IN THE MATTER OF

MODULE 3 OF THE UK COVID-19 PUBLIC INQUIRY

The pandemic worsened the financial difficulties experienced by many RCN members who reported difficulties in establishing their entitlement to sick pay, and issues around the level of pay that shielding members were entitled to from their employers. The RCN's position was that health and care staff should not suffer any

into the nursing workforce. 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.

The likely impact of nursing staffing levels on the ability of the UK to react to the pandemic, however, was known well before the events of 2020 and after. As early as June 2003, Exercise Shipshape highlighted the importance of standing NHS surge capacity. A report by the Health Protection Agency in 2005, however, suggested there were limited resources to surge staff in the event of an extended outbreak such as SARS. The report by the Chair in respect of Module 1 also highlights severe staffing shortages in the NHS and social care as one of the factors directly adversely impacting the ability to 'surge up' capacity during the pandemic.

Low nursing staffing levels during the pandemic impacted patient care and staff morale and contributed to increased numbers of nursing staff considering leaving the profession. Elevated staff sickness levels (in addition to those self-isolating and shielding) during the pandemic further exacerbated the workforce shortages and had a direct impact on the sustainability of services and the ability of staff to deliver safe and effective care, placing patients at risk of missed episodes of care. Nurse-to-patient ratios were diluted, impacting the level of care that could be provided. Meml

inexperienced staff with too much responsibility which consequently had a significant detrimental impact on their mental health.

Policy makers in UK Government hid behind a narrative that the pandemic was to blame for the ongoing collapse of the healthcare system, refusing to acknowledge the extent of the workforce shortage until June 2023. This failure in accountability and transparency further damaged an already depleted system and workforce, the effects of which cannot be remedied quickly enough to ensure patient safety and to meet the expectations of the wider UK public.

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

As the Chair's report for Module 1 indicates, the importance of PPE arose regularly in preparation exercises prior to the Covid-19 pandemic. The Chair's report also confirms that the need for a stockpile of fit-tested PPE in sufficient quantities prior to a pandemic was clear. Existing stocks of RPE and PPE, based on modelling for an anticipated influenza pandemic, however, were insufficient. Without adequate and proper RPE and training in its use, nursing and midwifery staff put their own lives, and the lives of their families and patients, at risk. These supplies should have been modelled on Health and Safety Executive recommendations concerning the need to comply with Health and Safety legislation, and the adoption of a 'precautionary approach' to the protection of healthcare workers. The level and quality of supplies should not have been dictated by cost or opinion or confusion over non-UK adopted frameworks such as the 'hierarchy of controls'. In our submission, the pandemic stock levels were vastly underestimated and that global demand, as expected in a pandemic, was not sufficiently considered.

23. 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 healthcare workers 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. Due to those challenges, there were reports that RCN members had been required to reuse single use equipment, to use equipment previously marked as out of date, to clean used gowns with alcohol wipes and to use alternative 'protective' equipment which had been donated and did not provide adequate protection or meet

the required standards. 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. Health care professionals described feeling like " or and that they were and were left feeling

The RCN regularly expressed its concerns in correspondence to the UK Government, Devolved Administrations and other relevant bodies including the Health and Safety Executive throughout 2020-2022, regarding the difficulties its members had in accessing adequate supplies of PPE. Further, one-size-fits-all protective equipment was a problem for frontline healthcare workers 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 brands 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.

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

Fit testing became a cause of significant concern.

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 as far as reasonably practicable -- Regulation 3 of the Management of Health and Safety at Work Regulations 1999 and COSHH. 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 risk assessment. Anecdotal evidence from members indicated 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 by employers. The Inquiry is invited to look further into this issue.

RIDDOR reporting

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 in healthcare settings.

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. 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.

Apart from the reporting of incidents of disease to the HSE, under RIDDOR there was

that the experiences of those on the frontline of healthcare was often not considered or dangerously overlooked. There were inadequate opportunities for those representing frontline workers to feed into the development and delivery of guidance, particularly IPC guidance, despite learning from previous incidents of the 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. In turn this had a detrimental, sometimes fatal, impact on those who were on the frontline of care.

The RCN is relying on this Inquiry to establish the facts of and to learn lessons from the impact of the pandemic on the healthcare systems in the four nations. It believes that there are many lessons to be learned identified in relation to governance, decision making and clinical practice. However, in order to inform and be prepared for the next pandemic, the RCN wishes to acknowledge that the greatest lesson to be learned is to ensure that there is a suitably resourced, educated and trained healthcare workforce in place that can respond to the next challenge at 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.

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. In hospital settings, when fewer nurses are on shift, patients have an increased chance of missed care, longer stays and in-hospital deaths.

In our respectful submission, this is not just a lesson to be learned but also a warning that with the current level of staffing, the number of vacancies and the long-term effects of the Covid-19 pandemic such as Long Covid, the country's health service and its workers are struggling to meet the health care needs of the population.

Dated 23 August 2024