People's Covid Inquiry February-June 2021

Witness Statement

Kirsty Brewerton

Session 5, 21 April 2021, Impact on frontline staff and key workers

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STATEMENT

I (name) Kirsty Brewerton

Job title/ role/ occupation Clinical Sister - NHS

will say as follows:

1. I make this statement for the purposes of the People's Covid Inquiry, which is to be held on 7 April.

2. I am able to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.

3. <u>What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible, attach CV to statement</u>

   I have been a qualified nurse for 7 years and have spent that time working within the NHS. April 2020, I began my role as a Clinical Sister on an Elective Orthopaedic ward, prior to that I had worked in an Emergency Department as a Staff Nurse. My choice to move on from ED was one of necessity, following 6 months off work struggling with depression which left me unable to enter the department without experiencing psychological and physical reactions. I had been studying for a master's in advanced clinical Practice prior to my mental breakdown, which I deferred, and I am unlikely to return and complete. I have spent the majority of the pandemic redeployed due to elective surgery being cancelled to cope with the pressures on the system. Whilst struggling with my mental health I found being creative aided my recovery, this prompted me to co-found a community organisation called Sitting Rooms of Culture. The group is aimed at inspiring creativity to aid psychological, social and physical wellbeing, whilst building connections and celebrating grassroots talent. This has recently formed into a Community Interest Company with me as CEO, we organise various events, projects and workshops some of which are aimed at healthcare workers.

4. What is your connection/ interest/ background/ experience relevant to the pandemic in England?

I have spent the pandemic working on the frontline alongside building Sitting Rooms of Culture. As mentioned, I expected to begin my role as a Clinical Sister on an orthopaedic ward last April, but when I arrived it was a COVID ward. We have seen the services provided by the NHS severely compromised, specialties like my own simply ceased for months at a time, the implications of this will be felt for many years to come. There is a backlog of cases for us to wade through, but it's important to remember those cases are people, and those people are suffering. I worked on over 10 different wards or departments over the past 12 months, some of them COVID wards, some general medical, all of them short staffed, under resourced and struggling to cope. We have been forced to provide a substandard level of care which not only impacts the patients and their families, but also the staff. No NHS worker went into this profession to do a poor job, we care for people, but that ability to care has been stolen. We cannot look after people to the standard we trained to – that is a devastating fact. The pandemic only exacerbated an already existing problem, we were on our knees long before COVID hit.

5. How are you able to assist the Inquiry – what is your expertise/ knowledge/ specialism?

I hope to convey the gravity of the situation we are facing within the NHS, and the frustrations we continue to swallow. For a long time we have felt powerless, we have witnessed the gradual decimation of services and the workforce, whilst our concerns have been disregarded. For years we watched reports of corridors endlessly lined with patients on trolleys, the situation worsening each winter, yet it took a global pandemic for these issues to be taken seriously. Even now the recognition of the severity and urgency of this problem seems to be a priority to everyone except the government, without serious intervention I fear for the future of the NHS. I willingly share the experience of myself, my colleagues and the patients I have cared for because I am desperate to see tangible change. Our resilience has been battered, despite the hero labels, we are not superhuman. It is not sustainable to expect staff to cover the workload that 100,000 vacancies creates, and more importantly it is unsafe. The lack of protection and resources provided for us over the past year has only further compounded the feeling we are unvalued, which is demoralising. Clapping on doorsteps feels hollow and messages of "protect the NHS" are meaningless when coming from politicians who left us begging schoolkids to make visors using their 3D printers. Furthermore the refusal to seriously address our pay by not giving the workforce the restorative raise they have asked for has had major impact on morale and will in turn affect retention. The cost of losing more experienced staff far exceeds that of a fair pay rise.

6. What in your view were the original vision and principles underpinning the NHS?

In simple terms, healthcare that is accessible and free to everyone in the UK. In a broader sense I think it was aiming to address the impact of social inequalities on health, there was and still is an unfairness in the system which predetermines life expectancy according to wealth. Unfortunately,

the pandemic has only further highlighted how there is still so much more to do in order to irradicate health inequalities within society.

We have listed a number of questions for Session 5: Impact on frontline staff and key workers.

How has the country's understanding of and respect for the role of 'key worker' changed? Has government policy reflected this?

5.1 How did pandemic policy cater for the risks and pressures of NHS staff and key workers, including BAME staff?
5.2 Were the occupational risks faced by NHS staff and key workers updated and was there an appropriate response from government?
5.3 Are risk assessments for at-risk frontline staff adequate?
5.4 To what degree has outsourcing, employment conditions and low pay had an impact on the work of key workers and the risks they face?
5.5 What short-term or long-term impact has there been on frontline staff including BAME staff?
5.6 What is the relationship between frontline staff and key workers, and socio-economic status, pay and the impact of the pandemic?
5.7 How could they be better supported in their work and better protected now and in future epidemics or pandemics?
5.8 What has there been in the way of workplace outbreaks and how have these happened?
5.9 What has been the role of the Health and Safety Executive

Please briefly outline your testimony below and attach references or articles which will provide the panel with relevant information.

In the decade since starting my Nursing degree I have witnessed the devastating effects of austerity on the NHS. My time in A&E was so difficult it was damaging, the moral injury of feeling unable to care for patients safely was too much to bear. Although a difficult time, the 6 months I had off prepared me mentally for the pandemic and is now something I am hugely grateful for. I received therapy and learnt various techniques to help me to cope with stress – something which would have been massively beneficial as part of my training. It also gave me a valuable insight into mental health and some of the signs and symptoms to watch out for, this enabled me to look out for the staff I was managing and put measures in place to support them. Mental health services for staff vary from trust to trust, there is no minimum level of support that NHS employers are required to provide, many have only invested in this area in response to the pandemic. What it demonstrates is another lack of appreciation for our workforce and the immense pressures we face, it is blindingly obvious that we are at risk mentally – but very little is done to monitor and mitigate that risk. With increased reports of PTSD and stress within the workforce there is a worry that the lasting effects will impact retention of staff.

Occupational risk has been spectacularly mismanaged, not only with the psychological damage to staff miscalculated, but frontline staff essentially used as cannon fodder. Initially access to testing was extremely limited, with a strict criterion which dictated who was eligible for a swab. For a while at the start of the pandemic that criteria included travel abroad, so they had to have recently

travelled to china in order to receive a swab. This meant there was a period where transmission was occurring between people in this country, however we were restricted from testing them. They would be treated in a bay with other patients, staff would not be wearing protective PPE and many colleagues were exposed causing them to contract the virus. There are many people I know who then went on to suffer with Long Covid – some having to leave their professions. I would be interested to know how many of these have been RIDDOR reported and investigated, there has been no guidance widely circulated for staff on how to report via RIDDOR specifically for COVID. There have been some reports of workplaces stating there is a lack of evidence that staff caught the virus at work, this is something that I feel needs further investigation.

I remember preparing myself for starting back at work following a long period off sick and reading about the lack of PPE. My mother was desperately searching on the internet to purchase ffp3 masks for me to wear at work as we knew guidance would leave me inadequately protected. I found that once on the wards I felt unable to wear this higher level of PPE when my colleagues were not, especially as a sister I felt responsible for their safety, if I couldn't source ffp3s for everyone then it felt unfair for me to wear one. This level of mask was not available for us unless undertaking aerosol generating procedures, however the list of these procedures was reviewed and many reclassified deeming them safe with a simple surgical mask. I believe guidance was hugely influenced by our ability to procure equipment, a lack of foresight, planning and investment left us vulnerable.

Guidance changed frequently and was not particularly easy to follow, often leading to confusion. I felt as a Sister responsible for the staff and patients on the ward, and at times the changes to guidance was really difficult to implement without questioning our ethics. In particular one instance where the guidance on shielded patients was revised – we were told to cohort these patients in bays together. This went against previous guidance, and basic common sense in my eyes, there was no risk assessment for me to refer to, so I felt unable to implement this and said I could not continue with my shift. The ethical implications on individuals making and implementing these decisions isn't something I feel was particularly well supported or planned for; however this did improve over time in my experience.

Risk assessments did take place, initially focussed on the shielding guidelines, however once evidence began to suggest BAME individuals were at increased risk, further risk assessments were implemented. The major concern I had was with the PPE, risk assessments mean very little when the intervention you're suggesting improving safety is inadequate. This became increasingly worrying during the last wave when we began to see different strains emerge. Despite evidence to suggest some of these variants were more transmissible and seeing these outbreaks sweep through wards affecting staff and patients- there was no change to PPE guidance nationally. At a time when we were on our knees battling the highest numbers seen, it would have been an obvious way to protect patients and staff. During the last wave we really struggled, I'm not sure how we would cope with another. The vaccination programme whilst hugely successful has taken more of our workforce away from their existing roles, leaving us desperately short staffed when infection rates were high. The worst I saw was one nurse attempting to care for 21 patients, but we also saw nationally accepted nursing ratios increase in ITU to fit demand. We cannot and should not accept this as purely a consequence of dealing with a pandemic, I truly believe if the NHS has started this fully staffed and well-resourced, we would have seen better outcomes.

I confirm that the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Kirsty Brewerton	*18/04/2021*
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SIGNED	**DATE**

Please return to inquiry@keepournhspublic.com

Thank you
Olivia O'Sullivan
Secretary to the panel
The People's Covid Inquiry

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