ILG0014

Written evidence submitted by a joint response from Royal College of Nursing, Unite the Union, GMB, Royal College of Speech and Language Therapists, British Dietetic Association, College of Paramedics, British Association for Parenteral and Enteral Nutrition, Fresh Air NHS and MedSupplyDriveUK.

Introduction

As a group of professional bodies, royal colleges and experts, representing people from across the United Kingdom, we have been pushing since the early part of the pandemic for the government to update and strengthen infection control guidance. This has included repeated calls to provide higher quality Personal Protective Equipment (PPE) to frontline health and care workers to prevent airborne transmission of COVID-19.[1,2,3] So far relevant UK government departments and advisory committees have refused to update such guidance or implement better protections. The submission focuses specifically on these concerns, although there are a great many other lessons that need to be learned about the government's response to the COVID-19 pandemic.

Risk management:

Current Infection Prevention and Control (IPC) Guidance for COVID-19 is insufficient, and fails to take an appropriately precautionary approach for the protection of healthcare workers providing direct patient/person care. It suggests that its pathways are examples of how organisations may implement IPC, but states that they must be underpinned by local risk assessment. However, that is not how this guidance has been interpreted by many services, and anyway, such risk assessment is impracticable when the national guidance only offers one possible choice for PPE irrespective of outcome of assessment. The latest changes to the IPC /PHE guidance relate to risk assessment to be conducted locally with the possibility that FFP3 masks might be used if high risk is determined. But the remainder of the guidance is unchanged so any assessment based on that guidance will still favour surgical masks for non–Aerosol Generating Procedure situations. This is unacceptable.

It is also clear that risk assessment is not realistic or practical for many situations that are unpredictable and where time is a critical factor e.g., when paramedics respond to an emergency call, or when community-based NHS staff go into homes. In cases such as these, healthcare professionals cannot know how many people may be present, have COVID or suspected COVID, are vaccinated and whether they are unable to reduce risks in the care setting. This is particularly relevant now given the exponential rise in cases of the Delta variant of SARS-CoV-2. This is why we believe that national IPC policy must take a precautionary approach - where this has been applied this has highlighted positive outcomes for staff. It would also provide greater clarity to local services that they should provide higher standard PPE where the situation demands it, and where healthcare workers believe it is necessary.

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[1] https://www.rcn.org.uk/about-us/our-influencing-work/open-letters/letter-to-the-prime-minister-on-protecting-health-care-workers-190221

[2] https://www.bapen.org.uk/pdfs/covid-19/agp-alliance-letter-to-boris-johnson.pdf

[3] https://www.rcslt.org/wp-content/uploads/2021/01/FINAL-statement-by-AGP-Alliance.pdf

It is sometimes suggested that a "hierarchy of controls" should be used, with PPE regarded as a final measure, but in situations like those outlined above and indeed in any high-pressure clinical environment, a precautionary approach is best. Our members deserve the best possible protection whenever possible and whenever they feel they need it. We also reject the explanation that health and care staff are mostly contracting COVID-19 in non-clinical or non-healthcare settings – clearly the risk is highest in healthcare settings and current protection is inadequate; the rate of nosocomial infection (mentioned later) makes that clear. It is insulting to health and care professionals to seek to blame them for catching the disease and passing it on to patients.

Transparency and trust

The lack of transparency around infection control guidance decision making has been a matter of serious concern. The minutes of IPC Cell meetings and its membership are not publicly available. Many of the decisions made, such as the decision on a change in status of COVID-19 as a HCID in March 2020, are not underpinned by minutes of any committee or the evidence used in support of these pivotal decisions. There was a similar lack of transparency or engagement from other decision-making bodies, such as *the Independent High Risk AGP Panel* until long after its formation, and after its findings had been published[4]. A key cause of concern for our members is the inclusion of a 'disclaimer' in the IPC guidance, an unusual feature, which they report disempowers many employers to take into account local risks and situations their staff encounter and to implement additional precautions to manage these on an on-going basis.

There has also been a serious lack of engagement with wider stakeholders and representatives of the health and care sector. Numerous signatories to this submission have had correspondence ignored or offers to meet to provide evidence turned down.

As individual professional bodies and trade unions, we have received significant feedback from members about a lack of appropriate PPE and the stress and concern this caused. Health Care Professionals described feeling like "Lambs to the slaughter" or [5] "Cannon fodder"[6] and that they are "scared" and left feeling "let down and frustrated"[7]. There has been a fundamental loss of trust and faith in the guidance and the support being offered to health and care workers to keep them safe. It is absolutely vital that we act to reverse this. There is a serious risk that the impact of the pandemic and the enormous backlog of services that will be coming in the near future could drive many health and care professionals to quit the sector[8].

Data & evidence

There has been a failure to update Infection Control and PPE guidance in light of the ever-growing scientific evidence of airborne transmission of COVID-19, as now acknowledged by WHO[9], SAGE[10], CDC[11] and others. Indeed, recently senior political figures, including Health Select Committee Chair Jeremy Hunt[12] and former Chief Advisor to the Prime Minister Dominic Cummings[13] have highlighted

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[4] https://www.gov.uk/government/publications/independent-high-risk-agp-panel-summary-of-recommendations
[5] https://www.bda.uk.com/resource/lambs-to-slaughter-frontline-ppe-need.html
[6] https://vimeo.com/514407892
[7] https://www.bbc.co.uk/news/health-56293951
[8] https://www.nhsconfed.org/news/2021/03/real-risk-that-thousands-of-nhs-staff-will-leave-unless-they-are-allowed-to-recover
[9] https://www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-how-is-it-transmitted
[10] https://www.gov.uk/government/publications/emg-masks-for-healthcare-workers-to-mitigate-airborne-transmission-of-sars-cov-2-25-march-2021
[11] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html

the lack of action on airborne spread. This has resulted in the UK lagging behind other parts of the world and has placed both healthcare professionals and patients at greater risk and continues to do so. There has not been a shortage of offers to discuss and put forward this evidence, but as mentioned above there has not been tangible engagement with stakeholders and external expertise. We believe that the failure to change advice has led to increased infection and deaths amongst both health and care staff and the patients they care for.

Unfortunately, we don't know the full scale of the impact because of a lack of data in England on health and care worker deaths by hospital and on PPE usage. Some trusts have refused to make this public. The Health and Safety Executive[14] exempted healthcare employers from reporting COVID-19 infections and deaths of their workers where PHE IPC guidance (wearing of surgical masks) was being followed

Research by the Guardian has found that at least 77,000 hospital staff in England caught coronavirus during the pandemic, while there were nearly a quarter of a million absences for Covid-related reasons.[15] These findings are likely to be a significant underestimate as they do not include responses from nearly half of trusts.

Coordination and delivery models:

There is significant inconsistency in the provision of PPE and on IPC guidance between services and geographies. Particularly in England, this is in part because the guidance offered centrally has been interpreted differently by different services, with some choosing to go beyond the (inadequate) recommendations for PPE, while others have kept to them strictly, even preventing the use of self-purchased FFP3 masks. We would also argue that current guidance on IPC and PPE for COVID-19 are inconsistent with pre-existing guidance for other airborne diseases such as measles or TB[16] and are in conflict with HSE regulations.

There is also a distinct lack of clarity about who is responsible for determining IPC and PPE guidance. ARHAI Scotland, which is responsible for the review upon which the current IPC guidance is based, in part, have stated that the UK Health and Safety Executive have approved the PPE section within UK IPC COVID-19 guidance[17]. However, we have been informed in writing that the Chief Executive of HSE has stated that they do not lead on IPC guidance and we have seen no evidence that they have approved IPC guidance. Furthermore, longstanding HSE guidance[18] makes clear that "that surgical masks provide the lowest level of respiratory protection compared to FFP respirators" and that "Consequently they should not be used in situations where close exposure to infectious aerosols is likely." Despite this, surgical masks are recommended in current IPC guidance as the only form of protection for nearly all instances where aerosols may be present.

Supporting and protecting people:

We know that the infection and most concerningly the death rate amongst health and care professionals in the UK has been high, especially compared to equivalent nations that have managed to keep overall infection lower.

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[12] https://twitter.com/Jeremy_Hunt/status/1387312218442711041
[13] https://theconversation.com/dominic-cummings-how-the-uk-ignored-evidence-that-the-virus-is-airborne-161634
[14] https://www.hse.gov.uk/coronavirus/riddor/riddor-reporting-further-guidance.htm
[15] https://www.theguardian.com/society/2021/may/25/more-than-77000-nhs-staff-in-england-have-caught-covid-shows-research
[16] https://www.nipcm.hps.scot.nhs.uk/chapter-2-transmission-based-precautions-tbps/
[17] https://www.nss.nhs.scot/news/arhai-scotland-response-to-royal-college-of-nursing-report/
[18] https://www.hse.gov.uk/research/rrpdf/rr619.pdf

Of course, protecting health and care workers with better standard PPE would also protect the patients that they are serve. Recently published estimates of deaths from hospital acquired COVID-19, give a figure of 8,700, but this is highlight unlikely to be the full picture[19]. Health Select Committee chair Jeremy Hunt MP has indicated that his committee believe around 20-40% of people who died from COVID-19 picked up their infection in hospital[20].

Financial & Workforce pressures:

At the peak of the worse wave in December-February 2021, the NHS in England, had over 50,000 staff off work per week due to having COVID-19 or needing to self-isolate, which placed even greater strain on an already over-stretched service. We would argue this figure could have been much lower had appropriate RPE (Respiratory Protective Equipment) been provided to reduce airborne transmission. At this time given the dynamic evolution of the pandemic and variants of concern the risks to health professionals and employers as a result of sickness or long-covid should not be downplayed. An increase in absence now risks both the ability to manage a third wave of infection and management

In the early phases of the pandemic, a lack of appropriate RPE may have been understandable, given the serious lack of preparation for such a pandemic. However, as the pandemic has progressed, evidence has grown and RPE innovation and availability has improved significantly, there should not be a financial reason as to why we cannot provide the right standard of PPE to frontline workers. Indeed, with £18 billion spent on PPE (NAO, May 2021), some of it unusable, there is no need to blame finances for failure to provide better PPE.

Organisations such as MedSupplyDriveUK have undertaken fantastic work with suppliers and manufacturers to determine that affordable and sustainable (environmentally friendly) respirators, which meet required standards, could be provided[21]. They would have the added benefit of providing PPE usable by those that might fail a fit test for disposable PPE. We know from individual hospitals, trusts and services that higher standard PPE can be provided[22].

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[19] https://www.theguardian.com/world/2021/may/24/up-to-8700-patients-died-after-catching-covid-in-english-hospitals
[20] https://www.bbc.co.uk/news/uk-england-sussex-57114810
[21] https://www.bmj.com/content/372/bmj.n109/rr-0
[22] https://www.southampton.ac.uk/publicpolicy/support-for-policymakers/policy-projects/perso.page