IN THE MATTER OF

MODULE 3 OF THE UK COVID-19 PUBLIC INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF THE ROYAL COLLEGE OF NURSING

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

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

3. The RCN continues to offer its condolences and its heartfelt thoughts to everyone who has lost loved ones during the pandemic. It will never forget the sacrifice of healthcare professionals, including those who passed away as a result of the pandemic and those who continue to feel the impacts on their health as a consequence of Covid-19 including Long Covid. The RCN is committed to continuing to advocate for and support those of its members that were impacted by the pandemic both physically and psychologically and who continue to be impacted 5 years on.

4. These written submissions develop the issues addressed within the RCN's oral closing statement provided on 28 November 2024, highlighting the evidence heard before the Inquiry in Module 3 and setting out the RCN's key areas of focus which it would urge the Inquiry to consider as it produces its report and recommendations.

5. The RCN's submissions will cover the following areas:

   A. The impact of the pandemic on nursing staff
   B. The exacerbation of existing inequalities
   C. Short-staffing of the nursing workforce and the inability to scale-up capacity
   D. The supply and distribution of Personal Protective Equipment ("PPE") and Respiratory Protective Equipment ("RPE")
   E. Fit testing, fit test training and difficulties in using PPE and RPE which arose due to physical attributes
   F. The failure to properly consider and acknowledge the airborne transmission of Covid-19
   G. The development of IPC guidance
   H. Risk assessments
   I. The severe under-reporting via RIDDOR
   J. Long Covid support for those who caught Covid-19 whilst at work

6. The preventable failures that led to devastating experiences for nursing staff and their patients during the Covid-19 pandemic cannot be allowed to happen again. There is an urgent need to publish recommendations that will address the widespread staff shortages and unsafe bed occupancy levels that are currently affecting the healthcare system across the four nations and for the UK Government and Devolved Administrations to act upon these recommendations.

7. In the context of the pandemic, the RCN's key focus was the protection of nursing staff and patients from infection acquired as a result of work or receiving care. The protection of nursing staff is critical not only to safeguard them from occupationally acquired disease, but also to ensure that staffing levels are maximised to avoid harm to patients through an under-resourced service. The nursing workforce is a finite resource and any impact on its ability to deliver care is a key risk to patient safety and the prevention of infection. The Covid-19 pandemic taught us that the experiences of those on the frontline of healthcare was often not considered or was dangerously overlooked. There were inadequate opportunities for those representing frontline workers to feed

into the development and delivery of guidance on their behalf, particularly IPC guidance, despite previous incidents making very clear that there was a need for this. Such a lack of opportunities resulted in guidance that was not fit for purpose, and which did not address issues that clinicians and health care workers were facing on the ground. Where such opportunities did exist, the views and suggestions of the RCN, and other frontline healthcare representatives, were not given sufficient weight. In turn this had a detrimental, sometimes fatal, impact on those who were on the frontline of care.

The impact of the pandemic on nursing staff

8. It is well known that nursing staff across the UK carried the heavy burden of the Covid-19 pandemic. As Ruth May, Former Chief Nursing Officer for England ("CNO") acknowledged in her evidence to the Inquiry on 17 September 2024, "*nurses were at the brunt of this*[1]". Our nursing community responded to the global health crisis in extraordinary ways, coming out of retirement, putting aside their studies, being redeployed to specialised or new clinical areas, working longer shifts than usual and putting themselves and their families at risk of illness.

9. Nursing staff played an indispensable role in delivering health and care services and went above and beyond during the crisis to support and care for patients. Many nursing staff were involved in extremely stressful and traumatic situations. In the short term, as professionals they focused on caring for patients, however the psychological impact of caring for increased volumes of very sick patients and distressed relatives, many of whom were at very high risk or highly emotional, cannot be understated. Striving to deliver high-quality, safe care in such adverse circumstances put nursing staff at a heightened risk of developing compassion fatigue and becoming burnt out.

10. Evidence shared with the Inquiry from RCN members highlights the sense of vulnerability felt by nurses, as well as feelings of fear, panic and dread at the emotional and physical toll of dealing with death, pain and suffering daily at levels they had never experienced before. Despite trying to give patients the best care, they faced an almost unimaginable scale of death and anguish in a health and care system which was completely overwhelmed in all care settings.

[1] [6/17/17-18]

11. Based on our regional intelligence gathered during the first wave of the pandemic, increased levels of staff absence had an impact on the ability of nurses to provide safe and effective care and had a significant impact on their own health and wellbeing. Registered nurses were under strain from increased workloads, while nursing support workers reported lower levels of supervision and feeling forced to work above their competency. This was further exacerbated during the second wave, with nursing staff displaying symptoms of Post Traumatic Stress Disorder ("PTSD"). The Inquiry has heard evidence from the respective Chief Nursing Officers who had reported their concerns about the ongoing impact of the pandemic on the wellbeing of the nursing workforce and their real fears about the long-term impact of PTSD[2].

12. Those fears were well-founded. As early as 1 May 2020, the results of the RCN Research Society's survey into the impact of Covid-19 on the nursing and midwifery workforce showed that staff were feeling depressed, anxious and stressed during the Covid-19 pandemic. There had been serious issues in gaining access to suitable and sufficient PPE and insufficient access to Covid-19 testing for health and care workers, meaning that many nurses and nursing support workers had been unnecessarily self-isolating, unable to work, placing additional pressure on other staff. Furthermore, alarmingly almost 30% of survey respondents reported experiences indicative of a probable PTSD diagnosis three-months after the first pandemic peak.

13. Research[3] undertaken in 2021 between King's College London and University College London which focused on the mental health of staff working in intensive care during Covid-19 showed a substantial burden of mental health symptoms were being reported by ICU staff towards the end of the first wave in July 2020. 40% of the 709 healthcare workers surveyed met the threshold for probable clinical significance for PTSD. The high rate of mortality amongst Covid-19 patients admitted to ICU, coupled with the difficulty in communication and providing adequate end of life support to patients, and their next of kin because of visiting restrictions, were highly challenging stressors for all staff working in ICU.

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[2] [6/85/12-22]
[3] INQ000474255_0056

14. The Inquiry will recall the powerful evidence of RCN member and nurse, Patricia Temple given on 04 November 2024, who recalled with sadness "*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.*"[4]

15. The Inquiry will also recall the harrowing evidence from Professor Kevin Fong given to the Inquiry on 26 September 2024, detailing his experiences and his discussions with frontline staff as part of his peer support visits as a national clinical adviser to the emergency preparedness resilience and response core during the pandemic. His evidence which described the trauma experienced by healthcare workers is vitally important and deserves setting out in detail:

> *"I was greeted at the entrance by one of the intensive care registrars. I asked him immediately what things had been like. He replied – I will never forget, he replied 'It's been like a terrorist attack every day since this started and we don't know when the attacks are going to stop'."*[5]
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> *"What were the nurses telling you?" A. "They were telling us that they couldn't operate at this level, they -- these diluted ratios, with one specialist ICU nurse covering four or six patients at a time. I remember in another hospital the nurses telling me that all you have time to do is to manage the alarms; you're not managing the patients. The alarms are going off constantly -- the syringe drivers, the ventilators, the beds, whatever you've got, the oxygen, and you're putting out fires, rather than caring for the patient."*[6]
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> *"…They didn't have enough staff to look after the patients coming through the door. They experienced the full range of challenge. They had a unit in which they had to*

[4] [25/11/12-22]
[5] [12/7/12-17]
[6] [12/9/18 – 12/10/2]

admit at times several of their own members of staff from their own hospital, and some of those people from their own hospital did die, and she told me about how difficult that was. To be a unit, to admit your own staff, to look after your own staff in the middle of all of this, and to watch them die is devastating. They were not alone. They were not alone in that."[7]

"The scale of death experienced by the intensive care teams during Covid was unlike anything they had ever seen before. They are no strangers to death. They are the intensive care unit. They look after some of the sickest patients in the hospital. But the scale of death was truly, truly astounding. I went into this and other hospitals where they said it would be routine to see three to five deaths a day. I worked on a shift where we had six deaths in a single shift. Another hospital told us that they had ten deaths in a shift, two of whom were their own staff. We had nurses talking about patients raining from the sky, where the nurses said that they -- one of the nurses told me that they'd just got tired of putting people in body bags, and at the hospital where they said sometimes they were so overwhelmed that they were lifting -- putting patients in body bags, lifting them from the bed, putting them on the floor, putting another patient in their bed straightaway because there wasn't time. We went to another unit where things got so bad, they were so short of resources, they ran out of body bags and they were instead issued with 9-foot clear plastic sacks and cable ties, and those nurses talk about being really traumatised by that because they had recurring nightmares about feeling like they were just throwing bodies away. These people are used to seeing death but not on that scale and not like that. And whatever the figures show you, the experience for them was indescribable. And when we talk about capacity in the healthcare systems, you know, the toll on those teams from that scale -- and it really was like nothing else I have ever seen and certainly like nothing else those teams had ever seen in their experience -- it was incredibly difficult."[8]

"I got there, I got onto the unit. It was just -- it was a scene from hell. The chief exec, the chief operating officer, chief medical officer, nursing officer, they were all

[7] [12/19/16-12/20/1]
[8] 12/21/11 – 12/22/22]

on the shop floor, all trying to do it, but this was a hospital in massive, massive trouble. We went in an intensive care unit first. The intensive care unit was nursing at 1:4 ratio, one specialist ICU nurse to four intubated patients, in the open area. In the side rooms, which have limited capacity, at 1:2. There were so few staff that some of the nurses had chosen to either use the patient commodes in the side rooms and some of the nurses had chosen to wear adult diapers because there was literally no one to give them a toilet break and take over their nursing duties. That was the intensive care unit. The intensive care unit was full. Their overflow areas were full. Their non-invasive ventilation unit, their respiratory unit was full. This was a hospital bursting at the seams…. When we got to the intensive -- when we got to the emergency department, we were told that a patient had died in an ambulance waiting to get into the hospital the night before. The same thing had happened that morning. The oxygen alarms are going off, the chief operating officer is trying to troubleshoot that with the estate's manager. It is genuinely the closest I have ever seen a hospital to a state of collapse in my entire career."[9]

16. As Professor Summers (professor of intensive care medicine and director of the Victor Phillip Dahdaleh Heart & Lung Research Institute at the University of Cambridge) noted in their evidence given to the Inquiry on 9 October 2024, "*you cannot be untouched by this, when you have seen what we have seen and done what we have done and if we want a working healthcare system this needs to be taken into consideration*"... *'We coped but only just' – what is often forgotten is that it isn't just a switch that can be turned on and off where we went from everything being okay to it not being okay and back the next second. We are a specialty of attention to detail. When we stretch those and we are unable to pay the attention to all of those details in the way that we would want to and that we know we are capable of, we are failing our patients really, or at least that is how it feels to us."*[10]

<u>The exacerbation of existing inequalities</u>

[9] 12/26/17-12/28/18]
[10] 19/71/3-19/72/9]

17. The Inquiry has already heard evidence in Modules 1 and 2 in which it has been widely accepted that the pandemic highlighted and exacerbated existing inequalities within society and impacted outcomes for certain groups in the population. Those who were most at risk of infection, severe symptoms and death were those with the worst health outcomes prior to the pandemic. The evidence heard during Module 3 of the Inquiry reinforces this position.

18. The RCN remains concerned at the unequal impact of Covid-19 on Black, Asian and minority ethnic people. Our members from ethnic minorities reported feeling unsafe and unsupported in the workplace, with a disparate experience of Covid-19 to their White British counterparts. By way of example, we received increasing reports of staff from ethnic minority groups being asked ahead of others to care for people with Covid-19. Anecdotally, our members reported feeling invisible, dispensable, and not valued. Some nurses reported experiencing racism and stigma because of how their race and ethnicity had been affected by Covid-19, so individuals believed that they were therefore also carrying the infection.

19. The RCN Second Personal Protective Equipment Survey of UK Nursing Staff published in May 2020[11] showed that for nursing staff working in high-risk environments including intensive and critical care units, only 43% of respondents from minority ethnic groups said they had enough eye and face protection equipment. This was in stark contrast to 66% of white British nursing staff. Furthermore, 70% of respondents from ethnic minority groups said that they had felt pressured to care for a patient without adequate protection as outlined in the PPE guidance, almost double the 45% of white British respondents who had felt this pressure. In July 2020, 19.7% of all staff working in the NHS and 21.8% of registered nurses, health visitors and midwives were from an ethnic minority background and Skills for Care estimated that 38% of the registered nursing workforce in social care were from an ethnic minority background.

20. The RCN was also concerned about pre-existing structural discrimination and institutional bias creating workplace conditions that also increased the level of risk for this group during the pandemic. The RCN undertakes a survey of its UK membership's

[11] [INQ000328873]

views and experience of employment every two years and has done so for the previous two decades. The 2019 employment survey[12] found that:

a) Nursing staff from ethnic minorities were more likely to work additional hours and far less likely to be employed in higher pay grades;
b) 65% of black respondents and 61% of Asian respondents are the main or primary breadwinner in their household in contrast to 55% of white respondents; and
c) 48% of Asian respondents and 47% of black respondents had experienced bullying from colleagues, compared to 38% of white respondents.

21. These multiple pressures resulted in greater exposure of staff from ethnic minorities to risk. In addition, it highlights why staff from this group may have been reluctant to ask their employers for a risk assessment or redeployment, fearing that they would be viewed negatively by management or colleagues as asking for 'special treatment'. Taken together, these findings suggest that there are problems with both overt and unconscious racism, structural discrimination, and institutional bias with the healthcare system which were brought into clear view during the pandemic. The UK Government must take action to reduce inequalities and the unequal impacts felt by those who are most vulnerable but who contribute so much.

Short staffing of the nursing workforce and the inability to scale-up capacity

22. The Covid-19 pandemic shone a spotlight on the critical role undertaken by nursing staff across the UK. It also highlighted that successive governments across the UK have underfunded the nursing profession and the wider health and care system over the past decade. Too few nurses have studied at university and joined the profession, too many have left their nursing careers and, of our colleagues that remain, too many feel overstretched and undervalued.

23. Nursing staff were left to work in a health service that wasn't resourced or staffed to deal with the pandemic. The voices of nursing professionals have finally been heard throughout the course of this Inquiry detailing the lasting distress and moral injury they experienced. But voices now need to be turned to action. We cannot fail to properly

[12] [INQ000328765]

resource and protect our vital profession. If we do not look after the people who deliver the care, they in turn cannot care for our patients.

24. There has been a continual boom and bust approach to nursing supply as well as NHS and care funding. Emergency funding packages have become commonplace because the system's finances are left to reach a critical stage before action is taken. As a result, health and care providers focus on the immediate financial and safety concerns at the expense of taking a longer term, strategic approach. Patient care and outcomes inevitably decline when the health and care system is continually fighting to maintain the status quo, unable to develop the necessary capability to improve and innovate.

25. Crucially, the size and characteristics of the healthcare nursing workforce, across all sectors, was inadequate to meet demand for care and service delivery prior to the pandemic, during the pandemic, and continues to be so after the pandemic. The Inquiry's findings in Module 1 bear repeating here. Public services, particularly health and social care, were running close to, if not beyond, capacity, in pre-pandemic times, normalised because of lack of long-term planning. Proper preparation for a pandemic costs money and needs the time and capacity of all involved to contribute. Had the UK been better prepared for and more resilient to the pandemic, some of that financial and human cost may have been avoided. Severe staff shortages and a hospital infrastructure which was not fit for purpose had a directly negative impact on infection control measures and on the ability of the NMC and the care sector to surge up capacity during a pandemic.

26. Ambiguity about responsibility for policy and funding interventions for the supply, recruitment, retention and pay of healthcare workers led to endemic and systemic workforce shortages. There is currently no specific legal accountability for the provision of staffing for taxpayer-funded services. As a result, costed workforce planning is not done consistently or strategically; nor is it based on credible modelling of population health to meet patient demand. This could lead to missed care and patient safety being compromised. Chronic staff shortages, especially in emergency and critical care nursing have impacted on the system's ability to cope both with the pandemic as well as ongoing service demands.

27. The Inquiry heard in this module how UK Government decisions on student funding left nursing in managed declined. The decision, taken by the then Chancellor of the Exchequer, George Osborne in 2017, to remove the nursing student bursary resulted in a 23% drop in nursing and midwifery applications. As Ruth May, CNO acknowledged during her evidence provided to the Inquiry on 17 September 2024 it was "*a catastrophic decision*" which ultimately resulted in England entering into the pandemic with 5,000 fewer nurses.[13] Ruth May noted that this was the equivalent of approximately 40 extra nurses in each hospital and that "i*t would have made a difference*" if the additional nursing workforce had been available.[14]

28. Despite the shortages being well recognised, the pandemic further highlighted the fragility of our health and care system; many student nurses disrupted their studies to support the emergency and were mobilised during the pandemic to address the shortfall in the workforce numbers. Nursing staff of all grades delayed retirement, and thousands of retired nurses returned to work. Many were redeployed to unfamiliar clinical environments, and organisations redesigned their service delivery model to maintain services to patients, residents in care homes, and the wider community. The impact on the nursing workforce and nursing students cannot be underestimated. Staff were redeployed to areas where they had no experience or expertise. The understaffing left inexperienced staff with too much responsibility which consequently had a significant detrimental impact on their mental health.

29. The Inquiry has received written evidence from Patricia Cullen, Former RCN General Secretary and Chief Executive[15] that our members raised a number of concerns relating to staffing, including staffing levels; the redeployment of staff; staff to patient ratios; insufficient training; and unsafe working conditions:

    a. *"Since the start of the pandemic, the team has been moved without consultation, over 4 times from different locations, finally to a community hospital 16 miles from their home base. During this series of moves they have lost their administrative support and faced changes to working patterns, again without*

[13] [6/20/12-13]
[14] [6/20/6-8]
[15] INQ000475581

consultation. The service has moved to 7-day provision, with many staff members regularly working 10 days straight shifts while covering for a number of staff required to shield or self-isolate"

b. *…Member was under impression that safe staffing levels in A+E should be 1 nurse to 4 patients. Due to short staffing Member is looking after 7 rooms in majors…Member feels her (nursing) pin and patient safety at risk. Member also triaging and concerned someone could deteriorate or even die in one of the rooms without her knowing…*

c. *"…Had only 1 hour training for Non-Invasive ventilation (NIV). Does not feel it is enough, is taught over several months in university…Now expected to look after NIV patients, should be 4 nurses to 8 patients. Now 1 to 6…"*

30. Nursing-to-patient ratios in critical care were stretched beyond breaking point. The surge in demand for critical care services was met by heavily modifying models of care and ICU staffing. These included a reduction in the ICU nurse: patient staffing ratio and skill mix, to a level well below the recommendations of the 2019 Guidelines for the Provision of Intensive Care. The Inquiry has heard evidence from Ruth May on 17 September 2024 regarding the regrettable decision to stretch the nursing-to-patient ratios in critical care resulting in some critical care nurses finding that they were responsible for caring for six patients. There is no doubt that the dilution of staff ratios affected the care those patients received as Ruth May readily acknowledged.[16]

31. The dilution of staff ratios had a very damaging impact upon the nursing workforce. In his briefing note[17] dated 29 July 2020 Professor Kevin Fong noted that there was evidence of significant negative impact on staff psychological health after having conducted a pilot Pulse Survey focusing specifically on frontline ICU and Anesthetic teams, across all grades and all roles; including doctors, nurses, healthcare assistants, operating department practitioners and administrative staff. Data was also obtained from 709 respondents, across five hospitals, at two separate time points. Overall, it was found that around 45% of the survey staff met the screening threshold for probable PTSD; with nursing staff being more likely to report more PTSD symptoms than doctors.

[16] [6/105/25 – 6/106/15]
[17] INQ000421181_0001

To put that statistic in perspective, in surveys of returning British military personnel, who had been actively engaged in combat during deployment in Afghanistan, the highest rates of probable PTSD, indicated by the same scoring system applied to NHS staff, ran at 17% (Stevelink et al., 2018). There is good evidence that mental health problems, such as PTSD, can substantially impair a person's ability to work effectively (Rona et al. 2008) and this is especially important in staff carrying out safety critical roles.

32. The dilution of nursing-to-patient ratios also had a severe impact on patients. Professor Kathryn Rowan, Director of the Intensive Care National Audit & Research Centre noted how those admitted to ICU on a 'busy' day (high bed occupancy) were 15-30% more likely to die.[18]

33. Dr Stephen Mathieu, President, Intensive Care Society noted in his witness statement that in order to be able to deliver pandemic level care would require the hiring of 2476 critical care nurses, 1238 of which with a postgraduate qualification.[19]

34. When set against this background, the Inquiry may well think that Matt Hancock's evidence given to the Inquiry on 21 November 2024 that "*the NHS was not overwhelmed by the pandemic*" was nonsensical and defied logic. As Counsel to the Inquiry rightly noted "*if you make a statement like "the NHS was not overwhelmed" and you can't get an ICU bed because you're old or you have Down's syndrome or because there aren't enough nurses, plenty of people would say that is "overwhelm", wouldn't they? And that's why it's not just semantics.*"[20]

35. Whilst there have been modest increases in the size of the nursing workforce, they have been significantly outstripped by the demand piled on the NHS during the pandemic. Nursing staff are now too commonly caring for patients in corridors or left in armchairs and too often are unable to give the quality of care they would want as Lord Darzi's Independent Review of the NHS in England highlighted.

[18] [15/1/20-15/2/6]
[19] INQ000472300_0057
[20] [36/52/8-13]

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

36. As the Inquiry's report for Module 1 indicates, the importance of PPE arose regularly in preparation exercises prior to the Covid-19 pandemic. However, existing stocks of PPE, based on modelling for an influenza pandemic, were insufficient. Without adequate and proper Respiratory Protective Equipment ("RPE"), nursing and midwifery staff put their own lives, and the lives of their families and patients, at risk. These supplies should have been based on Health and Safety Executive ("HSE") recommendations made in the HSE's report 'Evaluating the protection afforded by surgical masks against influenza bioaerosols', the need to comply with all relevant health and safety legislation, the adoption of a 'precautionary approach' to the protection of healthcare workers and, taking into account infection control guidance which reflected the latest available PHE scientific and clinical evidence, not dictated by cost or opinion or confusion over poorly understood and implemented frameworks such as the 'hierarchy of controls'.

37. As Sir Christopher Wormald (Permanent Secretary to the Department of Health and Social Care) made clear in his evidence to the Inquiry on 12 November 2024, the pandemic stock levels were vastly underestimated and pressure on global demand and supply, as expected in a pandemic, was not sufficiently considered. The Inquiry heard how, as at 18 February 2020 having been advised in June 2019 to get gowns, there was not a single surgical gown in the stockpile[21]. This failure to have any surgical gowns in the stockpile came at significant economic cost but also caused distress to nursing staff on the frontline who were having re-use or sessionally use gowns or in extreme cases to wear bin bags in an attempt to protect themselves.

38. Distribution of PPE was slow and not transparent. Public commitments to supplying adequate PPE had not translated into increases in consistently deployed and accessible stocks of suitable and adequate PPE across all health and care settings. The wider health and care system, outside of acute NHS hospitals, continued to provide care to vulnerable people in society yet there had been a disproportionate focus on considering supplies only for NHS hospitals.

[21] [INQ000389241_0057]

39. Due to inadequate preparatory supplies of PPE, there were reports that RCN members had been required to reuse equipment, to use equipment previously marked as out of date, to clean old gowns with alcohol wipes and to use alternative equipment which had been donated and did not provide adequate protection. Whilst public donations of supplies were signals of support to frontline staff, they did not replace the legal responsibility of system leaders and governments to ensure that correct PPE was provided. The RCN received reports of members wearing makeshift gowns out of bin bags, ski-masks or swimming goggles when PPE of the required standard was not available.

40. Our members reported that insufficient supplies of PPE resulted in some equipment made available to them being of an unsatisfactory standard. When existing stocks began to deplete, PPE was tested and re-labelled and items such as facemasks that had passed their expiry date were provided for staff. RCN members raised their concerns about out-of-date equipment being circulated to health and social care staff:

    a. *"We have been using an expired FFP3 mask in my hospital. The original expiration date was 2015. A yellow sticker was placed on to it with a 2017 expiration and another sticker on top of it showing a February 2020 expiration date. I have a video of the expired FFP3 boxes we been using in intensive care covid unit."*

    b. *"We are a team in endoscopy who have been given out of date masks 8yrs out of date and we are extremely anxious to be using them which we are at the moment. The only assurance we have been given is an email from Occupational Health saying they are fine with no reference to being out of date. Please can you inform us what we should do?"*

    c. *"I noticed yesterday that our FFP3 masks are expired - both boxes - last expiry date was mid 2019 - but both had had expiry dates under these stickers - one being 2014 the other 2016. When I questioned this my line manager went to stores to check and came back to tell me that Procurement had passed them as safe to use. When I questioned her further about the reason for expiry dates I was told they had been tested. Where do I stand?"*

41. Unfortunately, we do not know the full scale of the impact of these failings because of a lack of robust data on health and care worker infections acquired as a result of their job, and deaths by hospital in addition to any associated with PPE usage.

42. It is the view of the RCN that a lack of clarity on use of the term "PPE", combined with a culture of assumptions that historical influenza guidance and views on its transmission and impact on a UK population in the 21st century, was inadequate, placed nursing professionals at unacceptable risk in the workplace when faced with a novel pathogen. Challenges around distribution and the inequality in supplies/distributions for healthcare and other non-NHS services were among the main issues.

43. Professor Fong recalled in his evidence to the Inquiry on 26 September 2024 his experience of visiting one hospital where staff were wearing cagoules and waterproof trousers bought by the Chief Executive from an outdoors shop. "*They talk about going to Screwfix to get visors. They talk about running out of theatre scrubs and having to go to the local private hospitals and beg them for their supply and, when they'd run out of that, they talk about having to have one shift where they had no theatre scrubs, and they went around in their underwear and gowns for the shift.*"[22]

44. Further, one-size-fits-all protective equipment was a problem for frontline nursing staff who had to wear this life saving equipment for up to 12 hours at a time. At the time of the pandemic a number of manufacturers were not producing masks which fitted female faces, particularly with the shape and design of masks being too big and causing many female nurses and doctors to fail the fit-testing process. Nor did the masks meet the needs for an adequate fit for members of ethnic minority groups as is addressed in the following section.

45. The Inquiry heard from RCN member Patricia Temple on 4 November 2024 regarding the confusion that was caused on the frontline regarding inconsistence guidance on what PPE should be worn. The Inquiry will recall her evidence was that "*PPE guidance lacked clarity and changed regularly. When to wear masks? Which masks? When should we wear surgical masks and when should we wear FFP3? Full PPE for a Covid*

[22] [12/41/3-9]

positive patient or only for Aerosol Generating Procedures? …The adequacy of surgical masks for nursing all but for actively positive Covid patients was stressed all the time and we were told that surgical masks would offer sufficient protection. We were also advised to use FFP3 with care as supply was not reliable and stocks might not be readily available. There seemed to be no consistent guidelines on what to use and when. Even Infection Control Practitioners did not seem to talk the same language. As the pandemic progressed more emphasis was put on wearing gowns, gloves, and masks for the care of Covid positive patients, with visors being added for those patients on Aerosol Generating Procedures. One could question the risk of not having donned this type of protective equipment from the beginning and throughout the pandemic, particularly when one thinks of the suspected Covid patients we nursed wearing only surgical masks, only to have them declared Covid positive later."[23]

46. As was highlighted in the third witness statement given by Rose Gallagher MBE to the Inquiry[24], the RCN undertook two extensive surveys of its members working across all health and social care sectors in April and May 2020, specifically about the use and availability of PPE. The first survey, titled 'Personal protective equipment: use and availability during the Covid-19 pandemic'[25] received responses from 13,605 members, including those working in environments with possible or suspected Covid-19 but who were not themselves undertaking high-risk procedures, and others who were working in environments where high-risk procedures were being undertaken. Findings showed that:
    a. Of those treating possible or confirmed Covid-19 patients in high-risk areas, around half (51%) reported that they were being asked to re-use items of PPE marked 'single use' by manufacturers.
    b. Of those treating Covid-19 patients elsewhere (i.e. non high-risk areas), over a third (39%) said they were being asked to re-use this equipment.
    c. Almost a third of nursing staff treating Covid-19 positive patients not on ventilators reported an immediate lack of face and eye protection.
    d. One in ten nurses were relying on face or eye protection they had bought or was homemade.

[23] INQ000486012_0003-0004
[24] INQ000475580
[25] INQ000114401

e. 70% of respondents had raised concerns about PPE. Concerns were most likely to be raised with their manager either verbally (91%) and/or in writing (13%).

47. The second survey, titled 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic'[26] received 5,023 responses and found that:
    a. 34% of respondents felt pressure to care for individuals with possible or confirmed Covid-19 without adequate protection.
    b. 56% of respondents from ethnic minorities felt pressure to work without the correct PPE.
    c. 44% of respondents said they were being asked to reuse single-use equipment.
    d. 58% said they had raised PPE concerns, the majority being raised with their employer, but more than a quarter (27%) of this group reported that these concerns had not been addressed.
    e. As efforts were made to manage the pandemic, staff reported difficulties in communicating with patients or colleagues when wearing full PPE and many had been working in unfamiliar clinical environments.

48. There was mounting evidence of the stark and deeply worrying unequal impact of Covid-19 on nursing staff from ethnic minorities as reported by survey respondents. The RCN's first PPE survey, published in April 2020[27], revealed that staff from ethnic minority groups were more likely to report that they did not have access to adequate supplies of PPE compared to their colleagues from white British groups. Staff from ethnic minorities, working in high-risk areas and requiring the use of PPE such as FFP3 masks were less likely to have been fit tested for their PPE in comparison to their white British colleagues (49% compared to 74%).

49. Staff members from ethnic minority groups reported feeling less confident in their employer's ability to protect them from exposure to Covid-19 in comparison to their white British counterparts: almost a quarter of ethnic minority staff did not feel confident

[26] INQ000328873
[27] INQ000114401

at all, compared to around 1 in 10 white British staff. Although a high proportion of respondents reported that they had raised concerns to their managers, these concerns were reported as not always addressed. Staff from ethnic minorities reported that they were less likely to have their concerns addressed in comparison to their white British counterparts. Very few reported confidential discussions about safe redeployment especially during the peak of the pandemic.

Fit testing, fit test training and difficulties in using RPE and PPE which arose due to physical attributes

50. FFP3 respirator masks offer a high level of protection and require users to undergo fit testing by a person competent to do so in line with health and safety requirements. This ensures the mask fits the individual correctly and a tight-fitting seal is achieved to protect the wearer from inhaled hazards, in this case SARS-CoV-2 virus. Provision of a different brand of mask to the one normally used by an individual necessitated users of FFP3 masks to undergo additional fit testing for each brand of mask provided and used. Where different brands of FFP3 masks are provided in succession, the fit testing of all staff using masks will be repeatedly required. This resulted in staff being withdrawn from clinical care at the height of the pandemic response to undertake the necessary face-fit training and drained precious supplies of masks. Some members reported that equipment to undertake fit testing was not available to them and that demands to 'fit check' not 'fit test' (as per legal requirements) placed nursing and midwifery staff at risk due to issues with masks not providing an adequate facial seal due to different face sizes/shapes. This created additional pressure and delays for staff and the system at this critical time.

51. Nursing leaders reported being given up to 17 different types of masks within one Trust which meant that the fit testing of all staff was repeatedly required, and some members reported that equipment needed to undertake the fit testing faced additional procurement and supply issues.[28]

52. One-size-fits-all protective equipment had been a problem for frontline nursing professionals who had to wear this life saving equipment for up to 12 hours at a time,

[28] I N0000475580_0027

despite Health and Safety Executive advice on a one-hour maximum wear time. A number of brands were not producing masks to fit female faces, particularly with the shape and design of masks being too big and causing many female nurses and doctors to fail the fit testing process. An illustrative selection of the concerns raised by members follows.

a. *Member wears a headscarf. Member has been told to remove this. Member is wearing only surgical mask. Employer says that member has to remove scarf as she has failed fit test.*

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

c. *"None of my team at the moment have been fit tested for an FFP3 mask. We have now been told that there are not enough masks to test everyone so we will not be fit tested. Instead they recommend picking any FFP3 mask and for checking instead. Is this correct and in line with current guidance? Is this not putting us at risk?"*

d. *"Staff test one mask and then get issued with a different type of mask so have to fit test everyone again. No one has the capacity to keep doing this."*

e. *Member has to wear PPE for every shift but member has been having problems – disposable masks don't fit member. Have previously been told to fit check instead of fit test – but that's now changed couple weeks ago. Need to fit test everything now but masks just don't fit member's face – has to fight to get one that does. Member needs size small and they're just not coming in.*

f. *"I am a nurse of 15 years. I have hearing loss and wear bilateral hearing aids. I am struggling with patients and staff wearing masks as I rely on lipreading and facial expressions. I am at the point of giving up."*

53. In evidence given to the Inquiry in Module 1, Sir Christopher Wormald confirmed the Department of Health had purchased and stocked lower levels of PPE suitable to fit minority ethnic staff working in healthcare, and that little planning had been done to consider the equality of PPE provisions. The RCN agrees with FEMHO that this is a matter of grave concern.

54. Professor Jaswinder Bamrah CBE (Senior NHS consultant psychiatrist, Federation of Ethnic Minority Healthcare Organisation) staggeringly recounted instances of Sikh and Muslim men having to shave their faces for the first time at the direction of the HSE who noted "*the requirement to be clean-shaven to support an effective seal between the wearer's face and tight-fitting respirator has been in existence for many years and is not a new requirement of the current pandemic*".[29]

<u>The failure to properly consider and acknowledge the airborne transmission of Covid-19</u>

55. Intrinsically linked to the adequacy and provision of PPE were the impacts caused by multiple agencies advising the Government's understanding and application of how the virus was transmitted, which was contradicted by historical evidence of other coronavirus outbreaks such as SARS and MERS CoV and the emerging scientific evidence. The RCN lobbied the UK Government and Devolved Administrations to review and accept that SARS CoV-2 should be managed as an airborne virus rather than one transmitted predominantly by droplets. However, the Government allowed or were persuaded to accept the belief that the virus was transmitted via droplets (unless in specific Aerosol generating procedures ('AGPs')) to permeate and inform every decision and guidance issued by its official agencies in relation to infection prevention and control during the pandemic.

56. The RCN notes this advice contradicted the advice provided to the wider public who were encouraged to open windows to remove infective particles lingering in the air in

[29] [18/27/8 – 18/28/4]

their homes as described in the Hands, Face, Space Government video of November 2020. Rose Gallagher MBE, RCN IPC Professional Lead noted in her evidence to the Inquiry on 04 November 2024 how:

> "*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 for where they worked, they noted the difference.*"[30]

57. Given the extent of its concerns, and its inability to influence alternative thinking and action to support the prevention of infection for staff and patients, the RCN was faced with no alternative but to commission an Independent Review of the UK IPC guidance, undertaken by Professor Dinah Gould, an Honorary Professor of Nursing at London's City University and Dr Edward Purssell, also from City University and published this on 07 March 2021[31]. The Inquiry heard from Rose Gallagher MBE in her witness statement, that it was never a measure that the RCN would have expected ever to take[32]. The report questioned the methodology used and evidence reviewed to inform UK wide-guidelines for infection prevention and control 12 months into the pandemic when opinions about the way that SARS-CoV-2 was transmitted had changed and it was becoming apparent that airborne transmission beyond the technical process of aerosol generating procedures was possible and likely.

58. The RCN's own independent expert report was shared directly with a number of key stakeholders, but at no time did these parties suitably address the concerns raised by

[30] [25/71/12 – 25/72/11]
[31] INQ000114357
[32] IN0000475580_0035

the RCN and initiate their own independent reviews, to critically challenge the accepted dogma at the time, as per the original request of the RCN. The later decision by the World Health Organisation to categorise Covid-19 as an airborne virus vindicated the RCN, but it came too late for those who had acquired Covid-19 as a result of inadequate PPE.

59. Ultimately, the RCN found that there was a serious lack of critical thinking and engagement by the UK Government and its agencies to consider the growing international scientific evidence of airborne transmission of Covid-19; the UK Government and health leaders displayed group think and dismissed such evidence and found in favour of ongoing enforcement of droplet transmission dogma despite the absence of any supporting evidence.

60. The Inquiry is invited to consider the evidence of Laura Imrie, from ARHAI, in which she noted that there were two constraints to adopting the precautionary principle in IPC guidance, contrary to the management of risk under Health and Safety legislation and consequently, the provision of PPE:

> *"I don't think we were in a position to use FFP3s widely in the NHS. As you're aware, due to the UK legislation to advise the use of FFP3 means that someone needs to have a face fit test. I know roughly in Scotland at the start of the pandemic there was around 7,000 staff members who had an up-to-date face fit test which is a drop in the ocean. And I believe that the other UK countries would have been in a similar position. That was one of the considerations. And there was also -- I am assuming what you're talking about is applying a kind of precautionary principle. There was also supplies. If we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have had a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would also have had high risk areas where we had identified for intensive care units, high-risk pathways that might have been left without the FFP3s."*[33]

[33] [26/149/6 – 26/150/17]

61. Expert evidence provided by Clive Beggs, Emeritus Professor of Applied Physiology in the Carnegie School of Sport at Leeds Beckett University, was critical of the IPC cell's failure to acknowledge airborne transmission until late 2021 and recommended that there needs to be better education about airborne transmission for nursing staff and those completing risk assessments[34]. The RCN strongly agrees with this position. All plausible routes of transmission should be considered in a future pandemic and a precautionary approach taken, with IPC national guidance reflective of this.

The development of IPC guidance

62. The RCN found that there was a serious lack of engagement from the UK IPC Cell, PHE/UKHSA, HSE and the Department of Health, amongst others when developing, reviewing and updating IPC guidance, despite previous experience as learning from previous international incidents on the use of PPE, and recommendations to do so. The RCN's expectation was that stakeholders such as the Royal Colleges, BMA and other relevant professional societies would be proactively engaged, especially given the seriousness of the situation, in the development of guidance to ensure appropriate contextual content and implementation in practice.

63. As the pandemic progressed the RCN's correspondence and proactive professional offers to support the development of such guidance were often ignored or offers to meet to provide evidence supporting critical thinking turned down. The RCN expected that, given the fundamental role of the nursing profession as the largest professional workforce in implementing IPC measures, that guidance-making bodies would want to engage with the profession. Nurses had, and have, unique and useful expertise in order to inform those who developed and approved IPC guidance and are ultimately responsible for implementing such guidance in practice. As Rose Gallagher acknowledged in her evidence to the Inquiry on 04 November 2024 "*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.*"[35]

[34] N0000474276_0053
[35] [25/29/2-6]

64. This lack of engagement prevented the RCN from being able to put forward practical and clinical rationale for amendments to draft guidance in order to protect patients and clinical staff during the delivery of care. This approach also impacted on the ability of stakeholders such as the RCN to consider the implementation of guidance across different care settings where specific considerations were necessary, such as mental health inpatient, community or prison settings. The response to the pandemic would have been more effective had government and associated agencies taken a more open and collaborative approach to working with key stakeholders with relevant expertise. Advice from the frontline of the nursing profession could have enabled decision-makers to have a clearer understanding of the practical realities for nursing staff and supported communication and implementation on publication.

Risk assessments

65. It is a legal requirement that suitable and sufficient workplace risk assessments are carried out by employers and adequate control measures identified to reduce risk from hazards as far as reasonably practicable -- Regulation 3 of the Management of Health and Safety at Work Regulations and Control of Substances Hazardous to Health Regulations. Given that legal framework individual clinicians should have been empowered by their managers to determine the correct level of RPE/PPE that they required based on their own dynamic risk assessments and informed by their organisation's workplace SARS-CoV-2 risk assessment.

66. The Inquiry has heard a wealth of evidence that such workplace risk assessments were absent or, where they did exist, were inadequate. The extreme experience of some members was that RPE deemed necessary by their individual assessment of risk in the workplace was physically removed from their work environment to avoid its use. This revealed a dangerous and worrying precedent and lack of understanding of legal requirements and failures in assessing and communicating risks by employers.

67. Professor J S Bamrah CBE during his evidence to the Inquiry on 08 October 2024 spoke of the delays experienced by healthcare workers that required risk assessments to be undertaken. "*In the first instance getting the policy off the ground was really very*

difficult…there were greater delays in actually implementing that policy and…were implementing it very variably in the Trusts."[36]

68. Nursing staff were significantly at increased risk of infection from Covid-19 (six times higher than some other occupations[37]) but did not receive adequate nor timely workplace and individual risk assessments. Had they done so, the deaths of some healthcare workers and those suffering from Long Covid could have been avoided.

The severe underreporting of Covid-19 infections for nursing staff via RIDDOR

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

70. The BMA has disclosed to the Inquiry the number of RIDDOR reports it understands (from a Freedom of Information request) the HSE received from NHS employers between 16 May 2021 to 19 February 2022[38]. Between those two dates, out of the 98 NHS employers listed, 51 made three or fewer RIDDOR reports in total for infections and fatalities. The RCN was aware of a significant variation in RIDDOR reporting and expected the HSE to analyse the reasons behind this. The RCN's view was that there were elements of the RIDDOR reporting guidance that actively dissuaded employers from making a report.

71. The RCN believes that the HSE failed to hold employers to account for failing to make proper judgements as to whether a confirmed diagnosis of Covid-19 was likely to have been caused by occupational exposure. All frontline staff deaths related to Covid-19 should have been reported as occupational fatalities as a precaution.

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

[36] [18/38/16-25]
[37] INQ000271363
[38] INQ000397330

Covid-19 infection was occurring. It also prevents external bodies from scrutinising whether the government's strategy is working in real-time. As Philip Banfield noted in his evidence to the Inquiry on 28 October 2024 "*an enormous number of healthcare workers who really can only have caught Covid in the workplace and are now disabled and unable to earn a living are required to undertake individual litigation to have their workplace acquired Covid recognised. And it is difficult for us because, you know, the RIDDOR reporting is supposed to be based on whether there is a reasonable chance – the goal posts seemed to move in the pandemic to balance of probabilities and then "well you don't need to report it if someone was using the IPC relevant PPE at the time"*[39] *and I would expect the system to protect me. And therefore if there wasn't and should have been an opportunity to highlight that harm was coming sooner, then we would have recognised that more needed to be done and we could quite possibly have saved many of the lives that were lost."*[40]

73. The fact that the rate of death amongst nursing staff was significantly higher than the general population of a similar age group highlighted the need to properly investigate the factors contributing to their deaths, and, in the light of the lessons learned, to give nursing staff the protection from risks that they needed.

74. Amanda Pritchard, Chief Executive of NHS England ("NHSE") in her evidence to the Inquiry on 11 November 2024 accepted from an NHSE perspective that on entering the pandemic there was no systematic national mechanism to capture NHS staff deaths[41]. Whilst NHSE recorded 559 deaths of NHS staff during the pandemic, there had been no formal system in place to record such deaths previously and this made reporting difficult. Stephen Powis in his evidence to the Inquiry on 07 November 2024 noted how "*I'm sure that there is more that we could do to perfect that, but I think we have learnt a lot from doing this.*"[42] More does need to be done in readiness for future pandemics. It is unacceptable that we were unable to know how many healthcare workers had died as a consequence of their work during the pandemic.

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[39] [21/146/9-20}
[40] [21/149/3-9]
[41] [29/144/23 – 29/146/21]
[42] [28/82/12-28/83/3]

Long Covid support for those who were exposed to Covid-19 whilst at work and the subsequent impact

75. The Inquiry heard powerful impact evidence from RCN Member Patricia Temple on 04 November 2024 regarding the lasting impact of Long Covid on her day-to-day life. Her issues with long covid persist to this day and she talks of noting with enormous dismay the ongoing dismissal from employment of nurses with Long Covid. "*The same people who made an enormous sacrifice, who put themselves at risk to care for others, are now being made to feel disposable. I feel that this is extremely unfair and that much more should be done to try and understand long covid and its effects and to provide a far more supportive environment for these nurses while they recover.*" [43]

76. The Inquiry heard how her financial and personal independence and her ability to earn my own living and not ask for help, which had long been a source of great personal satisfaction and a much-valued achievement, had been detrimentally affected and how, in turn, the loss of this independence has had a profound effect on her and her psychological well-being. Her work, her nursing record, her nursing identity and her nursing image, a most prized possession and one that she has fought hard to develop, improve, maintain, preserve and to role model, over many years were cut short with her long covid diagnosis and her employer's inability to make reasonable adjustments to allow her to return to work in another role. A hard loss indeed.

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

[43] INQ000486012_0004-0005

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

79. A new RCN report into members' experiences of Long Covid, (RCN (2024) *Survey of RCN's Members Experiences of Long Covid*, further shows the devastating and life-changing impact this has had for many members. 65% of respondents said their symptoms have a consistent and ongoing impact on their daily life while 7 out of 10 respondents have taken a financial hit due to the impact of Long Covid, with some reporting a negative impact on their emotional and mental wellbeing.

> *"Having suffered from Long Covid for 18 months, and been through a roller coaster of health issues, with little understanding from my employer, who makes you feel like you are 'milking' the absence. If only they knew how bad day to day life with Long Covid symptoms. Not to mention the financial impact. When you have managers saying – we may need to pay you off on capability terms without me even having yet returned to work – talk about putting the pressure on. Feeling like you are holding people up/back also impacts on your mental health. Anxiety of how long will this last. How will I cope going back to work etc. No one fully understands the true impact.*"
>
> Female, aged 55-64, long covid symptoms for 12 to 18 months

80. The Inquiry has heard expert evidence from Professor Chris Brightling and Professor Rachel Evans regarding Long Covid. They noted how healthcare workers were at higher risk of contracting Covid-19 during 2020, and particularly during the lockdown period when everyone else was isolated, they were at much higher risk of developing Covid-19 and therefore higher risk of developing Long Covid. It is estimated that 2 million people are still living with Long Covid. There are a number of challenges for healthcare workers who are suffering with Long Covid not the least of which is that they often contracted

Covid at work whilst trying to help people. "*The NHS needs to really support people returning to work. The vast majority of people I see actually try to return to work too soon, that it is the thing that is prioritized over everything else. So even though they can barely do something, they're telling you that they're still trying to get to work. healthcare workers try to return to work far too soon even though they can barely do anything…Long Covid is not fixed, it is incredibly variable changeable, and the fatigue really needs a very carefully planned, flexible, phased return. So the NHS can do a lot better to facilitate that*".[44]

81. To date, despite most European countries and many countries globally classifying Covid-19 as an occupational disease, the UK government is yet to follow suit. As a minimum, the UK Government must enact the recommendations of the Industrial Injuries Advisory Council (IIAC). The IIAC, in their November 2022 Command Paper, recommended that the list of prescribed occupational diseases for which Industrial Injuries Disease Benefit can be paid should be expanded to include health and social care workers with 5 serious pathological complications following COVID-19 infection. This should be the starting point, paving the way to recognition of Long Covid as an occupational disease and the subsequent benefit paid to workers who have suffered financial losses as a result of occupational exposures. The increased risks of Covid-19 infections faced by nursing staff from ethnic minorities, and thereby increased risks of Long Covid, require particular consideration.

82. As RCN member Patricia Temple told the Inquiry on 04 November 2024, "*you can't be clapped for one minute and disposable the next*".[45]

Conclusion

83. In light of the issues raised within these closing submissions, the RCN makes the following recommendations for the Inquiry to consider:

84. **There needs to be a suitably resourced, educated and trained healthcare workforce in place that can respond to the next infectious disease challenge at**

[44] [22/117/19] – [22/118/17]
[45] [25/19/16-17]

speed. Staffing levels need to be based on workforce projections that reflect actual population need, with safety-critical nurse-to-patient ratios enshrined in law. Without an adequate number of medical, clinical and healthcare workers, with the right mixture of skills and who are able to deliver the appropriate standard of patient care to meet the demand of the country at the present time, in the absence of a pandemic, then there is a poor prospect of the demand created by a future pandemic being met. Transparency with the public, who expect care in such circumstances, must be in place in order to manage expectations and enable public support to follow advice and personal preventative actions.

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

86. During the Covid-19 pandemic, a vital opportunity was missed by UK government and its agencies to recognise the value of the contribution the RCN could have made due to its access to clinical expertise and strategic oversight/intelligence on nursing issues impacting on delivery of health and care services especially to the most vulnerable in all settings. **Full and proper engagement through partnership working with the nursing profession on infection prevention and control national guidance, from the formative stages through to implementation and monitoring, is needed to ensure guidance is robust, fully informed, evidence based and effectively implemented**.

87. **There must be professional nursing representation equivalent to medical representation at briefings/meetings etc. regardless of whether these are led by the CMO or other health leaders.** The emergency response to incidents like pandemics requires multi-professional support and engagement where all professional disciplines are considered equal.

88. **Transparent governance and visibility of all cells, their membership and response teams to enable a full understanding of incident response mechanisms and risk management as situations evolve.** This should apply to UK wide and devolved cells.

89. **There must be input from non-IPC specialists when producing future IPC guidance, including health and safety experts, occupational hygienists, aerosol scientists, occupational health, and wider professional stakeholders such as paramedics, midwives, speech and language therapists, etc. whose roles align with nursing care and wider public service delivery such as education.** A holistic approach avoids group think, ensures that IPC guidance is implementable and provides an opportunity for specialisms to raise concerns at an early stage in the process before guidance is finalised and published. This is a key lesson which should be implemented in the development and production of future IPC guidance. Had this been in place during the Covid-19 pandemic, as it was for swine flu in 2009, concerns over the applicability of IPC guidance and AGPs could have been addressed prior to publication.

90. Taking forward the recommendation of the RCN's own Independent Review [INQ000114357] that **the team responsible for issuing and updating the interim IPC guidance should form a post-pandemic group with an independent non-IPC Chair to undertake a wide multi-professional stakeholder debrief on lessons identified and implement recommendations based on this**.

91. **The government must adopt a longer-term approach to sustainably manufacturing, procuring and maintaining stockpiles of PPE as well as other medical equipment essential for staff and patient safety.** Procurement should be harmonised between government departments, and additional resource should be factored in to enable the expertise of clinical procurement staff to be central to decision-making processes.

92. **All governments and employers in the UK must ensure that all nursing staff, regardless of practice setting, geographical location, role, employer or finances, have access to the necessary PPE of the required standard, to use when required**. The quality and quantity of PPE that an essential health and care worker receives should not be left to chance.

93. **The needs and perceptions of ethnic minority nursing staff should be fully explored and addressed within pandemic learning.** This should seek to understand the underlying causes, which have contributed to worse outcomes for staff from ethnic minorities and must be tackled. As a result of inadequate supplies, our members reported examples of clearly unsafe practice including using equipment previously marked as out of date; re-using single use PPE, cleaning down old gowns with alcohol wipes, and even having to use donated equipment. Our ethnic minority members reported more difficulty in accessing PPE throughout the first wave of the pandemic.

94. **There should be urgent funding for the development of reusable respiratory PPE that is acceptable to staff and patients and a mechanism to enable UK manufacturing to avoid future supply chain disruption.**

95. **There must be greater transparency and governance of the procurement process for PPE at government level during incidents where demand increases.**

96. **There needs to be comprehensive data collection and systematic reporting on deaths, infection rates and self-isolation rates for nursing staff (capturing protected characteristics such as ethnicity and gender data)** in order to accurately scrutinise the impact of infection, prevention and control measures in real time. This should apply to all care sectors not just hospitals.

97. **There needs to be proper management and support for the health and wellbeing of nursing staff at all times but particularly at times of national response to incidents**. This includes enabling staff to take breaks in suitable rest facilities and annual leave and reviewing and controlling working patterns to prevent long shifts or excess hours being worked. We invite a particular recommendation that all employers make available and fund timely access to confidential counselling and psychological support for all staff, to which they can self-refer. As Professor Fong rightly recognised, "*we go in and we check our machines and our drugs every day to make sure that they are there when we need them in a difficult moment. No one really does that for our staff. We do not have the right mechanisms to measure and monitor, protect and promote the wellbeing of the human workforce upon whom everything depends, whether you are in a pandemic or not. Wellbeing of the workforce should be a central strategic priority for the*

NHS, whether it is in the pandemic or not. And it needs better resourcing and it needs better attention than it has had".

98. **There must be effective self-management and support in the community for those with Long Covid**. It is vital that the findings of research into Long Covid amongst health and social care staff inform workforce planning needs. Support for these staff members needs to continue and the impact of Long Covid, in terms of increased long-term absence, needs to be factored into workforce planning.

99. **The UK government must classify Covid-19 as an occupational disease and afford healthcare professionals better support through policies, guidance and occupational health provision.** In addition, the RCN calls for a key worker compensation scheme to provide financial support to healthcare workers suffering from long covid.

100. The RCN has been grateful for the opportunity to contribute to Module 3 of the Inquiry. The Inquiry's recommendations are keenly awaited: lessons must be learned, and the same errors must not be repeated when the next pandemic inevitably occurs. Healthcare workers deserve better.

RCN Legal Services

December 2024