Module 3 Week 7

1. Patricia Temple (Impact Evidence, Royal College of Nursing)
2. Rosemary Gallagher MBE (Professional Lead for IPC Royal College of Nursing)
3. Nick Kaye (National Pharmacy Association)
4. Professor Fu-Meng Khaw (Public Health Wales)
5. Aidan Dawson (Public Health Agency Northern Ireland)
6. Laura Imrie (Clinical Lead for NHS Scotland Assure and Antimicrobial Resistance & Healthcare Associated Infection ("ARHAI")
7. Professor Nick Phin (Director of Public Health Science and Medical Director)
8. Professor Dame Jenny Harries (Chief Executive of UK Health Security Agency and former Deputy Chief Medical Officer for England)
9. Professor Simon Ball (Former Chief Medical Officer for University Hospitals Birmingham NHS Foundation Trust, including Queen Elizabeth Hospital Birmingham)
10. Professor Sir Stephen Powis (National Medical Director, NHS England)

Patricia Temple (Band 5 Staff Nurse – Impact Evidence, Royal College of Nursing):

Patricia Temple qualified as a nurse in 1972 and worked as a band five nurse in a cardiac care unit from March to November 2020. She provided bedside care to both Covid and non-Covid patients, primarily those with cardiac problems. There were instances where patients were admitted without showing symptoms of Covid and later tested positive. Staffing levels often dictated whether nurses were floated to other wards. Patricia mentioned an incident where they were instructed on a Friday to start wearing masks on a Monday, which seemed illogical to her. She felt that they were not always fully informed about the situation, particularly regarding Covid-positive patients. There was confusion about the adequacy of surgical masks versus FFP masks. Patricia contracted Covid and later discovered that the mask she had been FIT tested for was withdrawn from the Trust. She faced difficulties in getting support from management when she developed Long Covid. Patricia ultimately had to take ill health dismissal due to permanent lung damage.

Rosemary Gallagher MBE (Professional Lead for Infection Prevention and Control ("IPC") and Nursing Sustainability Lead at the Royal College of Nursing):

Rosemary Gallagher is a registered nurse specialising in infection prevention and control. She advises the Royal College of Nursing on matters related to infection prevention and control. During the pandemic, the development of guidance was led by Public Health England in collaboration with other stakeholders. The Royal College of Nursing tried to ensure that the professional voice of nurses was heard. There were many enquiries from nurses across health and care settings asking us to explain or to rationalise the difference

in levels of PPE. Nurses started to express doubt about the predominance of the droplet mode of transmission.

The RCN was excluded from key meetings during the pandemic. During the pandemic it appeared that it was only the Medical Royal Colleges around the table. Nursing is the largest part of the professional workforce so it's absolutely critical that a representative from Nursing is around the table and able to provide insight and critical thinking.

Rosemary highlighted the need for a precautionary approach to PPE rather than saying there was no evidence to justify why IPC should be changed. She mentioned that there was confusion and a lack of confidence among healthcare workers regarding the IPC guidance and nurses expressed concerns about the adequacy of surgical masks when it was known they did not protect against airborne particles.

Surveys in April and May 2020 of members revealed that half of the respondents said that during Covid pandemic they felt pressure to care for a patient without adequate protection as outlined in the current PPE guidance.

Members were asked to reuse PPE. That added to the concern and further eroded confidence that nurses were being protected when they went to work. The RCN issued guidance on refusal to treat patients if appropriate PPE was not provided. This was only to be used a last resort and to my knowledge no nurse did refuse to treat.

Rosemary emphasised the need for reusable respiratory protective equipment and better communication about changes in guidance.

Nick Kaye (Chair of the National Pharmacy Association)

Nick Kaye discussed the challenges faced by pharmacies during the pandemic. He highlighted the significant increase in demand for pharmacy services and the critical role pharmacies played in supporting the healthcare system. He emphasised the need for better communication and support from the government and health authorities. Nick also mentioned the difficulties in obtaining personal protective equipment (PPE) and the impact of staff shortages on the ability to provide services. He stressed the importance of recognising the contributions of pharmacy staff and ensuring their safety and well-being.

Community pharmacies should have access to PPE on the same terms and at the same time as other healthcare providers. When testing became available for healthcare professionals, it was not made available to those working in pharmacies at the same time.

The categorisation of community pharmacies as retail settings in respect of PPE and the categorisation as a private sector provider in respect of testing reflects an under appreciation of our role in providing critical healthcare. Those things were changed but it felt like an afterthought when people were giving their all to deliver care in an unprecedented time. We need to be recognised as healthcare professionals and part of the healthcare family.

Professor Fu-Meng Khaw (National Director of Health Protection and Screening Services and Executive Medical Director of Public Health Wales)

Professor Khaw started working for Public Health Wales (PHW) in June 2021, having previously worked at Public Health England.

During the pandemic, PHW built on existing surveillance processes to monitor and control outbreaks. Linking various datasets made it possible to make assumptions about whether the acquisition of Covid-19 occurred in the community or the hospital and they published reports of those outputs.

In the early stages testing was very limited so we had to prioritise tests to those who needed it most and for diagnosis. There were few tests in the community meaning the data was mainly coming from hospital cases and mainly symptomatic people.

Systems of notifications of deaths in hospital were not reliable. Some official information was available through the ONS but that came with a data lag of 10-15 days which was not acceptable because we wanted a rapid surveillance system to indicate the trends in mortality occurring in hospitals. So, in April 2020 we created an e-form for causes of deaths that would allow electronic reporting. But it became clear that there were elements of the form that were not as well completed as they might be and there was missing information. It was intended that the form would capture whether the person who died was a Health Care Worker but there was a significant element of missing data in this particular question amounting to about 17% missing data.

Data on ethnicity is low. PHW used Onomap software to classify ethnicity based on names, but it has a habit of overestimating the white population and in particular underestimates the black population.

PHW did not have a role in providing advice on hospital capacity but did model reasonable worst-case scenarios.

The IPC cell within PHW called HARP. It was HARP who engaged with the UK IPC cell. HARP didn't create IPC guidance itself, but it applied the UK IPC guidance. There were no differences of opinion, we were completely aligned. There was no need to independently assess the routes of transmission, benefits of masks etc because the UK IPC cell looked to emerging evidence and issued updates on the guidance. BJC Note – But if they were not conducting their own assessments, they would have no reason to disagree with what the UK IPC cell was saying hence why no difference of opinion. I am led to believe that the UK IPC cell did not consider the shortage of PPE in considerations as it was outside the scope.

There were differences within PHW about the use of FFP3 masks compared to FRSMs. HARP raised concerns at an IPC cell meeting that there was pressure for more precautionary measures and the confidence of staff in high-risk pathways was being lost. That would have informed the decisions of the IPC cell.

Nosocomial infections were a significant issue, with over 50% of Covid cases in wave two being hospital-onset. Lessons were identified from wave one, but I don't have the information to confirm or otherwise whether the lessons were learned. BJC Note - Suggest they were not learned if 50% of cases where

nosocomial infections however Prof Khaw stated the percentages reduced from a total of 70% in wave 1 to 24% in wave four.

Aidan Dawson (Chief Executive of the Public Health Agency Northern Ireland)

Aidan Dawson has been in his position since July 2021 and does not have a clinical background. Given the time he commenced his role, there was much on which he could not comment.

We had a considerable lack of information on what was happening in the community in terms of tracking the disease. We had good information about what was going through ICU and the hospitals, but we continued to have a lack of information through primary care until August 2023. Community care continued to be a blind spot.

We had very poor data on ethnicity and disability. The consensus of 2021 had people from black and ethnic minority background of 3% so there wasn't the focus that was required or deserved. It amounts to 67,500 people from a population from over the 1.9 million on whom the impact was not tracked. I do think the size of the population did lead to an oversight. I don't think we served that population well in terms of our data and data collection.

PHA did not include data on staff illness and deaths. It would have been very difficult to differentiate whether staff deaths were due to them acquiring the disease in line with their work, or whether or not they had acquired it in the community. We didn't see that the data would help us manage at that point in time. It is data we collect now.

The Northern Ireland IPC cell didn't produce its own guidance, it followed and applied the UK IPC Cell. We had input into the national cell and therefore I don't think there was a necessity to replicate that. Northern Ireland has always relied on health NHS England and now UKHSA to provide us with guidance in many areas.

I'm not aware of discussions in December 2020 about colleagues not feeling adequately protected. There was always a degree of concern that people wanted to use PPE etc beyond what was recommended. People were genuinely frightened and always sought to have a higher level of protection than was being recommended within the guidance. We had discussion with Trust representatives to provide the evidence to say we have confidence in the guidance and there is nothing to dissuade us from it.

We never had concerns about the lack of PPE across Northern Ireland. I'm not aware of any reports of people ever saying that they didn't have access to appropriate PPE as advised in the guidance. BJC Note – our contention is that the advice was based on what was available rather than what would have provided the maximum protection. I think there may have been general concerns where people felt that they should have been using higher levels of PPE than was recommended, but that goes back to the fear issue.

There was no tracking of whether IPC guidance was being followed. There was an assumption that it was being adhered to. Was it specifically tracked on whether or not the IPC guidance was effective, I don't think it was, don't believe it was.

Q. Is that not a failing as the body sets the guidance to check to see whether it's actually working or not and how it's being applied?

A. Yes.

Analysis of whether restricting visiting had an impact on hospital infections was not carried out. None of us felt that stopping visiting was a satisfactory way but I don't think anyone could think of a better way of doing it. But if you are not tracking whether it had an impact there is nothing to say whether another option might work better.

I do agree that use of air filtration was not given sufficient priority.

Data on disability was not collected during the pandemic.

I accept that there appears to have been a failure on the part of the Public Health Agency to identify the importance of widespread testing of healthcare workers and patients in various settings.

In Jan 2021 NHS England offered testing to visitors to maternity settings and to end-of-life care to facilitate visits at those very important times however it wasn't until September 2021 it was made available in NI.

I can understand the concern of the Northern Ireland Covid bereaved that there was a failure to appreciate the detrimental impact of those restrictions on visiting. I can understand the timeline gives the impression that there was a lack of urgency or understanding about the importance of it. I wasn't there at the time, and I haven't asked my team about it so it's hard for me to understand what their considerations were. I can understand why the Northern Ireland Covid bereaved might be so concerned that I haven't had those discussions with those teams and that it might appears that there has been a lack of reflection by PHA.

Laura Imrie (Clinical Lead for NHS Scotland Assure and Antimicrobial Resistance & Healthcare Associated Infection ("ARHAI")):

What came out of the IPC cell was as a result of wide consultation, it didn't come from the IPC cell members.
I think yes if you have an emerging pathogen then we should take the highest precautions. There is always a risk that airborne can be a route of transmission, but you have to weigh that up against all the unintended consequences when you apply that pre-cautionary principle.
I don't think we were in a position to use FFP3s widely in the NHS because of the requirement to have a fit test. That was one of the considerations.
If we wrote guidance as a precautionary principle to put everybody into FFP3 then not only would they have a large amount of the workforce that couldn't comply with the guidance, and therefore couldn't come to work, we would have also had high risk areas such as intensive care units or high risk pathways that might have been left without the FFP3s. They were probably two of the main constraints to following a precautionary approach of recommending an FFP3 without the evidence.

Supply was not driving the advice, but it was a consideration. If we had said to health care workers “we think you should have an FFP3 mask, but we don't have the masks to give you, “I think that would have been an unbearable anxiety for somebody going into work and looking after Covid patients.
Clinical teams viewed patients as a far higher risk than they did their colleagues, so their behaviours were adjusted when in a staff only area. I think in hindsight, if there was another similar pandemic I think we would go in quite strong and say it's masking for everybody all the time.

Professor Nick Phin (Director of Public Health Science and Medical Director at PHS

The placing of the NHS in Scotland on an emergency footing from 17 March 2020 to 30 April 2022 impacted on PHS' operational autonomy, In particular in relation to public health advice. This meant, for example, that while PHS continued to offer the Scottish Government advice on the wording of relevant guidance documents, the Scottish Government was under no obligation to accept that wording.

Genome sequencing provides a genetic fingerprint of a sample meaning that if you have two samples with the same sequence, they are linked. If 15 people in a ward you would want to know whether it was a single strain that spread to everyone or if they each had different genome sequences, that would mean you were talking about 15 different introductions of the virus. It was useful in identifying gaps and weaknesses and providing assurance where there wasn't an issue about the adequacy of infection prevention controls.

Scotland went into the pandemic with the worst health inequalities in western and Central Europe and the lowest life expectancy in Europe. We tend to operate healthcare services at 85-90% capacity which actually leaves little room for expansion to deal with critical incidents. And that's good if you're actually running a system where you're trying to maximise your efficiency and effectiveness. What it doesn't help with is where you're suddenly having to respond to an incident.

The rapid expansion of intensive care facilities is just one part of it. The one thing that hampered the actual provision was having the staff necessary to be able to make it function. It's one thing to have a bed but if you don't have the staff able to operate it and to look after the patient then that's a problem.

Professor Dame Jenny Harries (Chief Executive of UK Health Security Agency and former Deputy Chief Medical Officer for England)

The aim of the shielding programme was very simple. It was to support those people who could predictably be at highest risk of a new pathogen to keep as safe as possible i.e. its primary aim was to prevent mortality. It was voluntary and protective. Thought was given to applying shielding guidance to households rather than individuals, but it was actually practically very difficult.

These individuals we expected to go into hospital frequently. We don't want them to be there, we want them to only go when they need it and to do that safely and to stay out of the way when they didn't need to. We would expect the shielding group to be going in and out of hospital, sadly probably with much, much higher mortality rates and being tested much more frequently.

UKHSA accepts that C19 is transmitted via an airborne route as well as potentially other routes. I think droplet was a reasonable assumption to start with what we knew but clearly the evidence has grown and changed as we've gone forward. I don't think anybody ruled airborne transmission out, it's the proportion which is the tricky part. The proportion of that, and of asymptomatic transmission turned out to be much more significant than was in the frame at the start of the Pandemic.

The real problem with testing at the early part of the pandemic was actually the capacity so it was clinical use first for management of patients and then obviously healthcare workers and their families and social care workers as well and key workers were the next priority.

Professor Simon Ball (Former Chief Medical Officer for University Hospitals Birmingham NHS Foundation Trust, including Queen Elizabeth Hospital Birmingham)

Largely modern estate from 2011. 46% I think single side rooms, so with suites and then in most of the rest of the rooms bays with bathrooms with four bedded bays so no open wards. This is not at all typical and would not reflect the experience of the vast majority of people in hospital during the Pandemic. It would be interesting to know the rates of NCT and compare with other older hospitals to see if this made a difference. The hospital was designed with capacity for 100 ICU beds of which 67 were funded (i.e. staffed) so very, very large capacity for intensive care.

We expanded the ICU bed capacity from the 67 to 126. In April 2020, the expansion would have required an additional 205 doctors and 429 nurses. That meant bringing in staff who were not currently working on ICU so staff nurses that were working on the wards, we had support from other hospitals within the Birmingham and Solihull system.

It's actually the skill mix that changed rather than the ratio, so there was one to one nursing on ITU but the skill mix changed so we would usually have an intensive care-trained nurse per patient, during the pandemic they weren't always intensive care trained nurses but they were overseen at a pod level of four by at least one intensive care trained nurse.

Professor Sir Stephen Powis (National Medical Director, NHS England)

There was as much stakeholder consultation as possible. Clearly there are pros in developing guidance quickly where the need to get information out rapidly is paramount but there were also downsides. We did what we could but there is a trade-off between getting guidance out rapidly and doing the consultation that you would want to do under normal circumstances. It's a set of lousy choices often but you have to make that judgment.

We were very clear that the Clinical frailty scale was not relevant to people with disability alone. NICE had issued some guidance a few weeks earlier which included the Clinical Frailty Scale. They withdrew that and we wrote out at the time to inform people that it should not be used, it's not appropriate.

The Decision tool was never authorised, it was never officially released. I was personally terrified that the NHS was going to be overwhelmed, and doctors were going to be placed in a position where they would not be able to make the professional judgment that they usually make in terms of treatments and escalation. And in those circumstances, I and my clinical colleagues felt that we should begin to explore a decision tool such as this.

It was halted because a number of us came to the conclusion that it should not be released. For me, the main reason was it was becoming increasingly clear that the peak of the pandemic was approaching, and we would not breach capacity so a tool would not be needed. I did have a concern about a poor reaction from the public too.

There might have been inappropriate use of DNACPR. There is a danger that there might be inappropriate use of a simple decision tool that takes away from that professional judgment.

The 2019 learning disability mortality review found that in some of the DNACPR notices they reviewed, learning disabilities had been cited as a reason for a DNACPR notice being placed on a patient's file. In response to those findings, NHS England in 2019 issued communications to make it clear that DNACPRs applied generally to patients with long-term stable conditions are entirely inappropriate.

We heard about blanket DNACPRs through a variety of sources at the end of March and early April and we took immediate action. We wrote out and communicated on a number of occasions during the pandemic to state that the use of blanket DNACPRs is completely inappropriate.

3 April Letter: learning disability and Down's syndrome should never be a reason for issuing a DNACPR order be used to describing the underlying or only cause of death. Learning disabilities are not fatal conditions."

We didn't at, national level, turn off or step-down screening services but decisions were made at local level to do that. In the face of the pressures around the peaks and depending on the screening service redeployment of staff, all services came under pressure. We tried to protect screening services as much as possible and then recover the lost ground as quickly as possible afterwards but in general I agree we would do as much as possible to preserve screening services during a future pandemic.