in other areas, estates and facilities to help me make sure that the infection control policies that we were writing were set in the right context and able to be implemented. And the same would apply but on a national basis, so it may not be a small group that write the guidance, but that doesn't mean that everyone has to be around the table at one time. There are different ways of working.

And the most important thing for me, as I've said before, is that infection control guidance has to be implemented in context. So one-size-fits-all doesn't necessarily work. So whilst you may not have an aerosol scientist working in a prison, for example, they would be able to take the principles and look at what that meant in different care settings with professionals.

Q. One other recommendation that you would urge her Ladyship to consider is funding for the urgent development of reusable RPE --

A. Yes.

Q. -- is acceptable to staff and patients?

A. Yes.

Q. Help us, why you urge that recommendation, and when you say is acceptable to staff and patients, what do you mean by that?

A. So we have to be prepared for future pandemics. There will be a future pandemic and it may well be one that is another respiratory virus, whatever that is. It may not be, it could be something else, but in terms of protecting us from infection where we are inhaling the pathogen, we need protective equipment. So our experience from this pandemic is that constantly fit testing, and looking for different multiple types or trying to draw on global supplies of FFP3s, wastes a huge amount of energy and resources.

We need to train our healthcare workers to become more accustomed to the wearing of respiratory protective equipment in the future so we need to find a solution that is comfortable, that both in terms of being able to breathe, but also heat, because our workforce is predominantly female and there are particular issues for the female workforce. We need to be visible. As I said before, we need to be able to lip-read or patients to lip-read for us, and to have our own equipment that we

take responsibility for, rather than put the shared pool of equipment -- which our members were very clear that they did not want -- is something that we need to look at in the future, but the design needs to involve many stakeholders, our patients, and the public. And it is an area where I think it would make a huge difference in the future.

Q. Final question from me, please. We often hear lots about what didn't work well during the pandemic. Are there any aspects of the healthcare systems response that you think did work well that we should adopt in the event of a future pandemic?

A. I was really impressed at how the nursing workforce, both those that were employed at the time but those that came back from retirement, actually responded to the pandemic, and also the public's response in terms of supporting us with that. So that worked extremely well, but in order to maintain it, that workforce needs to be confident. So we need to address the learning, rapidly, to support that.

There was a real sense of camaraderie, and from my personal perspective I'm incredibly grateful to all those that supported me through intelligence and guidance, and answered my endless questions and the check-ins that came with assuring me that what we

advised as the RCN, or what the RCN needed to consider, was both appropriate and relevant and the right thing to do. So I'm very grateful to them.

MS CAREY: My Lady, those are all the questions I ask. There are some questions from core participants.

LADY HALLETT: There are.

Ms Peacock.

Behind you, Mrs Gallagher, but if you could make sure your answers go into the microphone, please. Thank you.

Questions from MS PEACOCK

MS PEACOCK: Good afternoon. I ask questions on behalf of the Trades Union Congress. My questions relate to the reporting of Covid-19 infections in healthcare workers to the Health and Safety Executive, which of course you've touched upon already.

You explain in your witness statement, I'm just going to return to it, at paragraph 133 that revised RIDDOR guidance produced by the HSE on 17 April 2020 had the effect of requiring definitive evidence that Covid-19 was contracted as a result of exposure in the workplace, and you set out the threshold and go on to say this revised guidance stipulated that it was most likely, even in a healthcare setting, that a case of Covid-19 would have been contracted in the community

rather than in the workplace.

The HSE has disclosed to this Inquiry the numbers of RIDDOR reports received by the HSE from NHS employers between two dates, and that's 16 May 2021 and 19 February 2022. The data they've disclosed shows that between those two dates, out of the 98 NHS employers listed, 51 made three or fewer RIDDOR reports in total for infections and fatalities.

And just for reference for others, that is at INQ000269831 at table 1.

So just reflecting on that evidence, and given what you've set out about the threshold for making a RIDDOR report, and the guidance that went with that, does it surprise you that RIDDOR reporting was so low in so many trusts?

A. It does, and the fact that we have this huge variation in reporting given that the whole of the UK was impacted by Covid-19 to me means that, well our expectation would have been that the Health and Safety Executive would look at why there was this variation, and was it down to people not understanding the change in requirements from RIDDOR reporting, or was it in fact down to some other form of bias that was present in the system? So, yes.

Q. And just reflecting on the fact that the guidance came with a warning that it was most likely contracted

outside of the workplace setting, is it fair to say that there are elements of the guidance that are in a sense dissuading employers from making a report?

A. Yes, the conditions as I recall that were required for RIDDOR reporting were felt to be very limiting in health and care settings, and the reality would be that in fact very few patients would, for example, rip the face mask off the face of the healthcare worker. It also meant that if it was acquired at work, there could potentially be questions and insinuations around whether staff and managers were complying with the PPE guidance through the IPC guidance.

So it was a very difficult situation, and certainly in terms -- it wasn't felt to be helpful for our members in terms of collating data in the first place.

Q. And do you have a view as to what the threshold or the guidance around making a RIDDOR report to HSE should have been or as to how the guidance should have been different?

A. I can't comment on that specifically, it's not my area of expertise, but what I can say is, for future incidents, the recommendation I would make is that we need to think very carefully about whether or not RIDDOR reporting is actually helpful in those situations, or

whether we need other forms of data to support us and the role of the health and safety executive which they would of course continue to have. What would be better in a different situation?

Q. So we need to really re-think the system and consider whether more wholesale reporting of infections is required?

A. Yes.

MS PEACOCK: I'm grateful, those are my questions.

LADY HALLETT: Thank you, Ms Peacock.

Mr Thomas.

Mr Thomas is also behind you.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: I'm representing the FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

In your witness statement at paragraph 128, you address concerns raised by ethnic minority members of the RCN regarding inappropriate treatment during the pandemic, and you note that the draft reduction framework was viewed as lacking cultural sensitivity and did not include comprehensive equality impact assessments. Yeah?

So here's my question. When the RCN launched its own toolkit in December 2021, how did it address these identified shortcomings?

A. Are you referring to the risk assessment toolkit?

Q. Yes.

A. When we developed this toolkit, as I said before, it was very much focused on COSHH but we were very mindful of how to support our black and ethnic minority members in terms of supporting their awareness raising but also how they could raise concerns in the workplace.

Have I gone off-track?

Q. No, no, I'm listening to you.

A. We focused it very much on the process that was there, but put a lot of effort into communication through our branches, through our representatives in helping to raise awareness across our membership. So the toolkit was applicable to all members but recognising that some members felt very challenged in terms of raising concerns, as we've identified in our PPE survey.

Q. Okay, well, just touching and following on from that. Were specific measures implemented to ensure that the toolkit was culturally sensitive and could be adapted to meet the diverse needs of healthcare workers from varied backgrounds?

A. In the process of developing and publishing the toolkit we have an internal quality assurance process and that quality assurance process has a number of criteria, and one of those is to undertake an equality and diversity

assessment. So that equality and diversity assessment was done as part of the process prior to publication of the toolkit. And that assessment takes into account existing evidence, how we worked with our stakeholders around that and how we implemented learning from previous incidents.

So I hope that goes some way to answering your question.

Q. Let me move on to my next question. The RCN conducted extensive surveys as early as April/May 2020. Could you explain why, despite this early data collection, the toolkit was not launched until December 2021?

A. The risk assessment toolkit really came about specifically after we had exhausted all other efforts to try and have the infection prevention and control guidance amended. So it was after June 2021 that we took the decision to put our energy into supporting people specifically around the risk assessment process.

This was predominantly because in many communications and conversations we were constantly referred to the hierarchy of controls within the infection prevention and control guidance which forms part of that risk assessment process. So -- and the reason we didn't implement the toolkit earlier was because our attention was focused on trying to influence

the guidance rather than specifically risk assessment.

Q. You would agree that timing was crucial, right?

A. I would.

Q. Let me move on to my last question. Were there specific challenges or constraints that contributed to this delay and in retrospect what steps might be taken to ensure that similar resources are made available more swiftly in a future health crisis?

A. If I can answer the second bit first. So our learning from this and recommendations we would make is that we need to educate and raise awareness amongst the whole of our workforce on what risk assessment means in practice and in particular what it means in the context of biological harms as opposed to, perhaps, chemicals that we might use in practice. So we have -- we need to look at what's needed and how we do that and perhaps who should be leading in implementing that.

Could you repeat the first part of your question, sorry?

Q. The first part of the question is ...

LADY HALLETT: Were there specific challenges or constraints -- have you found it, Mr Thomas?

PROFESSOR THOMAS: Yes, I have.

Were there specific challenges or constraints that contributed to the delay?

A. Not specifically. We were trying to focus, because everything fell from the IPC guidance, so that became our main focus to try and amend and get adapted. It did include some reference to expanding health and safety content within the guidance, but that took utmost of our concentration in the early stages of the pandemic and it wasn't, as I said, until we felt we had exhausted that we felt that we needed to produce something different. We looked at a number of options and the toolkit was something that was the final sort of decision that we came to around that.

PROFESSOR THOMAS: Thank you.

Thank you, my Lady. Those are my questions.

LADY HALLETT: Thank you, Mr Thomas. Are you okay to return this afternoon; you were warned?

THE WITNESS: I am.

LADY HALLETT: I shall return at 2 o'clock this afternoon.

(12.59 pm)

(The short adjournment)

(2.00 pm)

Questions from MS MITCHELL KC

LADY HALLETT: I think it's Ms Mitchell next, isn't it?

MS MITCHELL: I appear as instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved, and my learned friend, when she was asking you questions, asked

about refusal to treat and I would just like to ask you a few follow-up questions on that.

You gave evidence that you didn't know of any examples of refusal to treat if a person had not been given appropriate PPE to do so. Might it be that the fact that you didn't know of any examples is because of what you also referred to earlier in your evidence as not raising concerns due to a general lack of confidence that they would be dealt with properly?

A. You mean as a barrier to not pursuing the refusal to treat guidance?

Q. Indeed.

A. In all honesty, I'm not sure. What I think may well have happened in practice, in settings where a number of patients were being looked after by a team is perhaps discussions took place around allocation of team members. So where specific risks were identified and members were hesitant or afraid for whatever reason, vulnerable family members at home being pregnant themselves, that they may have reallocated some of those resources. So it wouldn't be a refusal to treat in its -- in those words, but we would move the staff around not to put staff under pressure.

Q. And can I just check, you started that as a hypothetical and then you ended it as an actuality --

A. Sorry.

Q. -- of moving staff around; did that happen, is that what happened?

A. No, I have no knowledge of that, but knowing how nursing teams work in different situations where there are particular issues, maybe there'd been an issue with a particular patient or a nurse might not be immune to chicken pox, for example, if there was a patient with chicken pox in the side room and things like that, it doesn't come out as a refusal to treat, but we might reallocate in the first instance. So I am hypothesising. I don't know the --

Q. You explained to us something perhaps very understandable that refusing to treat and -- refusing is an incredibly difficult to talk about and a really difficult ethical issue. Is it possible, in those circumstances, that these issues, the way you're describing them, were sometimes fudged? What I'm looking to see is, do we really not know the real position in relation to whether or not there was or wasn't refusal to treat?

A. I can only report on what I know or don't know, and I don't know of any instances where refusal to treat was implemented. That's not to say that theoretically that may have happened, but it's nothing I'm aware of. It

may be something around the language. As nurses we may not talk about refusal to treat in that terms, but that's the language that -- the technical language that's been used in the guidance that the RCN has issued. So that's why we really need those conversations to unpick, have clear language, and talk about this issue, because it's such a huge ethical issue for everyone involved.

Q. And following up from that, had there been refusal to treatment, would you know about it, ie, would it have been recorded and would you have been informed?

A. The only potential way that I can see that I would find out about it would potentially be if it came through RCN direct call line. The key message of the guidance was: talk to us. So I would hope that members would have contacted us somehow through the various routes to enable us to have that conversation about the situation, about the risks and about the implications for them, for us to then signpost them on perhaps where they might go next.

Q. Finally, you said that the guidance was produced as a resource, and you said so that members didn't make rash decisions; what did you mean by that? Did you mean a rash decision in relation to refusal to treat, or a rash decision in relation to continue to treat without

the appropriate PPE?
A. I was thinking of the former, but we do any that a lot of nurses continued to work and put themselves at risk, knowing they were at risk. And there is very much a culture within nursing where the -- which we all accept, which is that the patient comes first, and there is an inevitable -- how did a nurse describe it to me? -- occupational hazard acquired with getting an infection as a result of caring for people, whether it's Covid-19 or something else.

And we need to change that culture, but we need to do it in a way that suits everybody's needs.
Q. And is that because whilst there's the need to treat people, there's also the danger of treating someone when you're not properly protected means that you're exposing them to further risk?
A. There is that, but also there's a wider issue around our finite workforce numbers as well. So there is this inherent tension between how do we approach a situation where staff are clearly at risk of acquiring infection and then being off sick which further depletes an under-resourced workforce, how do we work through these huge ethical issues, and that has to be part of our future pandemic planning.
MS MITCHELL: My Lady, those are my questions.

LADY HALLETT: Thank you very much, Ms Mitchell. Very grateful.

Next, I think it's Ms Shepherd -- behind the pillar, I don't know if you've got a direct line of sight.
A. I have, thank you, my Lady.

Questions from MS SHEPHERD

MS SHEPHERD: Good afternoon, Ms Gallagher. I appear on behalf of Covid-19 Bereaved Families for Justice Cymru. I have two topics to ask you about. The first is testing.

Now, for context, the Welsh Government did not introduce routine testing of healthcare staff until December 2020 although full roll-out was supposed to commence from January 2021. In fact, it did not occur until much later in 2021, and in some cases as late as July 2021.

So, questions arising from that. Were any concerns raised by RCN's membership regarding the absence of regular testing for healthcare workers during that implementation period?
A. I can't recall specifically at this moment, I would need to refer to our RCN direct inquiry to get that information for you.
Q. Thank you. The second question is, are you aware of any

impact that the delay on implementing regular test wooing have had on patient or staff safety?
A. Not directly, and I don't recall any specific actions coming to me in particular. We were talking at the time around testing from a UK perspective and some of the general issues around that and how to manage staff that were found to be infected but asymptomatic and isolation etc, but in relation to Wales specifically, I don't recall anything.
Q. I'm going to move on to my next question then, which is, there is a letter from September 2020, where the Chief Nursing Officer for Wales, who is Professor Jean Wright, and the Deputy Chief Medical Officer in Wales, Dr Chris Jones, wrote to all health boards in Wales, and I am just going to very briefly quote from what they say:

"We are writing to reiterate the essential requirement for routine SARS-CoV-2 testing in unplanned emergency and urgent admissions to our hospitals.

"We are concerned to discover that following an investigation into a recent outbreak that not all emergency admissions to one of our hospitals is being tested. We have become increasing aware of the significant amount of Covid-19 transmission in

patients who are asymptomatic or presymptomatic."

They go on to say that routine testing of admissions is critical.

Was the RCN aware of any operational difficulties in implementing testing in September 2020?
A. I can't recall any specific issues around implementing testing at that phase. A lot of the discussions, as I recall, centred around how we would manage staff and staffing if staff were found to be positive, but I don't recall anything specific, sorry.
Q. Final topic and final question. At paragraph 87 of your witness statement you say that:

"At a time when strong evidence of the transmission dynamics of SARS-CoV-2 may not have satisfied those developing and approving IPC guidance, the RCN expected a more precautionary approach to be adopted rather than the position of no evidence to justify no change to IPC guidance."

Are there any particular measures that you say should have been adopted on a precautionary or a common sense basis?
A. A lot of our activities, you will have heard, focused on preventing the risk of essentially inhaling the virus and staff becoming infected, therefore we're generally naturally drawn to wearing respiratory protective

equipment, but our focus actually was also around improving ventilation in health and care facilities although the mask discussions got most of the attention. So we did feel that there was a scarcity of information within the IPC guidance on ventilation that would then have enabled staff to perhaps think more -- in more detail around the hierarchy of controls and then come to decisions around what PPE was required.

Q. One follow-up. When you talk of hierarchy of controls, you're really saying that before we even get to RPE, we should be thinking about what we can do to reduce the amount of virus in the air first?

A. That's how the hierarchy of controls is supposed to guide people to think about how you can reduce risks, but the hierarchy of controls isn't a linear process. You can consider and implement more than one control at once, so it's not something that you have to move through from level to level, and in fact knowing that the ventilation in many areas was insufficient would help guide practitioners to that decision around RPE. I have an analogy if that would help, but I don't know if there's time.

MS SHEPHERD: I'm in my Lady's hands.

LADY HALLETT: Very well.

A. The analogy a colleague described to me which I found

very helpful because around the confusion around the hierarchy of controls is how you protect people inside a castle from an invading army. So when you have a castle or a fort and an invading army, you have a number of controls in place to prevent that army reaching you on the inside. So you might have a moat, you have a drawbridge, you have a number of other controls. You don't wait until the army has swum the moat, got through the drawbridge, climbed the wall, and got into the inner courtyard before you issue them with a bow and arrow. You give them a bow and arrow that's available first while you try and use the other controls that you have in place. So that's what I mean by not being a linear process, but lots of people got very confused about the hierarchy of controls and felt they couldn't move to PPE. And that's why the hierarchy of controls were viewed as being too restrictive.

MS SHEPHERD: Thank you, Ms Gallagher. Thank you, my Lady.

LADY HALLETT: Thank you, Ms Shepherd. Ms Alexis. Behind you.

Questions from MS ALEXIS

MS ALEXIS: Ms Gallagher, I ask questions on behalf of the COVID-19 Airborne Transmission Alliance, CATA, and my

questions relate to the topic of IPC guidance, please. You've helpfully told us, and it's at paragraph 210 of your witness statement for those following, about a widely-attended PPE IPC guidance stakeholder engagement meeting that took place on 3 June 2021 and we know that you attended that on behalf, of course, of the RCN and also present was the chair of the IPC cell, Eleri Davies, the Chief Nursing Officer for England, Ruth May, the National Clinical Director of Infection Prevention and Control, Mark Wilcox, as well as Dr Barry Jones, the chair of CATA, amongst numerous others.

A. Yes.

Q. And at this meeting serious concerns were raised by and on behalf of healthcare workers on the frontline regarding the IPC guidance not reflecting the scientific evidence that Covid-19 was an airborne virus. Now, my first question is this. What did you, please, on behalf of nursing healthcare workers hope would be achieved following this large stakeholder meeting on 3 June 2021, please?

A. What we hoped for was agreement between all parties around how we could clarify the language of airborne transmission of Covid-19 that would then allow for greater protection of healthcare workers given where we

were at that point in the pandemic. It wasn't about having every healthcare worker in an FFP3 mask all the time because clearly that's impractical, as well as being very uncomfortable, so it was about making it easier for healthcare workers to do the right thing to protect themselves in those particular circumstances and up until that point the feedback from our members was that actually the guidance didn't allow them to do that.

Q. What, if anything, changed in relation to the IPC guidance as a result of this meeting, please?

A. So in effect there was no change. We hoped, because the meeting was a very professional one, to be able to continue the dialogue to move things forward. There were a number of people there and we used examples around reusable respiratory protective equipment, some was a new design, some were powered respirators, as examples of what was also possible. But actually we, in effect, didn't get out of the meeting what we hoped we would achieve.

Q. And you've said there in effect there was no change. Why do you think this was?

A. In all honesty I'm unclear. I think by that time for whatever reason the guidance was so wedded to being predicated on droplets that it just didn't change.

MS ALEXIS: Thank you, my Lady, those are my questions.

LADY HALLETT: Thank you, very much Ms Alexis, very grateful.

Next I think is Ms Munroe who is in clear sight.

Questions from MS MUNROE KC

MS MUNROE: Good afternoon, Mrs Gallagher. My name is Allison Munroe and I ask questions on behalf of Covid-19 Bereaved Families for Justice UK.

Two topics. BAME nurses, and within that umbrella a question of migrant nurses and IPC guidance and messaging, both of which you've been asked about in some detail during the course of your evidence this afternoon and this morning. So just a few specific, I hope, and focused questions in relation to that.

Firstly, on 1 July 2020 the Royal College of Nursing published submissions reflecting on issues contributing to unequal impact based upon the experience of your own members.

My Lady, for reference that's INQ000328840.

And in that submission you reported a lack of confidence amongst BAME nurses in raising concerns regarding adequate Covid-19 protection. Something like 68% said that the main reason being that they did not believe any action would be taken and almost a third, 29%, were fearful of speaking out.

Now, specifically looking at migrant nurses, one

of the issues identified by the RCN as contributing to this unequal impact was the precarious position of migrant nurses especially in light of the hostile environment.

Could you briefly, Mrs Gallagher, tell us why the RCN believed that that had an impact, a negative impact in terms of protection of migrant nurses?

A. Nurses recruited from overseas you're referring to specifically there?

Q. Yes.

A. To come to the UK to work as a nurse from overseas within the pandemic would have been an enormous strain for our nurses, particularly those from black and ethnic minority groups that had come from overseas. So in addition to having to adapt to the culture within the UK and how our hospitals and our healthcare system works, they would have been faced with many new and different ways of working that would have been, you know, very challenging to them. We know that our overseas recruited nurses were suffering potentially financially from not being able to access public funds, and we knew that Covid-19 was exposing some inherent inequalities within certain nursing groups. So all of these would have combined really to undermine their -- or not give them confidence around how they would be listened to and

how their concerns would be taken seriously.

Q. Thank you. In your evidence this morning in relation to BAME nurses and the lack of confidence in raising concerns, you reiterated that the RCN needs to understand why and it would be really helpful you said for the RCN to understand the related lived experiences of your BAME colleagues in the workplace.

Now, going back to these submissions from July 2020, the RCN also in those submissions gave examples of a contributing factor that in some places organisational cultures may inhibit BAME staff from raising concerns for fear of reprisals and that management structures favoured white British staff which further caused BAME staff to feel disengaged and unheard.

Are these examples part of a systemic structural racism that existed and exist within health and care provisions that the RCN urged should be tackled in the same submission document?

A. I'm not sure if I can answer the question around structural challenges in place. We do know that there are inequalities in relation to how black and ethnic minority nurses are able to move and progress within nursing and that there is a predominance of them to be present in the adult social care sector but also within

band 5 and band 6 roles. So not being able -- not seeing and working with senior leaders from black and ethnic minority backgrounds could be something that our nurses feel is compounding their lack of concern or confidence in terms of raising concerns.

Have I answered your question?

Q. To an extent, yes, thank you. Related topic. Do you agree that there was an issue in terms of disparity in support faced by agency nurses?

A. I don't feel I can answer that. I think agency nurses as a whole have really quite a difficult role.

I've worked as one myself. Some prefer it, some it's because it's the only way they can work around family and home commitments. So I would say that although the reliance has reduced somewhat and the use of nursing banks has increased with organisations that should offer more support for all staff including those from black and ethnic minorities, I think we would have to really go back and talk to those nurses and understand if we are to really be able to answer that question around the disparities.

Q. Based on what you've just said you may not be able to answer the next question, which is whether or not you agreed that that impact particularly on Filipino and BAME nurse because they make up quite a large proportion

of agency nurses.
A. Filipino nurses certainly are a large proportion of our overseas recruited nurses and they have very close connections with other Filipino nurses and relatives that are here in the UK so they will often, you know, socialise and stay within the groups that they feel confident in.

So, again, I think the learning is that we really need to understand their lived experience but also we need to be much better in terms of when we collect data on those protected characteristics so we can also use the data as well as the lived experience to bring everything to understand things better.
Q. Thank you. Then finally in the time left, just briefly on IPC guidance and communication you dealt quite extensively with that this morning. My question is in relation to a specific email chain, again for reference, INQ000417625, between yourself and Dr Lisa Ritchie regarding the review of IPC guidance and selection of respiratory protections. It's an email chain dated 23 November 2020. You stated in that email that UK IPC guidance and policy:

"... does not currently support any mention of airborne transmission. However, we seem to have conflicting language and advice."

My question is this. From the answers you have given this morning it's clear that nothing or very little was done to address that confusion arising from conflicting language and advice. You set out your concerns and they remained extant until January 2021. The question is this: could and should more have been done to address the confusion in respect of the conflicting messaging around airborne transmission?
A. So, yes is the short answer. It should have been done. The language was confusing for staff that would have been using the guidance and what members and nurses said to me that were not working in the speciality of IPC because we're very familiar with the language and we can interpret and unpick most of it but actually to those on the frontline, they need clear unambiguous language and guidance that enables them to do the right thing at the right moment in time. So it felt, in their words, as if the guidance had been written for IPC specialists but not necessarily for clinicians implementing it at the frontline. Thank you very much indeed.

Thank you, my Lady.
LADY HALLETT: Thank you, Ms Munroe.

Ms Sangeetha. You look surprised; you weren't expecting to be called?
MS SIVAKUMARAN: It's a different name, Ma'am. It's

Sivakumaran.
LADY HALLETT: Oh, I'm so sorry. Forgive me.

Questions from MS SIVAKUMARAN

MS SIVAKUMARAN: Sorry, my Lady.

I will be asking questions on behalf of the Long Covid groups. We have a number of questions relating to matters raised by Patricia Cullen, the general secretary and chief executive of the RCN in her statement to this Inquiry, so please do say if any of these matters are outside of your knowledge.
A. Thank you.
Q. The first topic touches on data collection which you have addressed briefly this morning. At paragraph 139 of your statement you note that there was no central data collection system in place to collate the number of healthcare workers who had or may have acquired Covid-19 in the workplace. Now, Patricia Cullen has also said in her statement at paragraph 173 that in relation to Long Covid, the exact number of healthcare workers who are affected by or who have been affected is unknown, as no national data collection took place, nor is it taking place today.

This lack of data was further exacerbated by the pausing of the self-reported Long Covid information in March 2023 by the Office for National Statistics. So my

question is: is there a significant gap in data collection on healthcare workers suffering from Long Covid?
A. Based on my limited knowledge of Long Covid, I would say yes, which is why we need better data collection. This is an area where we're learning fast, so that makes it even more important to have data collection so we can go back and understand things in more detail.
Q. Thank you. And turning now to support for nurses with Long Covid, Patricia Cullen says that the RCN received a large number of calls from members about Long Covid. I think she numbers that at 50 calls from November 2021 to December 2021 and 500 calls in 2022. She states that although keen to get back to work, many RCN members found workplace support was lacking and reasonable adjustments difficult to secure. And many faced reduced pay and some have lost their jobs. We've also heard from Patricia Temple today about the difficulties nurses with Long Covid face in returning to work.

Could you outline RCN's recommendations for improving support for healthcare workers with Long Covid?
A. I'm not able to go into a lot of detail, but the RCN is certainly calling very clearly for it to be recognised as an occupational disease that will allow nurses who

acquire, in this case, Covid-19 in the workplace to receive the financial and physical support that they need in the long-term.

Q. Thank you, and I think Patricia Cullen has also referred to recommendations from the report of the all-party parliamentary group which, in addition to recognition of Long Covid as an occupational disease, recommend production of guidelines for employers and private and public sectors for managing the impact of Long Covid amongst the workforce, and collecting accurate and comprehensive data which I think you have already mentioned on Long Covid, and the launch of a compensation scheme. So those would all be recommendations that you would endorse?

A. Yes, they would.

Q. Finally, I want to return to your evidence about IPC guidance. You've explained today RCN's concerns about the inadequacy of IPC guidance in place for healthcare workers. To what extent was the risk of the long-term consequences of Covid-19 factored into decision-making about the necessary IPC measures for Covid-19?

A. To the best of my knowledge on the long -- I don't recall the long-term consequences being part of the conversations around developing the guidance. Once we started to realise that Long Covid was becoming an issue

and it was one of the impacts of this pandemic, then really it became very clear that the only way to reduce the risk of acquiring Long Covid -- and I can only talk about healthcare workers whilst they're at work, because clearly exposure in their private lives isn't something that we can manage or control in any circumstances, but whilst healthcare workers are at work we should be doing everything, because not only did these healthcare workers get sick with Covid-19 -- most of the time, not all the time but most of the time -- but then there is then the additional risk of them going on to acquire Long Covid.

So the only way to stop Long Covid is to not get Covid-19 essentially is what I'm saying. Yes.

Q. So then moving forward to the present day, do you think there is now sufficient consideration of the risk of Long Covid in assessment of necessary IPC measures to prevent transmission of Covid-19 in healthcare settings?

A. We're now in the position where the IPC guidance has moved to the National Infection Control Manual, so we're not using pandemic guidance currently.

I don't recall, I would have to check, but I don't recall having seen any reference to Long Covid in pandemic IPC guidance and I don't recall any reference to Long Covid in the National Infection Prevention and

Control Manual, although I would have to say that that's not the purpose of the National Infection Control Manual as a to-do guide, if that makes sense.

Q. It does. I think my, and I believe possibly your last question: are there sufficient public health communications warning about the risk of Long Covid in healthcare settings?

A. I don't hear conversations around Long Covid in the context of healthcare acquired infections, whether that is in terms of the impact on patients or on staff. It's something that we should certainly look at and look to embed within our education of our healthcare workers, both in terms of patients and staff, as I said, knowing what we know now, some four years on from the beginning of the pandemic, but there's still a lot more work that we need to do on Long Covid.

MS SIVAKUMARAN: Thank you. Those are my questions.

LADY HALLETT: Thank you very much, and apologies again for the confusion of your name. I'm so sorry. But I was misled. I will blame it on someone else.

Right, I think that concludes the questions.

Thank you very much for your help, Mrs Gallagher.

A. Thank you, my Lady.

LADY HALLETT: You've helped me before and I don't know if I'm going to have to ask you to help me again, but we'll

maintain a careful analysis of whether we really do have to impose on you, but thank you for all you've done.

THE WITNESS: Thank you very much.

(The witness withdrew)

MR MILLS: My Lady, may I please call Nick Kaye who can be sworn.

MR NICHOLAS ROBERT KAYE (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Mr Kaye, I hope you haven't been waiting too long.

THE WITNESS: Not at all, my Lady. Thank you for the privilege to address the Inquiry.

MR MILLS: Your full name, please?

A. My full name is Nicholas Robert Kaye.

Q. Mr Kaye, you have provided a statement to the Inquiry. The reference for that is INQ000340104.

Since April 2023 you have been the chair of the National Pharmacy Association, that's the NPA?

A. That's correct.

Q. Can you begin your evidence by telling us, please, who the NPA represents and the work it performs on their behalf?

A. Yes, so the National Pharmacy Association is a representative organisation of pharmacy owners that's just over 100 years old, we celebrated our 100th

anniversary in 2021 whilst I was vice chair. We represent -- there are 7,000 community pharmacies and most of our members are smaller family-owned businesses.

One of my -- the phrases one of my colleagues uses which I do like to use is that we're almost a family of families, and that the National Pharmacy Association board is then elected from those members.

Q. Is it right that over 50% of the NPA's membership are from an ethnic minority background and that that percentage is reflected in the membership of the NPA's board?

A. Yes, Mr Mills, it is, and at the time of the statement I think it was 7 out of 14 and that, although we've had elections, is reflective as well.

I should also say the NPA acts as a head office, if you will. Being a small business you can all feel very isolated and actually specifically and pertinent to this Inquiry that isolation could be something that our members specifically relied on both for insurance advice, guidance, policy decision-making, from the National Pharmacy Association.

Q. During the pandemic you have mentioned you were the vice chair of the NPA?

A. I was.

Q. You were also I think working at a pharmacy in Cornwall;

is that correct?

A. Yes, it is. I was working in a pharmacy in Cornwall in Penryn delivering frontline services. Yes, I was doing that role.

Q. Our first topic together this afternoon will be the key changes to the work of pharmacies during the pandemic but, please, Mr Kaye, before we turn to it can we briefly consider the condition of community pharmacy prior to the pandemic?

A. Yes, thank you. So community pharmacy, I think, across all four nations was under particular strain, I think, in England reflected by reduction in funding. Also a workforce under huge demand, I see that specifically in my sort of rural area in Cornwall, but that's reflected in other rural areas such as Cumbria, Northern Ireland and Wales. And that it would be right to say that pharmacists as a profession had the ability to maybe work in other sectors, so the community pharmacy workforce was strained and the funding envelope was also challenged pre pandemic. So a system that was functioning but certainly strained.

Q. At paragraph 39 of your statement you make the observation that during the pandemic pharmacies took on a bigger role --

A. Yes.

Q. -- as a, your words, "first port of call for patients struggling to access other parts of the health service". Can you help us, why did pharmacies assume this role?

A. So I think -- I'm exceptionally proud of all community pharmacies for the way in which they stood up within this time frame as being accessible, yes with waits, yes with those other things that we had to put into place maybe we'll talk about later but, you know, being an accessible healthcare professional where someone could still walk in and see you was a unique part, I think, of community pharmacy at that time.

And I think both people were -- we have to go back, people were scared, people were frightened, we didn't have all the answers but we certainly were dealing with lots more inquiries both from the standard things you'd expect within medicine supply but also maybe more technical general healthcare questions being fired at us from all angles.

Q. I wonder if we could go on screen, please, to INQ000319520.

This is written evidence that the Pharmaceutical Services Negotiating Committee submitted to the House of Commons Health and Social Care Committee in November 2020. At paragraph 6 we read that -- and I'm paraphrasing here -- PSNC asked 9,441 pharmacies to

pick a day in June or July 2020 and record how many informal patient consultations they had. And the results indicated that the average pharmacy carried out 15 informal patient consultations a day.

To give that figure some context at paragraph 7, the report indicates that if the pharmacies hadn't been there, this would have led to an additional 65 appointments in each GP practice each week in England.

Do these figures give us a sense of the scale of the role that pharmacies assumed?

A. Yes, I think this does give a scale of what was taking place and I think also the recognition at that time standard work was also -- what we call standard work, traditional work in the community pharmacy was also at a heightened level and, again, on reflection those were, you know, queries that could have been relatively basic or, in my own experience, those that were relatively complex, you know, from somebody telling me that they'd a cough, that they were coughing up blood for three weeks, could they -- what would be the advice?

So that shock absorber, I think, of healthcare advice I think is really proportionate. And, again, you know, 65 appointments, when you're a community pharmacist and some of the people we represent, you are not only lead clinician, duty clinician, manager,

business owner, counsellor, all those other things, it's an extremely important part of what we do but I do think I would like to say that, you know, I don't think we resent that work, the clue is in the title, the community pharmacy is part of its community and that's what we thought we were -- what we do, try and support and help.

But an unprecedented increase in demand, Mr Mills.

Q. At your paragraph 65 you touch on another of the major roles that community pharmacies picked up. That is from April 2020, pharmacies began delivering medicines to the shielded population. How did it come to be that pharmacies were tasked with this particular role?

A. So I think pharmacy was the right place for it to be tasked given that we're the experts on medicines, we're the last part of that supply chain. I think the medicine supply chain came under a huge amount of pressure at this time. I think there was something about, as well, the way in which people were able to step up and manage that, you know, from an NPA point of view we were helping giving guidance about, you know, who should be delivering medicines, how they should be delivering medicines, the use of volunteers, you know, that keeping going whilst maintaining supply to the most vulnerable people that we were serving was something

that we thought was absolutely critical and crucial and yeah, I think was welcomed at the time.

The other thing as well is it also protected those people from coming into environments like a community pharmacy which I guess the government perceived as being something which was a dangerous place to be, which is interesting as we move forward.

Q. How many deliveries took place in the first month this was introduced, approximately?

A. I think in England, I think it was just over 490,000.

Q. And similar schemes operated in Scotland, Wales and Northern Ireland?

A. Indeed.

Q. Given the -- you used the word "strain" when we were talking about the position of community pharmacy prior to the pandemic.

A. Yes.

Q. Given that strain, how did community pharmacies meet the demand of this task?

A. So community pharmacies and community pharmacists and their entire teams worked harder, longer than they probably ever had, putting things that were unprecedented in place, I think. From a witness there's a recollection of a husband and wife couple who actually spent 10 weeks working apart to keep their businesses

running because they were both pharmacists, and didn't see each other for that amount of time, so that they could run teams in parallel. People going into work at 6 o'clock, leaving at 11 o'clock because, as I've said already, the clue is in the title, we are there to serve the communities within which we're based. The use of volunteers, the use of other members of the team were really important.

But it really was that overall effort of understanding our patients, the people that we serve to try and make sure that they had medicines and advice.

Q. Next, please, the contribution to the vaccine rollout.

A. Yes.

Q. The Inquiry has heard evidence from Dr Michael Mulholland of the Royal College of General Practitioners.

A. Yes.

Q. His statement, if we can have it on screen, please, is INQ000339027. And I'm reading the last sentence of paragraph 65:

"According to the National Audit Office's report into the rollout of the Covid-19 vaccination programme in London, by the end of October 2021, GP practices working in [primary care network] groups and community pharmacies had delivered 71% of all doses of the

Covid-19 vaccine administered in England."

Are those statistics reflective of the contribution community pharmacies, together with GP practices, made to the vaccination effort throughout the UK?

A. So I would recognise those as being significant as primary care working together to deliver that. I think it's really an interesting point as well that they're not large new infrastructure centres, they are the use of the infrastructure that existed at that time, being -- whether that's slightly changed within primary care networks or community pharmacies delivering things in a different way, but I think, as well, given the strain that we've already described, that implementation phase of the vaccination by both parts of that primary care sector is really important to be noted from a practical delivery point of view.

Q. Can I ask you precisely about that. Are you able to give the Inquiry a sense of the impact that the administration of providing the vaccine had on the workload of these small community pharmacies?

A. Yeah, so it did increase those significantly, both from the regulatory process of having to be approved by NHS England, in England and other parts of the UK. It wasn't classed as a business-as-usual-type activity

Covid in the same way that maybe flu vaccination would be, it had other things to go through, so there was not only time had to be taken to be involved in the programme but then also the way in which that was administered also added additional workload and strain.

Some very small community pharmacies in rural locations I know tried to change the way in which they worked, designate a certain afternoon or work in a different way, to try and meet that demand whilst also trying to protect themselves at that time because, again, if you're a single-handed operation you need to balance that risk of business continuity with the giving of the vaccine.

Q. In a future pandemic, would you recommend the removal of this administrative barrier for community pharmacies providing such a critical role?

A. I'd recommend it from now, because it still exists.

Q. Can we next consider the challenges pharmacies faced in adopting --

LADY HALLETT: Sorry to interrupt, just before you go on, so I understand.

A. Yes.

LADY HALLETT: Could you give me more of an idea of what administrative barrier it was?

A. Yes, so there were a couple of things, my Lady. There

was one around the way in which the designated supply of vaccine was held centrally, so there were things where people had to be designated as certain centres, whether that was primary care networks or community pharmacies, so -- there then also had to be a commitment to do a certain number per week, so there was something about the ability to deliver at the time was considered such a precious resource, so I think as things have moved forward, I think that may be not so important now, and actually business as usual would be much more appropriate, but people were then having to try and create space to deal with that, and I know that the National Pharmacy Association certainly help people. I know of one pharmacy in a very rural location in Cornwall where there was no other access for quite a long time, but to help that person both through the administrative burden and then work out what his work plan would look like were something that we needed to act as a head office for delivering.

Now, those numbers weren't massive, but they were hugely important to that community that was there, and quite an elderly and vulnerable community as well, my Lady.

LADY HALLETT: And who imposed the burdens? Was it the NHS?

A. So, yeah, it was part of NHS, the delivery, both primary

care networks and community pharmacy had go through, for want of a better description, accreditation process, my Lady.

LADY HALLETT: Thank you.

MR MILLS: Can we first think about PPE together.

A. Yes.

Q. At your paragraph 73, you say that PPE was not initially available to community pharmacy teams through the NHS.

A. That's correct.

Q. Is this because community pharmacy was considered to be a private sector provider?

A. Of course, when 90% of the income of most of our members comes from the NHS, it seems logical to call it a private provider, Mr Mills.

Q. I appreciate that is the NPA view and indeed your view of that categorisation.

A. Yes.

Q. Are you able to help us, insofar as you are aware of them, the reasons for that categorisation?

A. I assume it's because -- and it's an assumption that, you know, some part of community pharmacy is involved in a retail element, whether selling medicines for over-the-counter sale, or whatever it may be.

Q. I see. Without NHS support --

A. Yes.

Q. -- in the provision of PPE, how did pharmacies source PPE?

A. So there was a myriad of ways and I think in our evidence there was a note where a dentist actually helped a pharmacy out with some that they had. I know that in previous witness statements given that one of my colleagues has suggested that they had some made by a local school. I personally -- we tried to source them from a DIY centre. There was all sorts of things that were going on in place to try and work out ways to try and keep ourselves safe. And I think what's really important as well is, back then, we didn't know what we were dealing with, you know, I'm now a dad of five; at the time I was a dad of four and I was having messages from my close friends, my best man at my wedding going, "Do you really want to go to work?" You know, "Are you really sure you want to do this? Is this really worth it?" And I'm sure that conversation was going on up and down the country, especially in those members with those single-handed businesses where they truly feel a sense of their community.

So we were doing, I think, Mr Mills, whatever we could to try and keep ourselves safe whilst deliver that care.

Q. Please can we go to INQ000319522.

This is the guidance for ordering PPE via the PPE portal.
A. Yes.
Q. Before we have a look at its contents, can I ask you in brief terms to explain how this portal functioned?
A. Yeah, so the way in which it would function, as I recollect, is you would both have to register it to make sure that you were eligible for its use, and then you would be able to, once that was verified, you'd then be able to order a set amount weekly, given where the setting that you were. And as we moved through that pandemic, the amount that you could order was changed.
So I note that I think from November 2020, there was a slight increase in the amount we could order and that felt more comfortable. But up until that point it felt quite strained and quite uncomfortable --
Q. If we look at page 9, please. This is a record of the various updates --
A. Yes.
Q. -- to the guidance. Underneath 3 August, we read:
"Added pharmacies and larger social care providers to the categories of provider that are invited to order from the portal."
A. Yes.
Q. Were you immediately able to order from the portal from

3 August, or did things take some time?
A. So I think the -- as my recollection, and this would be my personal recollection, would be that yes, it was you were able to register and then be validated to order, but orders tended to be sporadic in the first instance.
Q. I take it then that PPE issues were not entirely resolved then by admission to the portal?
A. Eased but definitely not resolved.
Q. Are you able to help us with some of the issues that continued?
A. Yeah, so there was lots of decisions made about where you wear it, how you wear it, you know, following those guidances but I think as well, we might come on to later, community pharmacies tend to be quite small environments, so actually maintaining things like 2-metre rules were quite difficult. So community pharmacy, I think, was somewhere where -- which was actually a high user of PPE for various reasons, and I think that was then reflected later with people like the National Pharmacy Association feeding that back. But initially, I'm not sure, given that we were decided originally to be retail, that that actually was -- our public patient-facing role, I don't think was fully acknowledged at that point.
Q. And we'll come on in due course to look at some other

areas where that may have been a problem. Can I just, on PPE, finish --
A. Yes, of course.
Q. -- with this, please. Looking to the future --
A. Yes.
Q. -- would you recommend that community pharmacies have access to PPE on the same terms and at the same time as other healthcare providers?
A. Yeah, I think that would be absolutely critical, given the nature of the work, and I think really importantly sometimes some of the language used was around pharmacists, but I -- really important for me to state that community pharmacies are much more than pharmacists although we have pharmacy technicians, medicine counter assistants, there are a huge team involved with that. So I think recognition of the whole team, not just the pharmacist. Quite often, when you walk in to a community pharmacy, it's not the pharmacist on the initial counter that would meet you and greet you, and it would be really important to me that those counter assistants, dispenser counter assistants, pharmacy technicians, pharmacy dispensers, that wider team is recognised in any future -- any future involvement with that, Mr Mills.
Q. You have alluded to the issues around social distancing.

A. Yes.
Q. Please can we go to INQ000319559.
These are the results of a survey conducted by the Royal Pharmaceutical Society, the RPS, in April 2020.
A. Yes.
Q. We read in the second paragraph that:
"... 94% of respondents said they were unable to maintain 2 [metre] social distancing from other staff ..."
A. Yes.
Q. "... 40% ... said they were unable to maintain social distancing from [their] patients."
A. Yes.
Q. Generally speaking, did the small size of pharmacies present an incredibly difficult structural hurdle to overcome in achieving social distancing?
A. So I think people that would work in community pharmacies would recognise, you know, you would need things to be easily accessible, the speed with which you can move around a dispensary actually makes it more efficient if it's more compact and you're not working large distance, purely from time and motion. There is a standing joke: it doesn't matter where you stand in a pharmacy, you'll always bump into someone in a dispensary because of the busyness and the way in

which things are going around. Plus the increase in workload; I think one piece of evidence had a record 30 -- 93 million items dispensed, I think, in March or April 2020 --

LADY HALLETT: Slow down.

A. Sorry. I get overexcited, my Lady. My apologies. Not enough coffee or too much, I'm not sure.

LADY HALLETT: "So many items ..." several million. I think we missed however many million.

A. 93 million.

LADY HALLETT: 93 million items dispensed March through April.

A. Yes. Thank you, my Lady. Apologies.

And I think that that's just the practicalities of the way in which community pharmacies are designed.

I think, as well, from the maintaining distance from patients, I think quite often, you know, a Perspex screen over a counter that is no bigger than what I'm sitting in front of now, when somebody -- when you're wearing a mask and someone is leaning around the side to go "Hello, can you help me with", would just give real life practicality of how that would be difficult to maintain the 2 metres.

MR MILLS: So, then, within the confines you have described --

Q. Broadly speaking, please, what was the purpose of these risk assessments?

A. The purpose of the risk assessments was to see whether or not community pharmacy teams were running as safely as they possibly could. The NPA issued risk assessments to complete based on both -- or the risk factors that were being promoted at that time, so ethnic minority, pregnancy, long-term condition, all the things that you would expect in a risk assessment -- to try and make sure that both pharmacy owners, pharmacy team members, were both aware of the risks that they may be putting themselves against, and then any mitigating factors they could do to try and avoid those.

Q. If we now consider the extent to which the end of July target was achieved --

A. Yes.

Q. -- please, can we go to INQ000319552. These are the results from a survey conducted by the RPS and the UK Black Pharmacist Association as of 25 June 2020, so a month or so away from the end of July deadline. In the first paragraph, second line, we read:

"... more than two-thirds of ... (BAME) pharmacists and pre-registration pharmacists across primary and secondary care have still not had access to potentially lifesaving COVID-19 risk assessments."

A. Yes.

Q. -- what measures did community pharmacies take to try and achieve those social distancing measures?

A. So there was, within the person and patient flow, there were lots of examples of where people were limiting the number of people within a pharmacy at a time, queuing systems outside of pharmacies which again was problematic for people maybe waiting when it was cold, but they were things that we had to do in practical terms.

And within the dispensaries, I think what you saw is you almost saw a buddying up and a team approach, because the 2 metres was going to be non-achievable. So how do you actually accept that wearing the best PPE you can obtain, but also making sure that business continued, was a practical way of trying to keep things going as opposed to not being able to maintain the 2 metres?

Q. Next, please, risk assessments.

A. Yes.

Q. At your paragraph 84 you explain that in June 2020, NHS England and NHS improvement asked pharmacies to complete risk assessments for their staff by the end of July 2020?

A. Yes.

To complete the picture, can we go to INQ000319555. This is a second survey by the RPS and the UK BPA published on 11 August, so after the deadline. The third paragraph reads:

"The new survey shows that nearly a quarter of all pharmacists are still waiting for this to happen."

"This" being the risk assessment. Appreciating that these surveys were of those working in all types of pharmacy across primary and secondary care, can I nevertheless ask you this: was the NPA aware of issues that were preventing risk assessments from being carried out in community pharmacies particularly in respect of their BAME colleagues?

A. So I think what I would say is that the NPA tried to support its members from an organisational point of view by both producing those risk assessments for people use, and trying to help with guidance of how people to fill them in and the things to make, the recommendations of what those risk assessments meant.

On reflection of were we aware that members weren't doing those, I don't think we were, but my personal reflection would be that people were probably overwhelmed, if I'm being honest, with all the other things that were needing to be done. I don't think that's an excuse, I just think that's a realistic

reflection.
Q. Can we now consider the instances where in your statement you have described that support provided to other healthcare professionals was slower to reach pharmacists.
A. Yes.
Q. First, the life assurance scheme. Can you help us, please, what did that scheme offer?
A. So in that scheme offered a compensation I think of £60,000 for those people that had been passed away with Covid-19. And I think there was an expectation that community pharmacists and their team would be part of that.
Q. Can you help us with when that scheme was announced?
A. So I believe it was announced on 27 April.
Q. Please can we go to INQ000271969. This is a letter sent by the NPA to the then Health Secretary on 29 April.
A. Yes.
Q. We read here, second sentence:
"Unfortunately, community pharmacy has not been explicitly included in your Department's communications about this scheme."
Just to complete the picture here, can we go to INQ000319544. This came the following day, 30 April, we see it just underneath the Tweet. Mr Hancock said:

"I'm glad to be able to confirm that community pharmacists are included in our death in service benefits. Because they are employed in a different way, it is arranged in a different way, but pharmacists are a vital part of our NHS family. They are of course covered."
Can I ask first, please, do you recall now whether you were made aware of this Tweet?
A. So I was made aware of that Tweet in my role as vice-chair of the National Pharmacy Association, given the letter we'd written the day before.
Q. Did this resolve, from the NPA's perspective, the concerns that it had outlined the previous day, namely that community pharmacy had not been explicitly included in the communications hitherto about the scheme?
A. I think there's maybe a couple of things I'd like to say on this.
I think it's right to say that that was a fairly quick turnaround and reaction and that has to be acknowledged, however, the fact that we weren't included to start with does make it feel like an afterthought, which, given some of the things that I've described and the effort the teams were going into, I think is demotivating and demoralising for those people giving that care.

Also, I would note as well that this says community pharmacists, and as I've already stated community pharmacy is not community pharmacists. I did note that there was a letter reply from Mr Hancock which also included pharmacy technicians and counter assistants, but again I think having then within that reply and that Tweet as teams as opposed to the individual professional, I think, would have boosted the morale of those people delivering that care.
Q. Next, please, key worker status. Were pharmacists originally included in the list of key workers?
A. No, as a dad of five, why would I be?
Q. Can you help us: when were pharmacists included? How long did it take?
A. I would have to have some recollection on that, I'm afraid, but I think it was 2, 3 months after the original announcement. We, the NPA, wrote a letter suggesting to schools that we, pharmacists were key workers, and people that worked in pharmacy teams.
Q. Can you help the Inquiry understand the practical and indeed the psychological impact of not immediately designating pharmacists as key workers?
A. So I think it reflects to my previous point, Mr Mills, on the fact that again it felt a little bit like an afterthought, you know, the evidence already stated

even from vaccination programme, 71% of Covid vaccines being delivered, yet community pharmacists and their team not being felt as if they were key workers. There was appointments and increase in healthcare advice which you've already described whilst maintaining medicine supply, but, again, not being classed as key workers is both demoralising and frustrating.
Yes, they were organised, and yes, it was sorted out, but again it feels more like an afterthought, Mr Mills.
Q. Would it be the NPA's recommendation that in a future pandemic, pharmacists should be designated as a key worker if indeed that term is used again from the outset?
A. I would and I would probably extend it further, I think to pharmacists and their teams. As I keep saying, you know, a community pharmacy is much more than the pharmacist but the team members as well I think are really important.
Q. Next, testing?
A. Thanks.
Q. When testing became available for healthcare professionals, was it made available to those working in pharmacies at the same time?
A. No.

Q. Are you able to help us with when testing did become available for pharmacies?
A. Again, I would have to check my recollection but I think that was again a couple of months after initial rollout and I believe that was because we were classed as being part of a private sector, as opposed to being part of the NHS family. Again, given what we've already mentioned that feels disingenuous.
Q. If I can assist with the timing --
A. Thank you.
Q. -- you say at paragraph 78 of your statement that testing eventually became available and confirmed for English pharmacists in November 2020. You have alluded to categorisation, I think it's right that when testing did become available, community pharmacies were categorised as retail settings --
A. Yes.
Q. -- as opposed to healthcare establishments?
A. Yes.
Q. Was effect did that have on the self-isolation requirements that community pharmacies had to observe in the event of someone within their team testing positive for Covid-19?
A. Yes, so this is where a lot of the practical implementation issue could occur because you would have

to then have everyone isolating as opposed to the individual and those people in contact with. And again within small teams that has a really difficult operational effect. We know of pharmacies where in rural locations they may have had to close because of this type of classification which ultimately resulted in a reduction of care for those peoples in that community.

So, again, as I said potentially slightly tongue-in-cheek earlier, Mr Mills, with 90% of most of our members' income coming from the NHS, you know, it seems perfectly reasonable to not class as a healthcare setting.

Q. Did the NPA offer any practical solutions to enable pharmacies to keep providing their services in the event of a positive test?
A. Yeah, so there were some practical things that we tried to do both from a guidance and keeping up-to-date point of view when classification and reclassification happened but we also worked with another organisation called the Company Chemists Association which represents larger organisations, people would probably be familiar with Boots, for example, and Superdrug as high street chains, allowing individual team members to be able to swap across different organisations and as part of the NPA we have a wholly-owned insurance company which meant

that we could allow those people to work and be insured to maintain supplies -- to maintain services within communities, as a practical way to make sure people kept getting their care delivered.
Q. In your view did the categorisation of community pharmacies as retail settings, and we have heard in respect of PPE the categorisation as a private sector provider, reflect an under-appreciation of their role in providing critical healthcare?
A. I would have to say yes. I would also note that those things were changed but it felt like an afterthought when people were giving their all to deliver care in an unprecedented time.
Q. Can you help us with when the retail setting categorisation was changed?
A. I think that was the month after -- December.
Q. Finally this, perhaps before we take our afternoon break, my Lady. In respect of testing for community pharmacies, are there any recommendations you would like the Inquiry to consider in the event of a future pandemic?
A. So I think it would be to consider us as being healthcare professionals and part of the healthcare family and for those testing recommendations to be uniform across all those healthcare settings, GP

practices, hospitals, pharmacies, I think that would be an appropriate and reasonable recognition of the work that was done by the teams.
MR MILLS: My Lady, would that be a convenient moment?
LADY HALLETT: Certainly. I shall return at 3.25.
(3.11 pm)
(A short break)
(3.25 pm)
LADY HALLETT: Mr Mills.
MR MILLS: My Lady.

Mr Kaye, funding. What financial support, please, did community pharmacies receive to enable them to safely perform all of the roles we have discussed this afternoon?
A. So I think it was different across different nations, Mr Mills, but I think for England, if I reflect to start with, there was an advance given of 300 million. So it's important to recognise that as what it is, that's an advance which needs to be paid back.

So community pharmacy for medicine supply gets paid in quite an odd way, in that the work you do today gets paid in three months' time. If you suddenly got an increase in prescription volume or medicine supply, your medicine supplier, your pharmaceutical wholesaler will want payment in 30 days. So if you've then got

a cashflow issue between purchasing the medicine and that money being received, that can be a problem.

So there was an advance given for that but then that needed to be recouped.

In Northern Ireland, something similar; Scotland had, I think, funding of 5.5 million, given to them.

So different nations dealt with it in different ways, but primarily it was by advance and then claiming of potentially Covid expenses afterwards.

Q. So we have the advance loan.

A. Yes.

Q. That needed to be repaid by the community pharmacies?

A. Indeed.

Q. We then also have reimbursement?

A. Yes.

Q. For -- is that for Covid-19 related costs --

A. Yes.

Q. -- expenses. At paragraph 120 of your statement you record that the considerable extra costs incurred by pharmacies to keep services going throughout the pandemic were not fully reimbursed until 2022.

A. That's right.

Q. So in addition to having to pay back the advanced loans, not full reimbursement for the expenses until 2022?

A. Yes.

Q. Can you help the Inquiry understand the sort of financial pressure that that delay put on community pharmacies?

A. So I think it's right to put into that context potentially some of the additional mental stress that has on somebody who is sometimes single-handed, as I've described the NPA as being those people's, our members' virtual head office. So not only are you in a situation potentially where, for some of the reasons already described, you're feeling a bit of an afterthought from some members of government, you're then actually worried, well, I'm going to work from 7 o'clock in the morning until 11 o'clock at night, examples of my -- separated from family members for 10 weeks but then can I actually pay my team, can I actually pay my mortgage?

And those in my NPA role are some of the most difficult conversations I have. People want to do the right thing, they want to give that care to the communities they serve but actually being able to pay their bills is another pressure and thought process that just invades the parts of their downtime if they've got any.

And I don't think that that should be under-recognised.

Q. Can we perhaps consider the consequences of the concerns you have put on the well-being of those working in community pharmacies by going to INQ000319535, please. And if we can focus on the table. Thank you.

This comes from the RPS's workforce and well-being survey 2022. We see along the top row the burnout scores through the Inquiry's relevant period at 89, 89, 88. Of particular note the figures for those working in community pharmacy are higher than those in other sectors --

A. Yes.

Q. -- as are the figures for women compared to men?

A. Yes.

Q. Can you help the Inquiry understand, please, some of the reasons behind these very high burnout figures?

A. It's hard to look at, isn't it? It really is, for me, you know, community pharmacy and being a pharmacist has been a fantastic profession. I get so much from it but that is a really stark reminder and reflection of what is going on out there, and I think my reflection on that burnout would be some of the things we've already talked about in not only uncertainty, uncertainty in how you're going to get the PPE you need, how you're going to get the medicines you need, how you're going to pay your team, that that becomes overwhelming, you know, and --

genuinely overwhelming.

It's probably one of the hardest things as being the chair of the NPA I have to listen to is people who are, "When's it going to get better, Nick? When's this going to change?" And that within the Inquiry is something that should be really recognised as people not feeling, I think, supported and part of that integral healthcare team.

I think, as well, you know, it would be right to say that, again, a female colleague of mine who was not on the NPA board anymore but just said that she felt not only overwhelmed with all the things I have described that I was having to deal with but also that additional caring responsibility which we have to be realistic falls on the women in our society more often than not and I think that that additional burden is unbelievably difficult to fathom.

Q. Please can we go next to INQ000271989.

This is an open letter that the NPA, together with the CCA, who you have mentioned already, published in April 2020. The letter asked the public to help pharmacists by doing seven things. We see them in these bullet points.

Can I perhaps invite you to take us through each of these points, and also think about whether this

letter had the desired effect, sent as it was in April 2020, against the context of those burnout figures that we have just looked at running from 2020 to 2022?

A. Thank you. I mean, my reflection I think on these asks of the public and I would say most people were incredibly understanding especially as the pandemic started and some of the things that people were being asked to do. I think the first point when people had an infection, a cough and fever, I know I've had people present to me who did have those symptoms but that's because they were trying to seek help and didn't know where else to go, maybe a lack of knowledge, a lack of understanding, and we would have to deal with those people in a really sensitive way to make sure that they got the care they needed but also that our teams were protected.

And I think that accessibility of community pharmacy came through with that but it was hard to deal with when you actually had people presenting with those symptoms which we did.

And again, family and those people that are, you know, symptom-free to collect those medicines. I think some of that was supported by the medicines delivery service that you've already mentioned, but for those

people that did feel as if they were needing a family member or friend to pick it up, then there were some of the questions -- as we've already seen about Test and Trace as those guidance changed, "Is it okay? I saw them last week" -- how does that deal with?

The other one as well is buying the medicines and supplies you only need right now. That's really hard. We heard things on media, on social media, in supermarkets there were no toilet rolls in, pharmacies there was no Calpol, you know, again as a dad of many children, as I've already described, there is a human being reaction to want to look after your family and that was quite hard and that caused some of the most challenging conversations about saying: you can only have one bottle of this or one bottle of that.

I think that sort of slight confrontational type experience led some pharmacy team members to have to wear body cameras and things which I'd never seen or heard of in my time but still continues unfortunately.

Repeat medications, as well. Especially those things around inhalers people. You know, people who needed inhalers, they were specifically -- you know, they were particularly worried about the continuation of supply. And having done lots of work on medicine supply, because I think it's a fascinating area that

needs some extra thought, as soon as you tell somebody something is going to go short it's a self-fulfilling prophecy, isn't it? This may be short, therefore I'll order four more to make sure I'm okay.

Instructions. People were pretty good at that, I think. More often than not they did listen to us.

And again, we did have incidences, I had incidences where people got, you know, we had to sort of treat them in a slightly different way and maybe be a bit more forceful because I had to then explain to the team that these were people that were scared, that were frightened just like us and, actually, you know, the way in which we needed to deal with the people had to reflect some care but some of the incidences we had weren't great.

And keeping up to date with everything that's online, well, you know, that was the challenge I think for everyone within the pandemic trying to keep up to date with everything, but we were just trying to get our way through that to keep people safe.

Q. Finally, then, lessons and recommendations.

A. Yes.

Q. In your statement and indeed in your evidence this afternoon, you have described pharmacies as the shock absorber --

A. Yes.

Q. -- for the healthcare system. Can I ask you to share any recommendations which you have not already had the chance to do so today that you would like the Inquiry to consider to better enable pharmacies to fulfil their critical role in a future pandemic?

A. Yeah, thank you, and thank you for the opportunity.

I think the shock absorber isn't mine, it is a phrase one of my colleagues used first, and it's absolutely perfect to describe, I think, some of the things that community pharmacy did at the time.

There's lots of recommendations in the report, but I think if I had to pick three that I would really want the Inquiry to focus on, I think a sustainable and resilient community pharmacy network. As I sit here today, seven pharmacies a week are closing across the four nations, and that is tragic for any future response. So a resilient network that exists, I think, is going to be key.

Infrastructure. It's hard to make infrastructure, whether that be large Nightingale hospitals, large vaccination centres, but reflecting on the evidence from your general practitioner colleague of 71% of vaccines being delivered across existing infrastructure, I think if that community pharmacy network is resilient and

exists, then get ready to use it, and to my Lady's comment earlier about who -- you know, about how that NHS bureaucracy could be maybe reduced, understanding those safety things that need to be in place, I think, would be really important.

And then really reframe community pharmacy, pharmacists and their teams, as a genuine part of the NHS family and a key delivery in healthcare, which we absolutely are. As I've stated before, 90% of the income of most of our members come from delivering NHS services. And they would be my three key asks: make sure that we're here, use us, and we are part of primary care.

MR MILLS: Mr Kaye, thank you.

My Lady, that's all I have.

LADY HALLETT: Thank you.

A few questions from Ms Campbell who is directly in my sight, I might add.

Questions from MS CAMPBELL

MS CAMPBELL: Thank you, my Lady.

Mr Kaye, my name is Brenda Campbell and I ask questions on behalf of the Northern Ireland Covid-19 Bereaved Families for Justice.

A. Thank you.

Q. Three topics, all of which in fact have been touched on

in your evidence already, but if I might take you back, please, to the opening stages of your evidence in which you mentioned that the NPA board reflects the membership --

A. Yes.

Q. -- of the NPA itself, and as much as over 50% of the NPA's membership comes from ethnic minority backgrounds --

A. Yes.

Q. -- and over 50% of your board also comes from black, Asian or minority ethnic backgrounds --

A. Yes.

Q. And I gather, from the way in which you answered the question initially, that is a source of pride for the NPA?

A. Yes, absolutely.

Q. Did or does the NPA consider that the diversity of your board in fact strengthened effective communication in the course of the pandemic between the membership and the leadership?

A. Yeah, I would say it did, and I think it's really important to understand that the NPA board elected from the members of the NPA, so to add to your question, not only the ethnic minority dimension, which was real, we had people who knew family members that were dying, that

was a key part of what was really important to us, but we also have an individual board member for Scotland, Wales and Northern Ireland so, actually, cross-country sharing of information, I think put the NPA in a really interesting place, to be able to share intel, information across all four nations.

So "yes" is the short answer to your question, but I think the board's diversity both in where people are elected from, and also the diversity of the group of people that we are, I think, makes us a board that was able to step up in this place.

Q. But can you give us any specific examples of that in terms of issues that may have arisen that your board was better placed to deal with?

A. So one that jumps to mind immediately would be things around actually vaccine hesitancy. So we had people in the community that were from an ethnic minority who were going, actually, this is really, you know, there's some vaccine hesitancy, there's some education pieces, and actually that frontline -- because people on our board were actually delivering care, you've got to remember that our board is made up of people that run their own business and delivering care, we had a lot of frontline intel that was coming up. So, you know, family members that were maybe shielding in a different way, or like

I say, vaccine hesitancy, that type of thing was directly from the frontline straight into the board, and then straight out into policy recommendation.

And I think as well, things like risk assessments we talked about earlier, our risk assessment was out in June, which was relatively quick, I think, as far as that was concerned -- because that's what our membership demanded.

Q. Thank you. Second topic, and it's -- the topic is entitled medicine shortages, but it's perhaps more focusing on the stress that that put on community pharmacists and their teams.

In your statement, you highlight the considerable amount of time that pharmacists and their teams had to spend sourcing medicines particularly when they were out of stock, and in fact the statistics are concerning. I think your November 2020 survey indicated that 50% of respondents were spending up to 5 hours per week, 40% between 5 and 10 hours per week --

A. Yes.

Q. -- and some over 10 hours per week. Every week.

A. Every week.

Q. Which in real terms is well over a day in normal working conditions, trying to source medicine on behalf of your patients and customers.

How did that impact the workload of those who remained in the store at the frontline to deal with your customers?

A. So it's a really -- really grateful for the question because that medicine supply function is a key part of what community pharmacy does, and actually the taking that time away from frontline delivery of care is really problematic, because community pharmacy is a team, it's not always the pharmacist that is having to deal with that, but it's definitely taking time away from other members, like you say, who are supporting someone else or if, you know, somebody needs to be shielded, that does have an impact, then, on the ability to do other functions within the pharmacy, such as dispense medications and do the day-to-day.

So it definitely does have an impact. Or, if you decide that you're going to replace that time, and you need more time and more staff, that then has a financial impact which, we've already touched on, was particularly challenging with the advances and things that were given at that time.

Q. Your statement reflects some examples of pharmacists who really went above and beyond in order to access patients' medicines.

A. Yes.

Q. But what about from the other end in terms of patient and customer confidence? How did it impact their confidence in the community pharmacy system?

A. So I think what it did was, as I mentioned earlier, I think as soon as something becomes publicised in the media or social media about something become short in supply, I think that's then a self-fulfilling proficiency, everybody then wants to grab something. I think, as well, what the government did was put in place the serious shortage protocol so what that allowed people to do is to -- and pharmacists and their teams to be able to go: actually, this medicine is out of stock, I don't have to send you back to another part of primary care to get that prescription changed, I can change this for you now. Or: your prescription is for three inhalers. Actually, so everybody gets one, I'm only going to give you one.

Those were some challenging conversations with people but they were things that were important to do to maintain that supply.

I think overall confidence -- this is a personal experience, overall confidence in supply chain remained high but there were then specific areas that went out of stock that were highlighted that then people had lots of questions and those drove a lot of demand. I think, off

the top of my head, I think there were 20 serious shortage protocols issued over the time frame, 14 of which were for HRT which then caused lots and lots of additional questions and things. So different groups.

I wouldn't say it was an overall lack of confidence but when something was highlighted certain groups then caused extra pressure.

Q. I know in your statement, and I'll leave it for present purposes, you have some suggestions of how that might be addressed in the future.

But if I might turn to my final topic and that is funding and, again, you have touched on it just very recently indeed. In Northern Ireland when you mentioned that there was some special advance funding available the figure in fact in Northern Ireland was some 35 million.

A. Yes.

Q. Now, that was to a sector that had been recognised was in need of much needed resilience and support. The 35 million special advance Covid funding was made available up until March 2021, so still very much in the grips of the pandemic --

A. Yes.

Q. -- and then it began to be withdrawn.

A. It did. And paid back.

Q. And paid back. And really that's the question. What is the impact on a sector that needs much needed support and resilience to give 35 million for that specific period of time, I think it's June 2020 until May 2021, and then say: right, it's time to start giving it back?

A. It's not only -- it's soul destroying and it actually impacts both, you know, the resilience of the network, the ability to invest, the ability, as you said, to actually somebody is taking 10 hours to source medicines, can I replace them.

Also, at the time, there was some uncertainty, I believe about how much of it would be reclawed, how quickly that would be reclawed, how -- you know, what that would take -- I think in Northern Ireland it was actually taken back over 24 months, I think.

Q. Yes.

A. But that wasn't known at the time, so that additional living of uncertainty I think is really, really problematic.

And, again, I would say your colleagues in Northern Ireland now with both vaccine programmes now that have come out, vaccines in care homes that have come primarily now through community pharmacies, I think shows to the testament of the network within Northern Ireland and how it did respond, but it was

really, really challenging at that time.

MS CAMPBELL: Thank you very much.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Campbell. Very grateful.

I think that completes the questions that we have for you, Mr Kaye. I see from your statement both grandfathers, father, uncle, aunt, brother, all pharmacists.

A. Yes, there was no hope for me.

LADY HALLETT: What happens if none of your five children become --

A. Well, the first one has decided to be a paramedic, so you never know, there's still some chance.

Thank you, my Lady.

LADY HALLETT: Well, it's interesting because as you may know, the previous pharmacist witness also was a family business where he was working.

Anyway, thank you so much for your help in this Inquiry and also obviously for the superb work that you and your colleagues did during the pandemic. We are really grateful.

THE WITNESS: My Lady, thank you.

LADY HALLETT: And I'm sorry you didn't get the recognition at the time that you should have done.

THE WITNESS: Thank you. I appreciate that.

(The witness withdrew)

LADY HALLETT: Right.

10 o'clock tomorrow, Tuesday, 5 November.

(3.47 pm)

(The hearing adjourned until 10.00 am on Tuesday, 5 November 2024)

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