

## Royal College of Nursing (RCN) submission: Public Accounts Committee inquiry COVID-19: Supply of Personal Protective Equipment (PPE), December 2020

### Introduction

COVID-19 has fundamentally changed the working life of health and care professionals and us as individuals, including not just how we live our lives but our expectations around how we build back an inclusive economy that promotes wellbeing, protects the vulnerable, improves outcomes in public services and creates a fair society.

The nursing and midwifery workforce continue to be unstinting in their professionalism and agility as key workers to provide care throughout the COVID-19 pandemic. However, their safety and the safety of their families and the patients in their care, was put at risk during the peak as issues with PPE persisted. Nursing staff were consistently raising concerns about the need for adequate supplies of PPE that meet the technical and clinical standards needed in order for them to do their jobs safely.

This submission details the most pressing and significant challenges nursing staff faced in accessing adequate and fit-for-purpose PPE throughout the pandemic. We also set out our expectations of how learning should be captured and acted upon.

While the scope of this inquiry is predominantly focused on the response to COVID-19 in England by the UK government, it is important to note that many of the issues detailed below were, at least in part, experienced by nursing staff in all nations of the UK. There were also concerns raised by the devolved nations, including in media reports, of PPE being redirected to England services ahead of fair and equal distribution across the UK.

### Recommendations

*We are calling on the government to:*

- Ensure access to adequate supplies of PPE that meets the required safety, efficacy and clinical standards, for nursing, midwifery and social care staff for use at the point of care, in all care settings.
- Initiate a public inquiry into the preparation and management of COVID-19 that covers all UK related issues that arose during this pandemic. We expect this inquiry to examine pandemic planning (including the adoption of learning from previous epidemics/outbreaks) the management of PPE as well as the procurement and long-term sustainability of national stockpiling (see appendix A).
- Include nursing staff and the RCN in all decision making and pandemic preparedness at all levels. This means nursing being involved in all committees for current and future pandemics, and professional nursing input sought on all decisions of national public health importance, including PPE.
- Provide assurance that care homes across England all have unhindered access to appropriately skilled and experienced infection prevention and control expertise and advice for both day to day and pandemic related issues.
- In the long term, conduct a targeted review of infection prevention and control, leadership and management in care homes undertaken by the Care Quality Commission (CQC) in conjunction with the Health and Safety Executive. This will ensure that in future care homes, residents and health and care staff are protected from risks of infection at all times. Funding must be available to ensure adequate PPE and training are in place for staff, residents and visitors in care homes.

- Create a Chief Nursing Officer in the UK government. The nursing profession should be more central in UK government strategy and decision making, as it is in service delivery.

## **Pandemic preparedness**

*England's preparation for a pandemic like COVID-19 was poor*

In 2018, the RCN was invited to be a part of a group tasked with preparing England for a pandemic. This group was the NHS England's Emergency Preparedness, Resilience and Response (EPRR). Its purpose was to provide specialist and timely advice and clinical leadership to NHS England and NHS Improvement (NHSE/I) in how to plan and respond to national incidents and emergencies.

Meetings were due to take place quarterly, however, these were infrequent, and few meetings took place in 2018 and 2019. To the best of our knowledge, the last meetings pre-pandemic took place in June 2019 and the group didn't meet again until January 2020 when COVID-19 was rapidly emerging. The rationale provided verbally for infrequent meetings was preparation for Brexit.

We have not been systematically involved with planning the response to the COVID-19 pandemic. This approach is in contrast to both the West African Ebola outbreak in 2014 and Swine Flu pandemic in 2009. On both occasions, we were involved with committees and/or sub-groups that fed into the guidance on the supply, selection and use of PPE and the implications for compliance with health and safety legislation.

We believe that the absence of engagement and a lack of adequate stockpiling seriously exacerbated the UK government's ill-preparedness for COVID-19, in particular in relation to PPE.

### **Access to adequate and correct PPE**

*Access to PPE was not the same for all health and care settings*

Throughout the first wave of the COVID-19 pandemic, nursing staff across the UK consistently raised concerns around the availability and quality of PPE. We surveyed members in April and May 2020 (see a detailed breakdown of this data in appendix B) and on both occasions, we found issues with stock availability and the slow distribution of PPE. Government and health agencies should have known that they would need significant stocks of PPE in line with pandemic planning as the crisis and the virus spread around the world in early 2020.

Instead, while some care settings reported adequate PPE, for example in intensive care, there were widespread and significant variations in the availability and quality of PPE elsewhere, with some NHS Trusts even relying on donated stocks, including homemade items. Care homes across the country were left particularly vulnerable due to the inequity of adequate supply between the NHS and wider health care services. Existing stocks of PPE, based on modelling for an influenza pandemic, were also insufficient.

The failure to adequately consider non-hospital based care needs and staff protection is a major learning point from this pandemic. As a result of inadequate supplies, our members reported examples of clear 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 (see appendix C).

Finally, our BAME (Black, Asian and Minority Ethnic) members reported more difficulty in accessing PPE throughout the first wave of the pandemic. For example, overall a third of respondents in our second member survey in May felt pressure to care for individuals with possible or confirmed COVID-19 without adequate protection. This was significantly worse

for BAME nursing staff where over half (56%) felt pressure to work without the correct PPE.

#### *Staff were often provided clinically inadequate PPE*

There were numerous examples of employers providing the wrong PPE to staff during the first wave of the pandemic. A good example is the fit testing of FFP3 respirator masks. These masks offer the highest level of protection as they can block liquid and solid aerosols containing virus particles. They also require users to undergo fit testing to ensure that the equipment is adjusted correctly for their personal use.

FFP3 masks differ by brand and make. As such, staff need to be fit tested each time a new brand of FFP3 is introduced. Where different brands of FFP3 masks are provided in succession, staff need to be constantly fit tested. Some members reported that equipment to undertake the fit testing was not always available and they were asked to use these without having been correctly fitted.

In addition, repeated fit testing identified brands of FFP3 masks that frequently failed to meet the standards and a lack of masks suited to different face shapes and sizes. This created additional pressure and delays for staff and the system at such a critical time. We raised this in a letter to the British Safety Industry Federation in May and received a response that they would work proactively to resolve this disparity with their members<sup>i</sup>.

#### **Guidance on using PPE**

*Nursing must be included in PPE procurement, guidance to staff and decision making*

Currently the two most important factors for the selection and use of PPE are the UK Infection Prevention and Control guidance and the procurement of PPE, led by the Cabinet Office. In neither process is there a clear structure for engagement. For example, the RCN's UK procurement specialist nurse network was not consulted to help develop the recent PPE strategy despite our forum offering to assist and provide their expertise.

This continued lack of clinical engagement means that PPE offered to staff sometimes isn't good enough quality to maintain health and safety at work. The example of FFP3 masks and visors shows that PPE provision should not focus on technical standards alone, but instead consider how PPE will be used in practice, including staff needs, working practices and safety concerns.

Clinically appropriate and well thought guidance is crucial to health protection and supporting nurses, midwives and other health and care workers to practice safely and effectively, ultimately keeping COVID-19 under control. Guidance must be based on the available scientific and clinical evidence, noting where evidence does not exist and reaching consensus with users on acceptable practice standards in this situation. It must involve stakeholder engagement, in this case professional nursing, to ensure that it can be implemented across the system. This is different to specialist infection prevention and control nursing advice which carries a narrow focus based on written evidence alone.

Unfortunately, stakeholder engagement has been limited throughout this pandemic, resulting in uncertainty from front line staff on how to use or implement the guidance effectively. The need for engagement of non-medical stakeholders was a central learning point from the Ebola outbreaks and Spanish experience and was reported to the Department of Health and Social Care (DHSC) at that time. For example, changes to Public Health England's (PHE) guidance, particularly on the re-use of single use PPE led to heightened anxiety for many staff and left many working in unsafe environments.<sup>ii</sup>

The RCN has made itself available throughout the pandemic to support and provide professional and specialist advice, member expertise and intelligence. However, we have

largely been excluded from decision making processes by the relevant parts of government and the wider health and care system, this is very disappointing given the role and contribution of the RCN and professional nursing in the H1N1 swine flu pandemic when we were members of the pandemic influenza clinical and operational advisory group (PICO-CSG), directly advising SAGE on clinical issues alongside medical colleagues.

The RCN is clear that the UK government must consistently seek independent professional nursing input into the production of national guidance that impacts on nursing obligations and practice.

## **Government and system response to PPE issues**

### *We raised concerns throughout the first wave*

In April 2020, we wrote an open letter to the Chief Executive of the Health and Safety Executive (HSE), where we called for their intervention to ensure the adequate availability of fit testing, and that employers comply with Regulation 4 of the PPE at Work regulations (1992) which stipulates '*that suitable PPE must be provided to employees who may be exposed to a risk to their health and safety while at work.*'<sup>iii</sup>. We received an unsatisfactory response and had expected the HSE to act given the extreme seriousness of the situation.

When raising concerns regarding the quality of PPE supplied to their employers, our members have reported that the process is confusing and complicated as there are two ways in which they are required to report defective items, depending on the problem, to the HSE or Medical and Healthcare products Regulatory Agency. This process must be clearer in the future.

### *Procurement processes and structures for PPE*

We were willing and able to support our procurement specialist nurses to fill the gap of professional and clinical expertise at the Cabinet Office. We sought engagement with government's PPE procurement process on many occasions but were excluded. We understand the government had to work at a rapid pace to procure and distribute PPE, but they did not take up our offers of help which would have mitigated basic errors and reduced PPE that was not fit for purpose reaching the frontline. We are concerned by the poor decision making, poor assurance systems and little engagement with key stakeholders at such a critical time. A pandemic requires an even more engaged, careful, considered approach rather than one that omits important steps.

In July 2020, we directly asked the Cabinet Office for the development of a single process to aid reporting and central oversight of PPE issues and to inform learning for a potential second wave. We are still awaiting a response to this request. Finally, we have called for a clear and accountable mechanism in place for staff to raise any concerns regarding PPE in the knowledge that they will be dealt with without fear of redress. We are also yet to see this implemented.

## **What the Government must do**

The responsibility for sufficient supplies of correct PPE is between system leaders, governments and all employers. A failure to provide provision adequate PPE is the responsibility of the NHS and social care employers as they are failing to follow statutory obligations in relation to PPE.

While supplies of PPE are now somewhat stable, there remain ongoing ad-hoc supply issues, such as gloves for chemotherapy units and aprons that aren't fit for purpose. The response to COVID-19 is likely to last a long time. Therefore, the government must develop a long-term strategy that ensures correct and sufficient PPE provision, not only for the ongoing response to COVID-19, but also future pandemics.

## About the RCN

With a membership of around 450,000 registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets, the Royal College of Nursing (RCN) is the largest professional body and trade union of nursing staff across the UK.

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## Appendix A – The RCN’s recommendations for a future COVID inquiry

### *A Future Inquiry*

At Prime Minister’s Questions on 15 July 2020, the Prime Minister confirmed that some form of public inquiry into COVID-19 will take place, but he would not be drawn to comment on any details about how an inquiry would be funded and or delivered. It is our position that the UK government should initiate a public inquiry into the preparation and management of COVID-19. The inquiry should cover all related UK reserved issues that are within the control of the UK government, including:

1. Pandemic preparedness at a UK level
2. Effectiveness of specific coronavirus legislation and regulations across the UK
3. UK coordination of the management of the outbreak including border control decision making
4. Procurement of PPE and testing kits internationally
5. The operation and output of SAGE in terms of decision-making, along with how evidence was gathered, prioritised, presented and used
6. The quality and effectiveness of public information and communication
7. Information sharing and communication between the UK Government and devolved administrations
8. UK coordination of data, especially relating to infection and deaths rates
9. Development of clinical and professional guidance at a UK level
10. Ongoing preparedness measures for future pandemics.

There should be a cross sector inquiry panel with a diverse range of socioeconomic and ethnic backgrounds. The panel must include representation from registered nurses. Furthermore, representatives from across health and social care settings, including nurses and other medical and clinical professionals, as well as local government and public health experts, should be facilitated to give evidence to the inquiry.

The inquiry should be initiated when the COVID-19 UK alert level reaches level 2 (number of cases and transmission is low, minimal social distancing) and should generate recommendations for the UK Government within an appropriate timescale.

Devolved administrations across the UK should also initiate separate public inquiries into their preparedness and the measures undertaken to control/manage the COVID-19 pandemic, covering all related devolved issues. Note: these issues will need to be included in the UK inquiry specifically relating to England. These should include:

1. Management of the outbreak, lockdown, testing prioritisation, border control, PPE, track and trace
2. Care Homes: support, response and role in future waves
3. Staffing and resources in health and social care
4. Procurement and long-term sustainability of national stockpiling
5. Impact on mental health
6. Impact on education
7. Impact on palliative care

8. BAME deaths and the interaction with wider societal factors which should include issues of deprivation
9. Accurate data, especially about infection and death rates
10. Memorialising the experience of families and individuals
11. Management of non-COVID medical treatment/social care delivery including domiciliary care
12. The deployment of emergency capacity (in particular the 'Nightingale' hospitals – although they are not all called this)
13. Impact on wider health services
14. Impact on the health and care workforce, including disproportionate impact on BAME staff, deaths of staff and the effectiveness of measures to protect staff from exposure
15. Effectiveness of engagement and interaction between central and local government
16. The role of workplace regulators
17. Quality and effectiveness of public information and communication relating to the pandemic (including accessibility, dissemination, timeliness).

## Appendix B – RCN member surveys on PPE

We conducted two online surveys on PPE (in April and May 2020), sent to all RCN members, across all health and care settings in the UK. The surveys were framed around the UK-wide published guidance on the recommended use of PPE, consisting of mostly closed quantitative questions. We explored access to PPE and associated training, where PPE had been sourced, any issues experienced; any pressure to reuse single use PPE, or to treat patients without the correct PPE; and how far concerns had been raised or addressed.

The first survey highlighted a key issue of concern in that members working in high-risk areas were being asked to reuse single use items of PPE, there were also concerns raised around the source of PPE. The second survey added to the mounting evidence of the unequal impact of COVID-19 on BAME communities, by highlighting a variation in experience in access to PPE between different ethnic groups.

13,605 of our members completed the first survey, and 5,023 completed the 2nd (comparisons between the two sets of results are therefore made with caution). Stated below are the key findings covering both surveys.

- In April, of those treating possible or confirmed COVID-19 patients in high-risk areas, around half (51%) reported that they are being asked to reuse designated 'single use' items of PPE. Of those treating COVID-19 patients elsewhere, over a third (39%) said they were being asked to reuse this equipment. In the same survey, one in 10 nurses reported relying on face or eye protection they have bought or made.
- The experience of nurses working in care homes (around 9% of respondents to the survey in April) varied from that of those working across other settings. For example, 43% of those working in care home environments with possible or confirmed COVID-19 residents, reported that they didn't have the eye/face protection they needed, compared to the survey average of 30%.
- Generally, the situation improved between our two surveys in April and May 2020, in terms of access to standard PPE and PPE required in high-risk care settings such as ITU since the first survey was conducted. However, there were also stark and contrasting findings in the experience and safety of BAME members. The following points relate to the findings from the second survey.
- Overall, only 28% were very confident that their employer is doing enough to adequately protect them from COVID-19 in their place of work, and a further 40% were moderately confident.
- A third of respondents felt pressure to care for individuals with possible or confirmed COVID-19 without adequate protection (compared to 50% in the first

survey). This is significantly worse for BAME nursing staff where over half (56%) felt pressure to work without the correct PPE.

- One in five respondents in non-high-risk areas are concerned about the supply of eye/face protection. The situation was worse for BAME respondents where one quarter said there was not enough eye/face protection or enough fluid-repellent surgical masks for them to use during their shift.
- Those working in care homes were most likely to report that they felt pressured to care for individuals with possible or confirmed Covid-19 without adequate protection (41%) than those working in a hospital (38%) or the community (24%).
- Over half (58%) of respondents had raised concerns about PPE and over a quarter (27%) of these were not addressed at all. The most common reason for not raising concerns was because they did not believe any action would be taken (68%). 29% were fearful of speaking out, nearly a quarter (24%) were worried it would negatively impact on their career or training progression and 1 in 5 said there was insufficient protection and support for reporting.
- BAME staff working in high-risk areas and requiring the use of PPE such as FFP3 masks are less likely to have been fit-tested for their PPE in comparison to their White British colleagues (49% compared to 74%).
- Staff members from BAME groups also felt 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 staff did not feel confident at all, compared to around 1 in 10 White British staff.

## Appendix C

Throughout the COVID-19 pandemic and more widely as our offer to our membership, we provide support services and run a call centre where nursing staff from across the UK can seek advice and access our specialist representation. Since the start of the pandemic, we have received 17,624 calls from our members on issues to do with COVID.

Anonymous examples of how our members described the situation they faced are listed below.

- Member in ITU being laughed at for raising concerns that the PPE provided was not the right quality.
- Members working in procurement report being given boxes of unwrapped aprons without any information – some gowns are soiled when received due to contamination during packing and distribution.
- Member in London reported to us that correct PPE was not being provided in cases with suspected COVID-19, PPE was only to be used for positive COVID-19 patients.
- Member working in mental health said that they don't have access to masks or hand gel.
- Members report that they were told they could face disciplinary action for wearing PPE to see low risk patients.
- 'How can I expect to play roulette like this' – member in community care
- 'I feel like I have been thrown to the lions' – member in community care
- Senior staff in care homes report trying to obtain supplies of PPE but their normal suppliers increased the price and this degenerated into "a bidding war".
- Staff in care homes described using makeshift PPE such as "flying goggles and swimming masks."

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<sup>i</sup> RCN, An open letter to Mr Murray, Chief Executive of the British Safety Industry Federation, May 2020. Available here: <https://www.rcn.org.uk/about-us/our-influencing-work/open-letters/joint-letter-to-british-safety-industry-federation>

<sup>ii</sup> PHE, *Guidance: Considerations for acute PPE shortages*, May 2020. Available here: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe>

<sup>iii</sup> RCN, *An open letter to Sarah Albon, Chief Executive of the Health and Safety Executive*, March 2020. Available here: <https://www.rcn.org.uk/covid-19/rcn-open-letters>