Witness Names: Rosemary Gallagher
and Suman Shrestha
Statement No.4 of Rosemary Gallagher
and statement No.1 of Suman Shrestha
Dated: January 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF ROSEMARY GALLAGHER AND SUMAN SHRESTHA

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

Rosemary Gallagher

1. I make this statement, about the RCN's views on the public procurement of Personal Protective Equipment (**"PPE"**) and Covid-19 tests, namely lateral flow tests (**"LFT"**) and polymerase chain reaction.(**"PCR"**) tests across the UK public sector in relation to the Covid-19 pandemic and the onwards distribution of the same, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 30 August 2024, in relation to Module 5 of the Inquiry. The facts and matters contained within this statement in relation to PPE and testing are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

Suman Shrestha

2. I make this statement, about the RCN's views on the public procurement of other key equipment and supplies, including ventilators, oxygen and continuous positive airway pressure (**"CPAP"**) devices across the UK public sector in relation to the Covid-19 pandemic and the onwards distribution of the same, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 30 August 2024, in relation to Module 5 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is

identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

3. Although provided in a single witness statement, each author is only able to speak to their area of professional expertise. To ensure clarity as to which part of the statement is attributable to which author, headers are used throughout with the name of the relevant individual.

Background of authors

Rosemary Gallagher

4. I am the Professional Lead for Infection Prevention and Control ("**IPC**") and nursing sustainability lead at the RCN. I was appointed to the role substantively in July 2009 and have retained responsibility for IPC and antimicrobial resistance ("**AMR**") since then. In addition to this portfolio, I have also led and supported a number of RCN member communities including forums or networks across a range of nursing practice areas including, for example, blood transfusion, renal nursing, breast care and cancer nursing, gastroenterology and procurement. I currently sit on a number of external national committees aligned with my RCN work, skills and expertise such as the Royal College of Physicians Patient Safety Committee, NHS England Emergency Planning Resilience and Response ("**EPRR**") Clinical Reference Group and English Surveillance Programme for Antimicrobial Utilisation and Resistance ("**ESPAUR**") group. I previously represented the Royal College at the UK AMR Diagnostics Committee and the New Hospital Programme Oversight Committee which is not currently meeting. I am also a Trustee for the UK Health Alliance on Climate Change and sit on the Executive Committee in that capacity.

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

Suman Shrestha

6. I am a Professional Lead for Critical Care at the Royal College of Nursing. I qualified as a Registered Nurse in November 2000 and have been working in critical care since 2001. I am also a Consultant Nurse and work in intensive care at an NHS hospital. I have been working as a Professional Lead for Critical Care at the RCN since August 2017 on a part time basis.

7. I worked as an Intensive Care Unit (**"ICU"**) Registered nurse, Advanced Critical Care Practitioner and Consultant Nurse throughout the pandemic in intensive care. I provided support and leadership to the clinical team in terms of education, training, and clinical management of ICU patients. Within the RCN, my role was to represent the RCN at national forums related to critical care and provide advice and support to the RCN and its members on matters related to critical care.

Brief overview of the role, function, aims and membership of the RCN

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

9. The RCN is the world's largest professional body in and union for nursing, with a membership of over half a million registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets. The RCN's members work in a variety of hospital and community settings in the NHS and independent sector – over 300,000 members are employed in the NHS. The RCN supports members across all four countries of the UK and internationally, and has offices in Scotland, Northern Ireland, Wales and nine regions across England. These offices support the activities of local RCN branches, as well as learning representatives, stewards and safety representatives in their area. Each of the four countries is led by a country Director, who sits on the RCN's Executive Team. The RCN Executive Team is responsible for delivering the RCN's strategic and operational plans.

10. As a member-led organisation, the RCN works collaboratively with its members to ensure that the voices of nursing and their patients are heard. The RCN promotes patient and nursing interests on a wide range of issues, including pay and terms and conditions, health policy and workforce strategy. It does this by working closely with the Government,

UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Reports of shortages of PPE

Rosemary Gallagher

11. The RCN interactive member support service, RCN Direct ("RCND"), which consists of a call centre and online platform, received more than 4,500 queries referring to PPE during the relevant period, of which approximately 400 related to queries on appropriate PPE for administering Covid-19 vaccinations. Of the remaining 4,100 calls almost 1,300 reported lack of access to PPE or lack of access to adequate PPE.

12. Approximately 700 of the queries related to a general shortage of PPE or a lack of specific items or sizes of PPE. Members told us that they were unable to access the specific type of FFP3 respirators that they had been fit tested for. We heard of problems in finding alternative Respiratory Protective Equipment ("**RPE**") when members could not tolerate wearing specific brands or were unable to pass fit testing due to the shape of their face. We also heard of ill effects of fluid resistant surgical face masks ("**FRSM**") or FFP3 respirator use, including discomfort and breathing difficulties, due to health conditions such as asthma. Our members reported concerns about out-of-date PPE, some of which broke upon use or had physically degraded. A small number of members reported being asked to shave facial hair to be fit tested, when this was inappropriate for religious reasons. We also received reports that members with hearing problems who worked with or provided care to deaf people were experiencing difficulties in communicating (for example lip reading) due to the non-transparent nature of FRSMs and FFP3s.

13. Approximately 570 contacts related to concerns about an inappropriate level of PPE, including the provision of PPE in the community setting and in nursing homes when compared to the level of PPE provided in hospital settings. The reports also included concerns about the downgrading of PPE during the pandemic and the classification of aerosol generating procedures ("**AGPs**") which in turn impacted the level of PPE provided.

14. The RCN took a number of steps to escalate and address these issues. 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 in order to gain a better understanding of the depth and scale of the problem members were reporting. The first survey, titled 'Personal protective equipment: use and availability during the Covid-

19 pandemic' **[SS/001 - INQ000114401]** 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.
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%).

15. The second survey, titled 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic' **[SS/002 -INQ000328873] [SS/003 - INQ000427462]** 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.

16. These survey findings were shared with a number of relevant stakeholders including the Department of Health and Social Care ("**DHSC**"), the UK Prime Minister **[SS/004 - INQ000328874]** the Scottish Cabinet Secretary for Health and Sport **[SS/005 - INQ000328878]**, members of the Welsh Senedd **[SS/006 - INQ000328820]**, Audit Wales

[SS/007 - INQ000427472] the HSE **[SS/008 - INQ000417594]** and NHS England and NHS Improvement **[SS/009 - INQ000427471]**.

17. The first RCN PPE survey was reported in an RCN Northern Ireland press release and web story and was subsequently extensively referenced and quoted in a report published in 2022 by the Northern Ireland Audit Office on the supply and procurement of PPE **[SS/010 - INQ000417702].**

18. The HSE responded to our survey findings on 17 April 2020 **[SS/011 - INQ000417596]** acknowledging the survey results and noting that HSE was working closely with other Government departments including DHSC, NHS and PHE to facilitate efficient procurement and distribution of suitable and effective PPE.

19. NHS England and Improvement in their response noted that there had never been a shortage of respirator masks or gowns and requested more data which was subsequently provided **[SS/009 - INQ000427471]**.

20. There was mounting evidence of the 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 **[SS/001 - INQ000114401]**, 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%). One member noted how:

> *"I stood my ground and highlighted it was preposterous she expected us to work without adequate PPE. My refusal to work wasn't me being insubordinate, it was merely me looking out for the safety of the other patients on the ward who were negative and my colleagues I was working with. The thing that worries me the most from this incident is how many staff have probably encountered this with said sister and have worked without adequate PPE … As I belong to an ethnic minority group myself this then poses the question that are we losing more BAME healthcare workers because they are being told to work without the adequate PPE."*

21. 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 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.

22. What follows, under relevant sub-headings, are illustrative quotes taken from RCND's call logs **[SS/012 - INQ000328870]** for the relevant period and the RCN's social media logs **[SS/013 - INQ000328871]** maintained from March 2020 to June 2022, detailing concerns raised by members and the subsequent actions taken by the RCN in an attempt to resolve these issues. Those in quotation marks are direct quotes from written correspondence from members, whereas those not in quotation marks are the RCND call operator's contemporaneous summaries of concerns raised by members as recorded in the RCND's call logs.

PPE procurement

Rosemary Gallagher

23. As well as reports specifically on the availability of PPE, members also raised numerous issues in relation to PPE procurement, such as equipment not being fit-for-purpose, a lack of clinical engagement in procurement decisions, and poor packaging of PPE which in turn impacted access to adequate PPE for nurses and other healthcare workers:

    a. "So far we have had 4 different types [of mask] from 2 different manufacturers, none have been clinically acceptable, they simply do not fit. I am aware that contracts have already been signed to purchase. When I have fed back to cabinet office that they don't fit, I was told any mask was better than nothing. Another company on a call wanted to know how the NHS fit test masks, and when I questioned them on which Trusts were already using their FFP3 masks, or had evaluated, they said none, yet they have also been contracted to supply into the NHS."

b. "The clinical engagement is being done AFTER the purchasing decisions have already been made. It is paying lip service to it and is too late once decisions have already been made based on tech specs, NOT clinical specification and evaluations."

c. "We also were sent some dust masks which were allegedly FFP3s, but no way would they pass a fit check."

d. "Packaging of Type IIRs is shocking, come wrapped inside the box, so you have to open the box, take the whole 50 masks out of the plastic packet and put them back into the box. Some you have to dispense from the side of the box, so you pull and loads come out. Certainly risk contaminating a box of masks."

24. I raised these concerns during a conference call with the Cabinet Office and NHS England ("**NHSE**") and NHS Improvement ("**NHSI**") on 08 July 2020 **[SS/014 - INQ000328881]**. To the best of my knowledge, the conference call only had England representatives present. This took place as a result of member concerns raised following the publication of an interim PPE procurement structure **[SS/015 - INQ000417641]**. Members had raised concerns at the apparent lack of clinical presence in the structure, the lack of detail on the links with the 'Clinical and Product Assurance' (**"CAPA"**) function of NHS Supply Chain, and the lack of transparency on the evolution of this work. Whilst the focus remained on procuring PPE that met technical standards, member concerns focused on the equivocal need for clinical acceptability of products to support their safe and effective use. Members also raised concerns on the procurement of sub-standard PPE sent to Trusts in England and highlighted the benefits of implementing clinical evaluation at an earlier stage of the process within the published structure. Meeting attendees acknowledged that local procurement was a challenge. A decision-making committee ("**DMC**") had been established to assess products where questions had been raised about their suitability for health and care settings. I was informed that this DMC was made up of technical assurance individuals and regulatory bodies. I requested a nursing presence via a specialist procurement nurse on the DMC to support decision making. Whilst we understand that there was no specialist procurement nurse, three nurses were present on the DMC.

25. The RCN understands that the Cabinet Office was responsible for purchasing decisions for NHS England and that individual countries had their own procurement processes in place. The RCN understands that Government worked with all four UK countries to support procurement and the mutual aid of PPE. We have no details of how this process worked or when it was implemented. It is assumed that information shared during the conference call on 08 July 2020 would have been disseminated to representatives in the other UK countries who were responsible for procurement of PPE.

26. By way of follow up to the conference call on 08 July 2020, I emailed NHSI/E on 16 July 2020 and forwarded a number of member concerns she had received regarding PPE procurement including photo evidence **[SS/016 - INQ000328900] [SS/017 - INQ000427455] [SS/018 - INQ000427444] [SS/019 - INQ000427445] [SS/020 - INQ000427446]**. I reminded NHSI/E that there were a number of experienced RCN members who would be happy to support evaluation of PPE procurement either via the DMC or as part of various groups looking into different aspects of current and future procurement of PPE. This was based on previous RCN involvement in procurement and clinical evaluation methodologies of consumables used by nurses to deliver patient care. To my knowledge, I do not believe that this offer was ever taken up and I am unable to locate any response.

27. I also took the opportunity in my email to explain that I had been contacted by one Trust who had raised concerns over the complexity of reporting issues with PPE as some items needed to be reported via the Medicines and Healthcare Products Regulatory Agency ("**MHRA**") and others via different routes, and how time consuming this was if there were multiple issues, adding unbearable pressures to specialist procurement nurses supporting NHS Trusts and wider systems at this time **[SS/021 - INQ000328894]**.

28. MHRA is the executive agency of the Department of Health and Social Care that acts on behalf of the Ministers to protect and promote public health and patient safety by ensuring that medicines and medical devices meet appropriate standards of safety, quality, and efficacy. The MHRA ran a dedicated coronavirus Yellow Card scheme which collected and monitored information on suspected safety concerns or incidents involving medicines and medical devices. Where PPE was for patient protection i.e. surgical gloves or masks, it would be classed as a medical device and therefore any issues were reportable via the MHRA yellow card system. Where PPE was for the protection of the individual wearing it, it was not classed as a medical device. Reporting of incidents or faults with PPE that was

not a medical device i.e. FFP3 marks, eye protection etc needed to be raised with the HSE. In addition to reporting issues via MHRA and HSE, PPE related incidents should have been reported via local incident reporting mechanisms such as by submitting a Datix and reporting to the NHS PPE dedicated supply channel via procurement teams. We do not know whether local Datix reporting was fed into national PPE coordinating groups in a standardised way or how local Trust data was being used across the wider system. In addition, NHS organisations could raise complaints to suppliers via an online form which would trigger an investigation. Our understanding at the time was that where complaints were received via the online form in England, they were reviewed by the DMC which included representatives from regulators in addition to NHS England, DHSC and HSE representatives.

29. On a practical level, the duplication of reporting and the different methods required made the system unworkable for those involved in reporting. A significant proportion of specialist procurement nurse time in England was required and this took them away from their critical roles in securing and accessing supplies for Trusts. Issues with procurement continued throughout the pandemic.

30. RCN members as specialist procurement nurses continued to work to support the reporting and resolution of PPE issues through the evolution of groups established to address these at pace in real time. Our learning from this situation is that a one stop standardised form should be developed that enables electronic reporting once only to capture issues aligned to the quality of safety of critical supply items, including PPE, in incidents such as a pandemic to enable accurate data, reporting and transparency of the situation and release valuable clinical time for healthcare workers.

PPE stockpiles

Rosemary Gallagher

31. Our understanding is that the PPE stockpile was based on what would be required in an influenza pandemic under a reasonable worst-case scenario. It was not sufficient to manage the reality of the Covid-19 pandemic. The volume of PPE needed was much higher due to the protracted nature of the pandemic and extensive needs of nursing and other healthcare staff in work settings beyond hospitals, particularly for nurses working in community settings including care homes and due to disruptions to global supply and distribution chains. Shortages of fit test solution to support the use of PPE, specifically RPE by healthcare workers was also problematic. The demand for PPE exceeded

availability and this evolved over time and affected all care settings including adult social care. Different elements of PPE were impacted at different times and for a variety of reasons. For example, the provision of FFP3 masks was impacted not only by supply but by a shortage of fit testing solutions to support the safe use of such items. A shortage of PPE items subsequently led to the PHE publication of 'Considerations for Personal Protective Equipment in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic.

32. PPE stored in the Pandemic Influenza Preparedness Programme ("**PIPP**") stockpile was insufficient in terms of the type and number of items required over a sustained incident period. This included a reliance based on the assumption that surgical face masks would provide adequate protection for healthcare workers, with RPE such as FFP3 masks only needed in certain circumstances. The PIPP stockpile was based on influenza planning, not coronavirus, and did not appear to have considered learning from other coronavirus incidents. Shortage of fit test solutions also occurred indicating the amount required to support use of FFP3 masks had been underestimated.

33. Some RCN members who had been provided with PPE by their employers were required by their employers to use equipment previously marked as out of date. Use of PPE in this condition posed a risk to health and social care workers and to their patients and had a significant impact on confidence in the system and the ability of employers to protect employees in the workplace as per expectations of Health and Safety legislation which remained current.

34. 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?"

35. The RCN understands that some PPE stored in the PIPP stockpile was managed in such a way as to ensure maximum shelf life and testing was undertaken periodically on some items to ensure they remained at the correct standard to provide the appropriate level of protection to wearers. The RCN was not aware of when the PIPP stockpile was distributed early in the pandemic, or the timescales for periods post expiration. The RCN noted, through discussions with members, the deterioration of some items such as nose bands and ear loops on masks **[SS/022 - INQ000417677].** The RCN understands, from evidence supplied by the HSE to the Inquiry that the HSE was aware that labelling issues, including those relating to the revision of expiry dates of PPE, caused some confusion for healthcare workers as to whether those items were appropriate for use and that the HSE "worked very closely with DHSC and others through the supply chain" on this issue. We raised our concerns with the NHS Supply Chain via email on 18 March 2020 **[SS/023 - INQ000328901]** and was informed that a communication was being drafted by PHE to address matters such as shelf-life testing and labelling. CEM/CMO/2020/018 Considerations for Personal Protective Equipment in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (Covid-19) Pandemic was subsequently produced.

36. The RCN advised members, via its dedicated PPE webpage, to not use PPE which was not fit for purpose, including PPE which:

- Did not fit correctly (for example, had a failed fit test).
- Did not meet the correct standard or specification (for example, was not CE marked to indicate that the manufacturer or importer affirms the goods

conformity with European health, safety, and environmental protection standards or did not meet other required standards) which would include items recalled by MHRA or HSE, for example ear looped FFP3 masks. The RCN actively disseminated and communicated MHRA and HSE alerts on how to report RPE and PPE failures as provided by national agencies, to members.

- Had degraded material present.
- Was donated by a third party with no assurance that quality standards had been met.
- Was dirty or unable to be adequately decontaminated.

Members were encouraged to refer to local level policies (i.e. Trust policies) on the use of PPE and to report any quality issues immediately to managers alongside completing a local incident form.

37. Some RCN members reported a lack of support when requesting RPE in line with their personal risk assessment under COSHH in circumstances when IPC guidance recommended surgical face masks as the IPC guidance was interpreted as unchallengeable. This combined with minimal visibility and alignment of health and safety statutory requirements and wider lack of local expertise in risk assessment of respiratory hazards left RCN members feeling frightened, unprotected and unsupported.

PPE distribution

Rosemary Gallagher

38. The RCN recognise that governments across the UK, health agencies and other bodies worked hard to resolve distribution issues. However, actions to mitigate issues with PPE distribution were regarded by our members as having been too slow and not transparent. Public commitments did not effectively translate into increases in consistently deployed and accessible stocks of adequate PPE. RCN members raised their concerns as follows:

a. *"I'm an Advanced Nurse Practitioner who visits nursing homes and would like to raise my concern about a lack of PPE/ face masks available to my colleagues who work in the nursing homes. There has been one confirmed case of Covid-19 in a resident who is now in hospital but there are 15 other residents*

symptomatic who won't be tested. The staff only have gloves and aprons but no masks and cannot get any anywhere. The situation is extremely unsafe."

b. *"I am an Intensive Care nurse on the front line of the Coronavirus Pandemic. Our trust is unable to provide us with the correct PPE to care for patients with confirmed Coronavirus."*

c. *"I work in a frailty assessment team, currently we see patients in the community i.e. in patients own homes and care homes for admission avoidance. We currently have no PPE and are expected to assess patients that could be suspected [of] Covid-19. I feel [I] would be putting myself and other patients at risk. These concerns have been raised to managers who have insisted we just continue as normal."*

The RCN also received reports of PPE being removed from PPE stations, and of staff being told they would be challenged if "caught" wearing certain types of masks **[SS/024 - INQ000328902]**.

39. The RCN regularly expressed its concerns in correspondence to the Scottish First Minister, Wales First Minister, Northern Ireland First Minister and Deputy First Minister and the UK Prime Minister regarding the difficulties RCN members had in accessing adequate supplies of PPE.

40. The RCN ensured, via its dedicated website page, that PPE supply and distribution processes across the four UK countries were explained for members and links to the relevant third-party websites were included to allow members to liaise directly with suppliers.

41. Local deviation from PPE procurement via NHS Supply Chain (England) led to variation in the quality and type of PPE available with donations of PPE/homemade products complicating oversight of the PPE status. The ability for NHS Trusts and other health and care providers to buy 'off catalogue' as an alternative to routine procurement routes remained in place. By way of example, the RCN received feedback from members that the purchase of gowns in April 2020 via alternative routes led to issues with availability of items via NHS Supply Chain (England). Health and care organisations struggled to receive full orders of PPE as supplied by national procurement agencies and therefore attempted to secure stock from a variety of sources. RCN members reported this included

sourcing items from other industries who did not usually provide to healthcare. This included fit test solutions or coveralls/visors from the fire service or construction industries. The local donation or manufacture of items such as visors for use by staff had the potential for variation in quality.

42. Due to ongoing PPE quality and supply issues, PPE continued to be procured locally, not via central procurement agencies, and therefore lacked governance oversight. As a result, poor quality transactions of PPE happened at the local level. The complexity of reporting these issues through official reporting channels (MRHA and HSE) clouded recognition at the national level.

Availability of PPE and the issues this led to including re-use of single use PPE

Rosemary Gallagher

43. There were shortages of essential PPE in all settings and health and social care staff were reliant at times on PPE items being donated or home-made in some cases. As the excerpts from RCND call logs demonstrate, many staff members were forced to compromise their safety to provide care to their patients. It is unacceptable for health and social care professionals to be exposed to avoidable risk to their own safety. As was evident from the responses received to the RCN PPE Survey in April 2020 (see paragraphs 10 and 11) there was a stark and deeply worrying contrast in the experience and safety of members from ethnic minority backgrounds compared to their white British counterparts.

44. Care homes were particularly affected by a lack of PPE, with some reporting that they were left with no option but to purchase their own or accept donations which did not meet required standards. In an honourable attempt to help frontline workers, members of the public produced PPE at home to support the overall effort. Whilst well intentioned, the RCN made clear that PPE worn by all health and care staff must, at all times, be of the correct standard as Health and Safety legislation was equally applicable to care homes and NHS settings. The RCN therefore discouraged healthcare workers from accepting any handmade PPE donations so as to ensure that healthcare workers had reliable and effective protection against infection and to ensure PPE was fit for purpose **[SS/025 - INQ000328903]**.

45. Conversely, a lack of PPE led some managers to 'stockpile' and preserve PPE supplies, which in turn led to some RCN members in different settings reporting that they

were told they could face disciplinary action for wearing PPE to see 'low risk' patients. Such scenarios represent a lack of understanding of fundamental health and safety responsibilities by managers in conjunction with IPC guidance inadequately reinforcing the need for local COSHH risk assessment as opposed to blanket use of specific items such as surgical face masks as described in IPC guidance. The lack of visibility of the HSE and wider health and safety communications resulted in a dominance of IPC guidance, without a complimentary focus on health and safety requirements and aligned educational needs. This, we believe, led to confusion and an inadvertent prioritisation of IPC guidance content in the minds of managers who lacked experience to objectively interpret its application in the workplace. It is the view of the RCN that IPC guidance should be complementary to, and enable compliance with, Health and Safety legislation, not take precedence. The RCN's view is that the lack of recognition in the UK IPC guidance that SARS CoV2 could be spread via the airborne route, as recognised in MERS CoV and SARS clinical guidance, outside of aerosol generating procedures, was also a major barrier to managers and employers adopting a proportionate and focused approach to the protection of health care workers in line with existing requirements.

46. The RCN was disappointed and concerned at an apparent lack of visibility of HSE/HSENI input in key guidance that affected healthcare workers access to and use of PPE. As a minimum, given the seriousness of the situation and the concerns raised regarding PPE, the RCN would have expected for example, to have relevant health and safety logos or supportive statements on all IPC guidance and for any relevant national communications to be provided to external stakeholders and supported and countersigned by health and safety leaders.

47. The RCN questioned during IPC meetings whether the HSE and Health and Safety Executive for Northern Ireland were members of the UK IPC cell where opportunities to input on guidance existed, but we did not receive confirmation. The terms of reference for the UK IPC cell and its associated membership were not available in the public domain for transparency.

48. Early IPC guidance published on infection prevention and control was limited in its reference to health and safety statutory requirements resulting in the RCN's view, in an assumption that NHS Trusts had in place the knowledge/expertise to implement IPC guidance in a pragmatic way that met both IPC and health and safety requirements. For example, in January 2020 'Wuhan novel coronavirus (WN-CoV) infection prevention and control guidance' makes only one reference to health and safety despite SARS CoV 2

having a High Consequence Infectious Disease' ("**HCID**") classification at that time. It stated, '*The hospital should be mindful of its responsibilities to persons who are not employees, under The Control of Substances Hazardous to Health Regulations 2002 and The Management of Health and Safety at Work Regulations 1999'.*

49. The RCN, as a member of the NHS Staff Council was a signatory to the published guidance on the need for COSHH risk assessments and adherence to health and safety requirements (February 2020) as previously described. This was issued due to concerns that clear communications on the need for risk assessment under COSHH were not present and that this limited opportunities for escalating or reporting of concerns.

50. Below is a summary of members concerns:

a. "Basically our PPE is apron, short gloves, fluid repellent theatre masks, and Christmas cracker glasses."

b. "We have bare arms & faces. We are on the front line with these patients. I've had to wear my own protective goggles from home, a shower cap & colleagues have made makeshift protection wear out of bin bags in order to treat COVID-19 patients, we feel we don't have confidence in the issued PPE on the ward. And feel we are at risk of being infected & passing this virus to our families at home."

c. "I work on a 48 bed Respiratory Ward. We are told that wearing a thin disposable apron, hand gloves & a surgical mask is sufficient to nurse a ward full of COVID-19 patients. How can this be a safe working environment when we're doing direct bedside nursing…"

d. Nursing covid positive patients in a bay, other patients attend unit same time who aren't positive. Advised to re-wear gowns at first, now advised to wear bin bags.

e. "My workplace is the Emergency Department and we do not have adequate personal protective equipment. Do I have to agree to put myself or my staff in situations caring for patients with Covid-19 without adequate PPE? We are being exposed with Covid-19 in open areas and only have a minimal supply of

paper surgical masks. Other areas like ICU have full PPE. They come through the Emergency Department first."

f. *"We have been told that we are expected to attend to patients with Covid-19 symptoms without face masks unless they are diagnosed and confirmed. If they are confirmed cases then we can get face masks as part of our PPE but if not we can only have aprons and gloves even if our patients have temperatures, a new cough or a sore throat."*

g. *"I have been informed that there will be masks delivered to the [nursing] home but staff are not to have these unless there is concern of an outbreak within the [nursing] home. I was not sure if these should be given beforehand to prevent any outbreak as the past week patients have coughed and spat on me."*

h. *Member works in critical care and they have run out of protective goggles. Employer has now provided goggles from B&M and told staff to re-use them*

i. *"We have minimal PPE, only 2 FFP3 masks (for whole Neonatal Unit) and no visors, only 6 pairs of goggles which are meant to be disposable but we have been told to Actichlor [disinfect] and reuse. We do have gowns but only for positive patients otherwise suspected etc. we are to use yellow plastic pinnies. Thrown to the lions."*

j. *"In the recent published guidelines section 8.1, it states that full gown, visor etc. are required if phlegm (cough) is induced with AGP (Aerosol Generating Procedure). What I don't understand is, if coughing is induced by a procedure and full PPE is required why on earth am I caring for up to four positive patients in one bay, who can all be coughing constantly, with just a surgical mask, plastic apron (which does not cover me because I'm overweight), goggles and fully exposed arms and a pair of gloves. Why?"*

51. Given the shortages of PPE experienced particularly during the early stages of the pandemic, PHE produced 'The Public Health England Acute Shortages Guidance' on 17 April 2020 which aimed to highlight the "*sessional use and re-use of PPE when there are severe shortages of supply. The considerations are to ensure that health and care workers are appropriately protected from Covid-19 where items of PPE are unavailable and should be considered as temporary measures until the global supply chain is adequate to meet*

the UK's needs". This followed the decision to downgrade SARS CoV2 as a HCID. This decision by the UK government did not remove the need for nursing staff and other health professionals to have access to and use of PPE, including RPE in line with risk assessment and the classification of SARS CoV2 as a Group 3 biological hazard. A Group 3 hazard is described in the HSE's Approved List of biological agents, as a biological agent that '*can cause severe human disease and may be a serious hazard to employees'*.

52. Whilst the RCN cannot comment on the Government's decision and subsequent transparency regarding the decision to downgrade SARS CoV2 as a HCID at this time, this decision did not, in the view of the RCN, justify the blanket application of IPC guidance on use of FRSM when caring for patients with Covid-19 as described in NHSE and NHSI correspondence dated 20 March 2020 **[SS/026 INQ000252604]**, regarding the supply and use of PPE and associated FAQs guidance of the same date **[SS/027 - INQ000384374]**. The FAQs do not refer readers to the need for risk assessment nor do they make reference to health and safety requirements under COSHH. This, together with the IPC guidance, served to override Health and Safety legislation without consultation or transparency on decision making.

53. It is a legal requirement that suitable and sufficient workplace risk assessments are carried out and adequate control measures identified to reduce risk as far as reasonably practicable, in accordance with Regulation 3 of the Management of Health and Safety at Work Regulations 1999 and COSHH. Individual clinicians should have been empowered to decide the correct PPE they required based on their own dynamic risk assessments and informed by their organisation's workplace risk assessment. Anecdotal evidence from members indicated that such workplace risk assessments were absent or, where they did exist, were inadequate. Reference to the hierarchy of controls as described in IPC guidance of March 2020 was, in the view of the RCN confusing as this represented unfamiliar language to many employers and staff (except health and safety professionals employed by the organisation), was not implementable given the airborne route of infection and poor ventilation in many areas and did not emphasise the risk assessment aspects of controls under COSHH.

54. The Public Health England Acute Shortages Guidance April 2020 was developed without full and formal consultation with the RCN. The RCN was not informed that work to develop guidance on reprocessing of PPE had been proposed or commenced and viewed this exclusion as detrimental to discussions and decision making. This situation was another example of failures to plan adequately and consider guidance beyond technical

aspects, led by 'experts' to the detriment of open debate and anticipated implementation challenges. The RCN made plain in its correspondence to the HSE on 17 April 2020 (see paragraph 106 below) that it was not acceptable to publish this guidance without appropriate consultation. Only sound scientific evidence and/or detailed discussions with relevant professional, scientific and legislative bodies should have resulted in any changes to existing guidance. Nursing staff needed to have confidence in health and government leaders and wider system working. This is crucial in times of unprecedented challenge where health professionals are at personal risk as a result of their role and work.

55. The reuse of single-use PPE, as suggested by PHE, was deemed unacceptable, and the RCN did not support this guidance which deviated from other UK countries positions (see paragraphs 63 and 64) **[SS/028 - INQ000328904]**. This was a significant risk to health and care workers and to their patients. Given the mounting concerns regarding limited availability of PPE, the RCN published advice to members regarding 'refusal to treat due to lack of adequate PPE' on 09 April 2020 **[SS/029 - INQ000328905]**. This advice offers a step-by-step guide to determine whether to refuse to treat. The guidance refers to the UK Infection Prevention and Control government guidelines and, in combination with the RCN's guidance document 'PPE – are you safe?" **[SS/030 - INQ000328947]**, sets out the steps that members should take to determine what they need in order to be safe and how to escalate matters and document these for record keeping purposes if they have not been provided with the necessary equipment, training, information, or if they have any concerns relating to those. The guidance also suggests that the nurse should 'take part in identifying changes to the way that you work that reduce the risk to you short of refusing to provide treatment at all'. It is clear that refusal to treat was a last resort only if all other measures had failed or were unavailable.

56. The RCN were concerned about the approach to PPE shortages in the Devolved Administrations. Scotland and Wales had committed not to implement The Public Health England Acute Shortages Guidance. The RCN urgently requested similar reassurances be given from Northern Ireland and England in correspondence dated 18 and 22 April 2020 respectively **[SS/031 - INQ000328906] [SS/032 - INQ000328912]**. A response was received on 11 May 2020 from PHE **[SS/033 - INQ000328907]** in which they noted that the guidance for shortages on PPE had been published at the request of DHSC and NHSE, and delivered by PHE and the HSE as severe shortages of face masks and gowns were predicted for the weekend of 18-19 April 2020. PHE acknowledged that due to the urgency of this guidance, it did not believe it had time for wider consultation.

57. Robin Swann, Minister for Health in Northern Ireland, responded on the same day, assuring the RCN that the revised PHE guidance had not been implemented in Northern Ireland **[SS/034 - INQ000328908]**. A letter from Conor Murphy, Minister of Finance was also received on 20 April 2020 in which he endorsed the RCN's stance on PHE's revised guidance on the grounds of staff safety **[SS/035 - INQ000328909]**.

58. These concerns were shared with NHSE and NHSI, Chief Medical Officer ("**CMO**") for England Chris Whitty and Chief Nursing Officer ("**CNO**") for England, Ruth May on 14 April 2020 via email correspondence **[SS/036 - INQ000328910]**. They noted that the implementation of PPE guidance was a matter for local employers who were responsible for adherence and training.

59. Donna Kinnair subsequently wrote to the Secretary of State for Health and Social Care on 21 April 2020 **[SS/037 - INQ000328911]** and the Chief Executive of PHE on 22 April 2020 **[SS/032 - INQ000328912]**, raising concerns about the lack of consultation with the RCN and advising that we were unable to endorse the guidance as our view was that members needed to have the necessary PPE required, which was their legal right, in order to be able to safeguard both themselves and their patients. We also demanded the opportunity to be included in future consultations and requested details of the evidence base on which the revised guidance had been issued.

60. A brief response was received from the Chief Executive of PHE on 11 May 2020 **[SS/038 - INQ000328913]**. The letter advised that the guidance had been rapidly issued at the request of the HSE in light of predictions of severe shortages of face masks and gowns. Although the letter indicated that PHE was committed to working with the RCN and wished to hear concerns raised by our members, disappointingly, the letter failed to provide details of the evidence base requested by Donna Kinnair.

61. We contacted PHE on 22 May 2020 **[SS/039 - INQ000328916]** following concerns received from members about the reallocation of half masks (respirators) between staff once cleaned at the end of the shift. We highlighted potential risks with this practice and requested that the current IPC guidance be updated to reference individual allocation of the respirators. We understand that our query was forwarded to the HSE Centre for Workplace Health who provided a brief response on 23 May 2020, advising that the reuse of half masks RPE is a normal procedure for a number of workplaces where there is a pool of RPE in use and that correct cleaning to the manufacturer's protocols is ensured by adequate supervision of staff **[SS/040 - INQ000427443]**.

Fit testing, fit testing training and difficulties which arose due to physical attributes

Rosemary Gallagher

62. One-size-fits-all protective equipment had been a problem for frontline healthcare workers who had to wear this life saving equipment for up to 12 hours at a 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. *"The PPE is very poorly produced, is one size, so for example the visors fall off and does not instil confidence."*

   e. *"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."*

   f. *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.

g. *"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."*

63. As a consequence of these concerns being raised, on 31 March 2020 the RCN wrote an open letter to the Chief Executive of the HSE, calling for their intervention to ensure the adequate availability of fit testing, and to ensure that employers comply with Regulation 4 of the PPE at Work Regulations 1992 which stipulate '*that suitable PPE must be provided to employees who may be exposed to a risk to their health and safety while at work'* **[SS/041 - INQ000328917]**. The RCN received an unsatisfactory response **[SS/042 - INQ000417540]** and had expected the HSE to act given the extreme seriousness of the situation (see paragraph 157 below).

64. FFP3 respirator masks - which are needed for the highest level of respiratory protection to prevent a hazard (SARS CoV-2) from being inhaled - require users to be fit tested to ensure that the masks fit correctly. Each brand of FFP3 mask fits differently and therefore users must undergo subsequent fit testing for each brand. 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 was an additional procurement and supply issue.

65. The RCN also raised the issue of gender and PPE, specifically how some brands of FFP3 do not appropriately fit female faces, with the British Safety Industry Federation ("**BSIF**") in correspondence dated 28 May 2020 **[SS/043 - INQ000328920]**.

66. Incidents of concern arose throughout the pandemic whereby a number of healthcare staff, including nurses, were put at risk due to the incorrect fit testing of respiratory masks. On 01 July 2020, Pat Cullen, the then Director of RCN Northern Ireland, wrote to the Public Health Agency, the Department of Health for Northern Ireland ("**DoH Northern Ireland**") and other Health and Social Care Trusts in Northern Ireland to express the RCN's concerns in respect of this issue **[SS/044 - INQ000328921].** Whilst an independent level 2 serious adverse incident review of this issue was announced by the Public Health Agency, the RCN sought reassurances regarding the composition of the review team and the terms of reference to ensure that the same was entirely independent.

67. On 03 July 2020, the DoH Northern Ireland responded **[SS/045 - INQ000328922]** noting how, in response to this issue, the Public Health Agency would also bring forward a regional fit testing assurance framework to ensure all fit testing was standardised across the region. HSENI were informed of this issue. HSENI wrote to all Health and Social Care Trusts seeking a report in respect of the fit testing incident.

68. A further incident arose in at least one NHS trust in England concerning the incorrect fit testing of respiratory masks, whereupon a Portacount machine had been set to US standards of fit testing, rather than UK standards. The RCN wrote to the HSE on 20 July 2020 **[SS/046 - INQ000417660]** raising this issue and asked that they investigate and alert other NHS organisations accordingly. A response was received on 30 July 2020 **[SS/047 - INQ000417582]** in which HSE confirmed they were on notice of the incident and had drafted an alert to send to all NHS Trusts and other health and social care sector providers to ensure all quantitative face fit testing machines were set to UK test protocols.

<u>Trends in reporting concerns about lack of access to adequate PPE</u>

<u>Rosemary Gallagher</u>

69. The majority of member concerns about lack of access to or adequacy of PPE were received at the very beginning of the pandemic with most of the concerns received in March 2020. Towards the end of April 2020, the number of monthly reports had dropped significantly and by May 2020 the number had fallen further to less than 50. After May 2020 the number of monthly reports did not increase until Autumn 2020 and winter 2020/21 when the number of reports received reverted to around the level experienced in April 2020.

70. The ICON study, a longitudinal survey to evaluate the impact of COVID-19 on the UK nursing and midwifery workforce was led by the Royal College of Nursing Research Society steering group. The survey was undertaken at three time-points: prior to COVID-19 peak, during the COVID-19 peak, and in the recovery period following COVID-19. Responses to the first phase on the study which was conducted between 2-14 April 2020 found that 44% of the correct PPE was always available. The second round of the survey was open between 28 April-12 May 2020 and received 4,063 responses. Key comparative findings from the second survey compared to the first survey suggested that PPE availability appeared to have improved, but 40% reported that the correct PPE was not always available.

The availability of ventilators and CPAP machines

Suman Shrestha

71. The RCN had limited involvement in determining and resolving the availability of ventilators and CPAP machines during the pandemic. Such issues were generally raised and managed at a local level. Trusts were asked to provide information to NHS England ("**NHSE**") on what equipment was held at a local level with some hospitals holding more stock of different types of ventilators than others. While there were conversations around the procurement of new ventilators, the RCN was not involved. Our focus in this area was primarily on the nursing workforce, how ICU beds would be staffed and how we could support learning for non-ICU nurses redeployed to this area during the pandemic.

72. Similarly, the RCN had little interaction with the UK Government and the Devolved Administrations regarding the availability of ventilators in hospitals during the pandemic.

73. Although the RCN was not involved in discussions around pandemic planning for healthcare delivery in relation to ICU ventilator capacity prior to the pandemic we had raised the issue of staffing levels and staffing ratios on many occasions. By way of example the RCN published the following documents prior to the pandemic:

    a. Royal College of Nursing (2019) Staffing for safe and effective care in England. Member briefing. London: RCN.
    b. Borneo A and Hadden C (2019) Standing up for patient and public safety: England policy report, London: RCN.
    c. Royal College of Nursing (2017) Safe and effective staffing: nursing against the odds, London: RCN.
    d. Royal College of Nursing (2017) Safe and effective staffing: the real picture. UK policy report, London: RCN.
    e. Royal College of Nursing Policy and International Department (2012) Mandatory nurse staffing levels, (Policy briefing 03/12), London: RCN.
    f. Royal College of Nursing Policy Unit (2006) Setting appropriate nurse staffing levels in NHS Acute Trusts (Policy guidance 15/2006), London: RCN.

74. The RCN is also a member organisation of The UK Critical Care Nursing Alliance ("UKCCNA"). The UK Critical Care Nursing Alliance (UKCCNA), established in 2013, provides a structured mechanism to facilitate collaborative working with all nationally

recognised critical care nursing organisations across the United Kingdom. The aim of the UKCCNA is to be proactive and visionary about service requirements, providing quality assurance, enhancing the service, quality of care, patient experience, and outcomes in critical care.

75. The UKCCNA published a number of position statements during the Covid-19 pandemic on ICU nursing workforce staffing. By way of example:

   a. Joint statement on developing immediate critical care nursing capacity, 25 March 2020.
   b. Critical Care nursing workforce post COVID-19, 05 May 2020.
   c. Emergency Nurse Staffing for COVID-19: Wave 2, November 2020.
   d. Nurse Staffing during COVID-19: Jan 2021, January 2021.
   e. Critical Care Nurse Staffing during Surge, September 2021.
   f. Joint Position Statement on Critical Care Staffing Standards, June 2022.

76. The RCN is clear that without adequate numbers of skilled ICU nurses, regardless of additional ventilators being planned for, the UK would not have sufficient staff to manage such equipment. Prior to the pandemic, the RCN had repeatedly called for governments in England and Northern Ireland to introduce legislation to create clear roles and responsibilities for workforce planning throughout the health and care system **[SS/048 - INQ000114252] [SS/049 - INQ000114328] [SS/050 - INQ000114341] [SS/051 - INQ000114340]**.

77. As a Nurse Consultant working in an ICU during the pandemic I was relieved to hear of attempts by the UK Government increase the supply of ventilators for use in UK healthcare settings. Of less importance in my clinical role was the procurement process, although my expectation was that equipment would be quality assured. Our primary concern in relation to the procurement of additional ventilators was staffing – we may have received excess numbers of ventilators and yet had no staff to manage them. Individual NHS Trusts would be better placed to answer questions on the procurement process.

78. To the best of our knowledge, we did not receive any reports of the following from members via RCND:

   a. members using alternative equipment as a result of any shortages of ventilators and related equipment and supplies

b. a patient who needed a ventilator was not able to access one
c. any major incidents being called as a result of intensive care or ventilator capacity being full or nearly full

Oxygen supplies

Suman Shrestha

79. The RCN was not involved in the process of planning and delivery of oxygen supplies either prior to or during the pandemic. In practical terms these issues were likely to have become apparent as ICU bed capacity increased in the early stages of the pandemic and were for individual Trusts to manage, including any incidents relating to low oxygen supply. As such individual NHS Trusts would be better placed to answer questions on these issues.

Access to LFT and PCR tests

Rosemary Gallagher

80. The RCN received approximately 856 contacts from members both the NHS and independent sector, including adult social care across the UK in relation to Covid-19 testing via RCND. The general themes of these reports are as follows:

a. No testing availability particularly at the beginning of the pandemic.
b. Members being asked to travel excessive distances to undertake a test.
c. Members being classed as ineligible for tests.
d. A member being sent away from a testing centre as they were 'too sick' to be tested.
e. Members being put forward for a test by their employer but waiting for a significant amount of time and contacting the RCN as they still hadn't been contacted for testing.
f. Agency and bank members finding it more difficult to obtain testing than their employed counterparts.
g. Members in particular Trusts and employers being refused testing for a variety of reasons.
h. Members being unable to access testing as they do not drive.

81. In late April 2020 **[SS/052 - INQ000525315]**, the RCN conducted an online survey with RCN members asking for their experience of access to COVID-19 testing. 22,043 people completed the survey. Findings included the following:

a. 76% of members overall who responded reported that they hadn't been offered testing.
b. 86% of temporary staff had not been offered testing compared to 75% of permanent staff.
c. Those working outside the NHS were slightly less likely to have been offered testing by their employers (79% v 75%).
d. 18,563 people who had not been offered a test, or who had been offered a test which they didn't need. Of these people 44% did not know how to access testing. In care homes and prisons, around half of these respondents didn't know how to access tests, and with temporary staff, this figure was 60%.
e. The respondents who had been offered testing (16% of respondents, n=3,499) were asked about their ability to access the test. Overall, 90% of these were able to access testing, though there was some variation across settings – 93% of those working in the community were able to access it, as were 91% of those working in hospitals. However, only 84% of those working in care homes were able to access the testing they had been offered. Again, there was a difference between staff working in NHS organisations (91% able to access testing) and non-NHS (85% able to access testing), and permanent staff (90% able to access testing) and non-permanent staff (85% able to access testing).
f. The majority (62%) of results of those who had accessed testing (n=3,133) were received within a few days.
g. Respondents who were offered testing but not able to access it (n=347) gave the following reasons:
    i. Too far to travel 21%
    ii. Too unwell to travel to the testing site 10%
    iii. No time slots available 9%
    iv. No public transport available 6%
    v. Caring responsibilities 3%
    vi. Time slots clashed with working hours 2%
    vii. Travelled to the testing site but were sent away 2%
    viii. Other reasons 67%
h. Of the large proportion (n=235) who gave another reason for not being able to access testing, over a quarter (27%) said it was because they can't drive or

don't have a car, 22% said it was because the test was not available when they needed it or that it was too slow to arrange and 15% of respondents told us it was because of a failure within the system for either booking tests or not responding to the referrals. Other reasons included not meeting the criteria for testing because of no/too few symptoms and issues at an employer level including delays, refusals or in some circumstances the employer charging a fee to test employees.

82. The ICON study, referred to in paragraph 88 above also addressed healthcare working testing for Covid-19. Of the 2,600 members of the nursing and midwifery workforce who participated in the initial phase of the survey between 2-14 April 2020 26% respondents had needed to self-isolate, of which 37% did not have personal symptoms and 64% missed four or more shifts due to self-isolation. These results point to stress and worry within the nursing workforce with almost one third of respondents reporting symptoms of depression.

83. The RCN escalated its concerns regarding LFT and PCR tests as follows:

UK and England

84. On 23 March 2020 **[SS/053 - INQ000417657]**, the then RCN Chief Executive & General Secretary Dame Donna Kinnair wrote to the UK Prime Minister calling on the Prime Minister to increase the number of tests for the virus for nursing staff so that those with possible symptoms of COVID-19 know whether they are infected or not. Dame Donna Kinnair, the then RCN Chief Executive and General Secretary asked the Prime Minister to personally intervene and act to ensure testing for COVID-19 is available for all nursing staff and our colleagues across the health and care system. To the best of our knowledge a response was not received to this correspondence.

85. In March 2020, the RCN also submitted written evidence to MPs and members of the House of Lords ahead of the Westminster Government debate on the proposed Coronavirus Bill. This included the urgent need for universal testing for healthcare professionals.

86. On 15 April 2020, a meeting on the impact of COVID-19 on healthcare workers from black ethnic minority groups took place, to which Simon Stevens, Chris Whitty, Prerana Issar, Yvonne Doyle, Yvonne Coghill, Ruth May, Steve Powis, Jacqueline Dunkley-Bent, Claire Murdoch, Nikki Kanani, Habib Naqvi, Na'eem Ahmed, Chaand Nagpaul, Donna

Kinnair, Victor Adebowale, Arlene Wellman, David Williams and JS Bambrah were invited **[SS/054 - INQ000418333]**. The overall themes from the call included protecting staff-by facilitating the uptake of testing which was assigned to NHSE as an immediate action item.

87. On 20 April 2020 **[SS/055 - INQ000572236]** Donna Kinnair discussed concerns about testing in a telephone call with Ruth May, the then Chief Nursing Officer ("**CNO**") for England. The CNO for England advised that a policy to help prevent nosocomial infection was in the process of being drafted and that this would include the universal testing of hospital staff. Donna Kinnair emphasised the importance of including care homes in testing provisions and the need for rapid response testers to facilitate appropriate testing of care home staff and residents. On the same day **[SS/056 - INQ000417857]** we were provided with the opportunity to comment on the draft guidance.

88. Donna Kinnair met with Helen Whately MP, Minister for Care on 21 April 2020. The meeting focused on the impact of Covid-19 on the workforce and patient care, in particular care homes. Key points discussed included testing of health and social care workers including the accessibility of testing services.

<u>Wales</u>

89. The RCN attended fortnightly meetings with Welsh Government Officials to discuss vaccinations and testing.

90. On 12 May 2020, **[SS/057 - INQ000572235]** RCN Wales wrote to the Welsh Government Minister for Health and Social Services seeking confirmation as to how the Welsh Government was reporting on the numbers of health and social care staff that had tested positive for COVID-19, had been admitted to hospital, had received intensive care and had died after contracting COVID-19. There were increasing concerns that BAME workers were facing a more significant risk, and so information about ethnicity was important to assess trends and make recommendations for future action as necessary. Without a detailed account of these factors, an analysis into what was driving the differences to healthcare workers mortality rate in certain ethnic groups would have been difficult to expose. RCN Wales therefore requested that the data shared should also include information on ethnicity of the healthcare worker; the role and setting of the individual; age; and any underlying health conditions.

91. The Welsh Government Minister for Health and Social Services replied on 11 June 2020 **[SS/058 - INQ000572234]**. He pointed to the testing data, Public Health Wales collection of data through their rapid mortality surveillance form on the key worker status of those who have died due to Covid-19, and the Office for National Statistics ("**ONS**") analysis. Mr Gething said that as part of the Welsh Government's wider work to understand the impact of coronavirus, it was working closely with the NHS and academic colleagues to draw together data sources including linking staff records with hospital records and surveillance data, securely and anonymously using the SAIL databank, to be able to consider the additional questions raised in the RCN's letter.

<u>Northern Ireland</u>

92. The RCN alongside the other health trade unions attended weekly meetings with employer representatives and Department of Health officials. These meetings provided an opportunity to raise issues and seek solutions to the many ongoing challenges including the lack of Covid-19 testing.

93. Early in the pandemic correspondence was forwarded to the Office of the First Minister and Deputy First Minister ("**OFMDFM**") raising concerns about a number of issues including the lack of PPE, lack of Covid-19 testing, and the confusion and ambiguity with infection control guidance.

94. On 02 April 2020 **[SS/059 - INQ000417519]**, RCN NI wrote to the First Minister, Deputy Minister and Minister for Health in Northern Ireland in strong terms, highlighting how Northern Ireland were being treated as an afterthought, particularly in relation to testing kits which were produced in Northern Ireland by Randox Laboratories as part of a UK-wide contract. Despite being manufactured in Northern Ireland, the kits were then shipped out of Ireland until such time as they made their way back to Northern Ireland under the UK supply chain. Of significant concern was that the Chief Executive of Belfast Health and Social Care Trust had been informed that a consignment of PPE destined for Northern Ireland had been "turned back". To the best of our knowledge, RCN Northern Ireland did not receive a response to this letter.

<u>Scotland</u>

95. On 23 March 2020 **[SS/060 - INQ000417556]** Theresa Fyffe, the then Director RCN Scotland, wrote to the First Minister of Scotland stressing that priority Covid-19 testing for health and social care workers is an absolute must. Our members need this in order to do their job while keeping themselves, and their patients, safe. To the best of our knowledge, we do not appear to have received a response to this letter.

96. In March 2020 **[SS/061 - INQ000418597]** RCN Scotland also submitted written evidence on the proposed Coronavirus Bill. We welcomed the Scottish Government's commitment to increasing testing capacity and prioritising key workers as testing was essential for both avoiding unnecessary staff absences and public confidence. We sought urgent seeking clarity on the timescales for priority testing for health and care workers and accompanying guidance.

97. In September 2020 RCN Scotland provided evidence to the Scottish Affairs Committee Inquiry 'Coronavirus and Scotland' **[SS/062 – INQ000346087]**. Along with PPE issues, one of the biggest concerns for health and social care workers was around Covid-19 testing for staff. Matters raised included:

   a. testing capacity in Scotland and delays in scaling up testing
   b. discrepancies between testing of NHS and NHS staff
   c. need for priority universal testing of staff, including those working in care homes

Lessons Learned

PPE

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

99. **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.

100. **The needs and perceptions of ethnic minority nursing staff should be fully explored and addressed within pandemic learning, and specifically PPE requirements**. 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.

101. **Health and care services' PPE supply and stockpiles should be prioritised in circumstances where PPE is in demand from all sectors including transport, retail and education**. This should complement other technologies such as air filtration units which should also be considered. PPE is essential to protect front line staff and effectively reduce virus transmission rates whilst maintaining vital services.

102. **The government must firmly reinforce the position that re-use of single use PPE is not acceptable under any circumstances**. It is likely that this situation will occur again therefore it is essential that broad stakeholder involvement is present in any discussions on mitigations strategies.

103. **There should be funding for the urgent development of reusable RPE that is developed with, and acceptable to, staff and patients**.

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

Critical Care equipment

105. **Lessons must be learned from previous pandemic planning exercises. Access to and the procurement of UK wide critical care equipment, including ventilators should be routinely included in pandemic planning**.

106. **Staffing levels must also be considered in planning. It is not sufficient to have adequate amounts of equipment but there must be sufficient numbers of appropriately trained staff to operate and maintain this equipment.** This issue was highlighted by the Nightingale Hospitals during the Covid-19 pandemic. Most of the critical

care health care professionals who it was anticipated would staff the Nightingale Hospitals were already working in NHS hospital intensive care units.

107. The NHS entered the pandemic not only after a long period of financial constraints but also with inadequate capacity and an ongoing workforce crisis. We need to establish how capacity, and therefore demand, is measured and reported. **There needs to be an independent review on capacity and demand for hospital beds including critical care beds**.

108. **A hospital bed should be defined as a fully staffed bed depending on the level of care that is planned to be delivered rather than a physical bedspace with equipment.**

109. **Sufficient numbers of critical care equipment to support children, young people and adults are required with capacity and demand measured and reported aligned to adult needs**.

110. **There needs to be timely access to gases to support oxygen delivery in the whole hospital environment (both critical care and non-critical care areas) as well as in community settings**.

111. **There must be an ability to scale up procurement of critical care equipment and supplies, including oxygen at pace**.

112. **The expertise of frontline healthcare workers must be utilised when planning and delivering patient care during a pandemic.**

113. **A range of healthcare workers must be trained to work on critical care units, for example nurses, midwives, physiotherapists and undergo periodic refresher training to ensure patient needs can be met at times of escalation**. It is not sufficient to just have the necessary equipment, staff must be trained to use it competently.

114. Critical care nursing is highly specialised and takes a number of years of training and education working alongside members of the multidisciplinary team. **Dedicated resources are required to recruit, train, retain and develop critical care nurses. We support the UKCCNA May 2020 position statement that a review of recruitment and retention strategies to encourage nurses into critical care will help ensure that we have sufficiently trained staff for a greater ICU bed capacity in the future**. As indicated in the Joint Position Statement by the Intensive Care Society, The Faculty of Intensive Care

Medicine and the UKCCNA, on Critical Care Staffing Standards, in June 2022 and endorsed by the RCN, this will also require a staffing model which allows some flexibility for emergency demand and ensures staff development and experience is prioritised.

115. **Hospitals should have a business contingency plan to source health care professionals during surge**. This may include redeployment of non-ICU staff and there needs to be plan in place for safe and rapid induction to equipment and work environment and ongoing well-being support for them.

Testing

116. **The ability to develop appropriate testing mechanisms and to scale up availability at pace is needed**. Appropriate relationships with industry need to be in place in advance of future pandemics to enable a timely and innovative response to support rapid testing.

117. **Lessons learned from mass testing during the SARS-CoV-2 pandemic should be included in future planning. This includes the need for ease of access to mass testing facilities and issues around local testing being carried out in NHS Trusts by Trust staff which reduced workforce capacity.**

118. **We must learn from the underestimation of the impact of asymptomatic transmission from the SARS-CoV-2 pandemic. Routine testing of healthcare workers will be required. The impact of positive asymptomatic cases in healthcare workers and the impact on workforce numbers needs to be factored into pandemic planning to reduce the spread of infection to patients and staff.**

Statement of Truth

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

PD

Signed ……… ………………………………..

Rosemary Gallagher

Dated ……13th January 2025…………………………………..

PD

Signed ……………… ………………………..

Suman Shrestha

Dated ……………16th January 2025…………………………..