Module 3 Week Two

Witnesses

1. Kevin Rowan (Head of Organisation and Services Department of the Trades Union Congress)
2. Rozanne Foyer (General Secretary, Scottish Trades Union Congress)
3. Dr Lisa Ritchie OBE (National Deputy Director of Infection Prevention and Control, NHS England)
4. Dame Ruth May (Former Chief Nursing Officer for England)
5. Professor Jean White CBE (Former Chief Nursing Officer for Wales)
6. Fiona McQueen CBE (Former Chief Nursing Officer for Scotland)
7. Professor Charlotte McArdle (Former Chief Nursing Officer for Northern Ireland)
8. Professor Susan Hopkins CBE (Chief Medical Adviser at UKHSA)
9. IPC Experts Dr Ben Warne, Dr Gee Yin Shin and Prof Dinah Gould

Kevin Rowan (Head of Organisation and Services Department of the Trades Union Congress)

Richard Brunt from HSE seemed to imply, that RIDDOR was principally a benefit for employers to manage health and safety in the workplace. But RIDDOR is an indicator that the health and safety management system has failed, and something needs to be looked at. It's not about apportioning blame but reporting that an event has occurred. RIDDOR reporting should trigger the Health and Safety Executive into enforcement and regulatory action, because it's evidence of an employer failing to manage health and safety in the workplace.

Q: Do you agree with Mr Brunt that RIDDOR was not intended to be used in a pandemic involving thousands of instances of infection

A: I don't agree. That data which would alert both employers and regulators to the Identification of significant risk. The fact that a medical certificate was required proving Covid-19 was contracted meant that there wasn't the gathering of intelligent data about the presence or risk of exposure to Covid-19 in the workplace. RIDDOR would have gathered data about risk in the workplace. That should have informed all concerned that healthcare settings were becoming a high-risk sector.

We were all learning about Covid and how infections were being spread. Where we are unsure about how viruses are transmitted, the safest approach would be to gather as much data as possible and to share that data as early as possible. RIDDOR would have enabled that to happen.

HSE IS a very effective organisation in high-risk sectors. My concern is that it didn't pivot to treat the healthcare sector as a high-risk sector. More engagement with employers would undoubtedly have improved health and safety management in those sectors. I don't think we saw any increase in engagement between the Health and Safety Executive and the healthcare sector during the period of the pandemic.

If people working in roles that do not come into direct contact with a patient but contract Covid-19, it's important that is recorded because we also know that people working in those less direct roles were less likely to be in the front of the queue for PPE. Their risk of exposure was different to healthcare workers on the frontline, but their lives and health and well-being is equally valuable. It is important that if they do contract Covid-19, that that is recorded and that might influence how health and safety is managed. Unless you have that data, you're not going to know that you need to change your health and safety management. The more information you have the better decisions you can make.

Rozanne Foyer (General Secretary, Scottish Trades Union Congress)

We found that many workers who were being expected to self-risk assess hadn't been given adequate training to do so.

We were not informed that HSE was stopping inspections. If we had been informed, we would have been extremely concerned, because healthcare settings were extremely high-risk areas for our members to be working in. We would have expected enhanced reporting, not a withdrawal of resource.

We were aware from trade unions at an early stage of the pandemic that there were issues with staff in healthcare settings getting access to PPE. At the very beginning there were some acute supply issues. It then became more complex with people being asked to reuse, wash and wipe down PPE, buy their own PPE, there was inconsistent supplies, there was sometimes PPE in the building but it was locked away, there was debate about the type of PPE being fit for purpose, there was a huge debate around the FFP3 masks being rationed to certain job roles and procedures, when it was actually felt that aerosol-generating procedures were happening much more widely than the provision of the PPE was being given out for. There were also issues with ill-fitting PPE and symptoms that healthcare workers were suffering from, because of that ill-fitting PPE. There were definite failures to provide appropriate fit for purpose PPE to the right people on the ground.

Chest compressions were not designated as AGP. Healthcare workers wanted it to be classified as an AGP and it caused a lot of resentment amongst the workforce and had a bad effect on morale.

Healthcare Workers were:

- 4 times as likely to be infected
- 7 times more likely to be hospitalised and to die

We need Covid to be recognised as occupational diseases

Dr Lisa Ritchie OBE (National Deputy Director of Infection Prevention and Control, NHS England)

I accept that FRSMs do not protect from aerosol. I do consider FRSMs to be PPE. They have been used in IPC in healthcare settings for a long time and are part of established guidelines nationally and internationally. They have been cited as PPE and part of IPC Kit.

Note from Broudie Jackson Canter - This is contrary to what the HSE say.

I agree that larger droplets behave ballistically and fall to the ground relatively quickly, whereas aerosols float and remain in the air for a much longer period of time. I disagree with Professor Beggs regarding the cut-off point of particle size between droplet and aerosol. Prof Beggs says anything above 100 is droplet. I maintain the cut off is 5 microns and this has been the established view for a long time.

Chair: Things that are well established aren't necessarily always right. Science moves on, understanding moves on.

I respect Professor Beggs' view and acknowledge that airborne is possible, particularly in ventilated and crowded settings. But the epidemiology and the scientific literature did not support airborne spread as the predominant mode of transmission. I accept that airborne spread is possible. I came to that view around June 2022.

The starting point for understanding likely modes of transmission of SARS-CoV-2, was what was known about SARS-CoV-1. The main route of transmission for SARS was droplet/aerosol and FFP3s were recommended. This paper was written ten years ago about SARS Coronavirus 1, it wasn't specifically targeted towards SARS-CoV-2. I think the paper did guide us in terms of droplet contact with the potential to be airborne transmitted. The evidence that SARS-CoV-1 could transmit by aerosol was weak, circumstantial and very limited in volume, so it was certainly possible but there wasn't evidence with any certainty to say that the airborne route was common/dominant.

If NERVTAG or SAGE said that that evidence was available that it was airborne, then that is what we would have put into the IPC guidance. The Guidance was approved by Public Health England, UKHSA, and the recommendations that were in the UK IPC guidance was consistent and aligned with the World Health Organisation. The IPC cell did not reach a consensus that there was a significant threat from airborne transmission that needed to be guarded against by use of respirators.

Ventilation is an important factor to mitigate against that far field aerosol transmission. If aerosol-generating procedures were being undertaken in those areas, then it was important to have good ventilation. My view remains that there was not sufficiently strong evidence that C19 was airborne to justify using FFP3.

The supply of PPE did not influence the IPC advice provided by the UK IPC cell. It is important to avoid unnecessary or inappropriate use of PPE, but the supply of PPE didn't influence the advice we gave. Dame Jenny Harries said that if we ever got to point where supplies of FFP3s were limited then we might have to prioritise them for those performing AGPs, but I don't recall us ever getting to that position.

I do not accept that FFP3 should be worn for routine care when there are other infection prevention and control measures in place. Wearing an FFP3 is not the silver bullet to prevent an infection. We are trying to control all the factors on an environment, it’s not just down to PPE.

Prof Susan Hopkins proposed a list of procedures that should be considered as AGPs. That list included CPR. I proposed a different list which did not include CPR. That list was the one that was used in the

guidance. Senior clinicians did think CPR should be included. It was reviewed by NERVTAG, and they said while chest compressions do produce aerosols it's no different to coughing.

There were checks and balances in place. If our UK senior clinical leaders or Public Health England or UKHSA had thought that the guidance was incorrect, then I'm sure that they would have made us aware.

I disagree with Professor Beggs. In my view a larger droplet is likely to have more viral particles, whereas a finer droplet is going to dry out quite quickly, so the viability of that causing any kind of infection subsequently is less.

I do agree that where there is uncertainty the precautionary principle should be applied but that would be a number of measures not just an FFP3 Mask. There are multiple other interventions from an infection prevention and control perspective that need to be put in place, because none of these transmission routes function in isolation.

If Public Health England had felt strongly that we were wrong with the recommendations not to move to FFP3 respirators for all, they could, as the lead organisation for infectious diseases in England, have trumped our decision.

Dame Ruth May (Former Chief Nursing Officer for England)

I was the most senior nurse in England. I was the adviser to the government, to DHSC, and to the NHS on Nursing. There are around 386,000 nurses and midwives working for the NHS in England.

I wasn't on the IPC Cell. My deputy CNO was responsible for this. We would look at IPC cell guidance, we would debate it. My role was around the operational implementation and how we would support staff.

I worked on the frontline on wards on 29 occasions. I saw for myself that nursing ratios were stretched. I was able to then go to Matt Hancock as the Secretary of State and give him my recommendation.

In England in December 2018 there were nearly 40,000 nursing vacancies. George Osborne had got rid of the student bursary which had paid the student fees and provided a maintenance grant. That meant that there was a significant drop, a 23% drop in nursing and midwifery applications as a consequence. There were 5,000 fewer nurses at the beginning of the pandemic because of that bursary decision. I reckon it would have amounted to around 40 extra nurses in each hospital. That I think would have made a difference. Maybe we needn't have made some of the decisions around critical care ratios.

We worked hard to increase the number of nurses. By November 2023 with using September 2023's data we delivered 64,000 additional nurses. Over 12,000 people joined the temporary register but only 2785 were deployed. The NMC doesn't hold data on their specialism. If we had known that, we would have been able to concentrate on certain specialisms first. There were bottlenecks with pre-employment checks. When we got to wave 2, a lot of these people went into the vaccine programme. We also brought in nurses from abroad. Many of them were from a BAME background. Given that they were disproportionately impacted, all Black, Asian and ethnic minority nurses had a risk assessment, and some were removed from clinical frontline care.

On Sunday 22nd March I was told we had 4000 critical care beds but that in 16 days' time, we would need 7000 beds. I was told that changing the ICU ratio from 1 nurse to 1 patient could be a consideration. I know there have been consequences because of it. I had experience of the 1:2 ratio and it affected the care that was provided. It is a decision that stays with me forever and it is why we did not do this in wave 2.

I was the national director of IPC for NHS England. I would see the draft guidance and have the opportunity to comment on it before it went to PHE for final approval. My role was more about providing executive leadership, supporting the conversation, supporting the coming together of UK-wide discussions, to challenge, and to ensure that the scientists had taken account of the latest evidence. If I thought a decision about the level of masks was wrong, I would question it. I did question Prof Susan Hopkins. I am not a scientist and relied on public health specialists. There was nobody saying there was evidence that FFP3 was needed all the time. I sought the view of PHE's most senior doctors', and their view was we didn't need to change the guidance.

The IPC cell recommended sessional use and re use – normally it was single patient single use. My main concern was the safety of our staff, and we just felt that this wouldn't be a safe option. This change to sessional use and reuse was agreed by Mr Hancock.

I fundamentally disagree with blanket DNACPR. It's a fundamental principle of the NHS to care for and treat people on an equal basis.

Professor Jean White CBE (Former Chief Nursing Officer for Wales)

The CNO role in Wales is a civil service role whereas it's an NHS role in England. So, my role was to give advice to Welsh Government ministers and support policy delivery.

Wales required its service to double the capacity of critical care nurses by doubling the number patients they were covering. The original guidance around dilution was quite extreme, it was something like one to six. The furthest we ever went was one to three and that was only in extraordinary circumstances and that's because the critical care network were giving a push back against the professional advisory groups.

England and Wales made face masks mandatory in non-clinical areas. Wales did not. We took the advice from the CMO. We found that the evidence around face coverings and face masks in a community setting was less robust than it was for clinical settings. There was evidence that wearing masks increased risky behaviour. The CMO was of the view that the evidence wasn't strong enough to require that. We felt that if you kept distance and had good ventilation, and had other sort of environmental factors in play, the risk was probably low.

I would probably give different advice now. Around 3 months later Wales did make masks mandatory. Partly to reduce confusion because there was different messaging across the UK and intelligence was growing about what was needed to prevent infection.

If you want to try to enable the system to keep delivering other care, you need to separate out those who have got an infectious disease from those who don't. Testing was available for those who had symptoms but there was an issue with asymptomatic testing because in the early days we didn't know it could be spread by those who were not showing symptoms.

We had a lot of stock of PPE, but the issue was around distribution. People on the frontline were not necessarily receiving what they wanted, we didn't run out of stock, we had everything but not necessarily in the right place.

I was the lead advisor on visiting restrictions. There were 5 versions of guidance. The first iteration in March was very restrictive. Over the iterations it became far more nuanced and permissive as we heard more voices about impact. Did we get the balance right? We get much better over time. It was only ever guidance so they were allowed to depart from it.

I had heard from various groups about concerns about having a blanket do not resuscitate cardiopulmonary resuscitation. They came from the disability advisory group that advised into government. But I also was aware from healthcare inspectorate Wales, which is our inspectorate body, that they had come across one GP practice that had sent out a letter suggesting to their patients saying certain groups of patients should consider signing this, which is completely inappropriate. Under no circumstances, is a blanket approach ever appropriate.

Fiona McQueen CBE (Former Chief Nursing Officer for Scotland)

I agreed with the visiting restrictions to prevent nosocomial infections.

In the early day I was unaware of the IPC cell and my team alerted me to the guidance being developed. In Scotland we have a working practice of working in partnership with the trade unions and the professional organisations so almost anything that we develop we develop in partnership. The Royal College of Nursing was concerned because they had not been involved in the development of this guidance and they had concerns about access to fluid-resistant surgical masks for some staff. My team had signalled to me there was real concern here because there was a UK body trying to develop guidance and it wasn't listening.

The advice I was given was it was droplet. At no time was I of the view that there was aerosol contamination whereby staff needed to have FFP3 protection.

I was aware of shortages, but my understanding is that everyone who needed it got it. Supply was the responsibility of national shared services. My Deputy was on the workforce meeting, and she assured that they were doing as much they possibly could.

Professor Charlotte McArdle (Former Chief Nursing Officer for Northern Ireland)

The role in NI is different to England. The Chief Nursing Officer sits in the Department of Health, and its primary function is to advise ministers, senior civil servants and government on matters that affect nursing and midwifery and to lead areas of policy development. The operational responsibility for the delivery of

care sits with the five integrated health and social care trusts in Northern Ireland and their executive teams.

My oversight of the IPC cell was a professional oversight because I'm not an IPC specialist so my role was to support the Chair in his role and to provide professional leadership and support. I certainly would have reviewed the guidance, but from a general nursing leadership perspective, as opposed to a scientific specific infection control perspective. Routes of transmissions was outside my area of expertise. Our regional IPC cell did not go against any guidance. We implemented the PHE / UKHSA guidance as it became available.

NI didn't have any spare capacity; it was very stretched. By providing nurses to the independent sector its diluting the workforce further.

I was responsible for leading the development of visiting guidance. At the start of the pandemic, we made a decision to restrict visiting which is a normal protocol in terms of infection prevention and control. We needed to restrict visiting to protect very vulnerable patients, to protect our healthcare staff and to protect the public. We didn't at that time think the pandemic would be as long as it was. It wasn't a decision that I either wanted to make or would want anybody's family to have experienced. But it was a balance of risk between protecting patients, staff and the public, and I really do understand the implications of making that decision. I've had very personal experience not being able to visit my own mother when she died in hospital, so I do understand. I am satisfied that in every reasonable instance that people were able to be with their loved one at the point of their death.

I wasn't aware of concerns about the inappropriate use of DNACPRs. The department developed an ethical framework to support clinicians to make those decisions in very difficult times,

On 1 March 2020 there were 88 critical care beds in Northern Ireland. The first wave surge plan dated 17 April; indicated a need for 140 Covid and 35 non-Covid critical care beds, so effectively doubling the number of critical care beds. That would have meant reducing the nursing ratios significantly.

We tried to maintain staffing ratios as best that we could in order to maintain safety. There were limits on what we were prepared to do. We all recognised that it was extremely challenging, and we would have to dilute the staff, but we could not have a situation where there would be no nurse in charge or no nurses with skills to care for patients in intensive care. It was agreed with the network to stay at 1: 1 for as long as possible and then move to 1: 2 and 1: 4. I don't believe during the pandemic we ever moved beyond the 1:4 ratio in ICU. I don't think we have the evidence to say that it impacted on someone's outcome, but it certainly impacted on experience of both staff and patients.

Professor Susan Hopkins CBE (Chief Medical Adviser at UKHSA)

We are not bound by WHO guidance. Public Health England acted as adviser to the UK IPC cell. PHE incident director was me and Professor Nick Phin.

From everything we have learned I think that we should be talking about general respiratory transmission and what we can do to reduce it, rather than talking about particle size. The important thing is: what are the interventions that will help us reduce the risk of respiratory transmission in a wide variety of settings to prevent people getting infected.

We were clear in 2021 that there was some element that was happening through the air, but there was uncertainty. Studies had shown that it was definitely possible, but it was not dominant because these are rare events rather than finding it in the air at all times. The evidence was weak that the FFP3s protected more than fluid-resistant surgical masks. FFP3 offer a higher degree of protection that's been studied in laboratory procedures, when we look at it in clinical trials of various different types it is very mixed actually and, in some studies, there is no difference between them. They are recommended in AGPs because they may help.

If the evidence was strong that FFP3s really protected people from it, and we saw a definitive reduction it would have been recommended. Even at the end of the pandemic, this was low quality evidence that it may have reduced infection. PHE did not consider there was sufficient evidence of aerosol transmission at the start of the pandemic.

Q: If it couldn't be excluded, why wasn't the guidance based on a precautionary approach and recommend IPC guidance that covers droplet, aerosol and contact transmission?

A. IPC guidance is built on the years of evidence from other respiratory viruses. Covid-19 guidance was based on the pandemic flu guidance which is a respiratory virus. IPC guidance is there to facilitate the use of a wide range of interventions to reduce transmission in healthcare, and that is based on the evidence. We would rarely say all of these other measures need to be done as a precaution, because that has risks and benefits.

I do not recall a lack of FFP3 masks being part of the decision-making process. Traditional infection prevention and control is only used where infections are suspected or confirmed and actually what we did was we changed that to all patient contact required fluid-resistant surgical masks or any contact in areas that AGPs were being performed

The supply chain was not resilient to this amount of PPE being used. The trade-off, therefore, in the views of a number of us who were developing this guidance was to use things sessionally. That was discussed with Health and Safety Executive who said that they would expect fluid-resistant surgical masks to last a few hours and FFP3 masks to last at least a day. It was driven by extraordinary demand. This was an unprecedented piece of guidance. This was an emergency situation whereas a last resort we wanted to ensure that the elements of protection that we could provide were the best we could do within the confines of the situation. It was so out of the ordinary that we asked the Sec of State for approval. The Sec of State is not going to disagree with the consensus health view.

There were moments where people did not have the right thing at the right time. There was never zero in the stocks. The stockpiles were insufficient for the scale of the pandemic and the scale of the personal protective equipment that was being used.

IPC Experts - Dr Ben Warne, Dr Gee Yin Shin and Prof Dinah Gould

Studies have shown that roughly one in three people who catch Covid are asymptomatic. Anybody coming into your hospital may be carrying Covid and be capable of spreading the virus. The incubation period is anything between 1 and 14 days so you could be asymptomatic for as long as two weeks, but average was 5 days. Future guidance should assume there will be asymptomatic transmission unless and until the contrary is proven.

IPC guidance becomes entrenched and is slow to change. Infection prevention people are very traditional and not very forward-thinking. They tend to be backward thinking people, they tend to be, we've always done it this way and it's the safe way and so we'll carry on doing it. I suspect that the use of FFP3 masks would have reduced the number of cases by a proportion, but we don't know that for sure.

Anything which induces coughing produces aerosols. Coughing by itself is likely to produce more aerosols than the procedures on the AGP list. Drawing a distinction between AGPs and general coughing on a ward for wearing an FFP3 is not a great distinction.

Estimates of the proportion of Covid infections acquired in hospital ranged between 5 to 20% of all Covid-19 cases identified in acute hospitals. It is highly likely that the true number of patients who contracted a hospital-acquired Covid infection in the UK was well over 100,000

It's now clear in my mind that Covid is transmitted through the airborne route. FFP3 would be what I recommend in a future pandemic. Before PPE steps down you need evidence that is a safe step to take rather than what happened in this case. We can understand why there are loud voices calling for precautionary principle for PPE and I think that all of our workforce would be more reassured if that precautionary principle was applied in a future emergency so that we only step-down PPE when evidence showed that that was reasonable and safe to do so.

Q: Where there is an absence of evidence about the route of transmission, start with the highest level of protection and as you work out the routes as the evidence emerges then make a decision to step down if that's appropriate. Is that it?

Dr Shin: I think that's probably our consensus view.

Policy makers have a duty to be transparent about whether logistics or supply issues have informed the guidance.