People's Covid Inquiry February-June 2021

Witness Statement
Professor Raymond Agius

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

It became very clear at the outset that the UK Government needed to radically reappraise the roles of key workers in society. Our inquiry asks: were the roles of key workers and the risks they faced understood; and were they supported and protected? Were employment conditions, in work poverty and 'health and safety' at work considered by government?

In order to answer these questions and to learn lessons over the course of the inquiry, the Panel will hear evidence from frontline NHS staff and, for example, staff from care services, transport and education. Session 5 provides a special focus on this. Evidence will be shared from the work of bodies including Independent SAGE, the TUC, health unions, National Education Union and a transport union – the testimony from front-line experience that was and remains essential.

STATEMENT

I (name) Raymond Agius

Job title/ role/ occupation Emeritus Professor of Occupational and Environmental Medicine

(The University of Manchester)

will say as follows:

1. I make this statement for the purposes of the People's Covid Inquiry, which is to be held on 21 April 2021.

2. I am able to attend and give evidence. If for an unforeseen reason I were to be unable to attend, I nevertheless agree to my statement being considered by the Inquiry in my absence.

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

In 2017 I retired from my substantive position as Professor of Occupational and Environmental Medicine, and Director of the Centre for Occupational and Environmental Health at the University of Manchester. I had held this position since 2001, and in parallel with this I was an Honorary Consultant in Occupational Medicine at the Manchester University NHS Trust.

I started working in the NHS as a junior doctor on qualifying in medicine in 1977, and gained Membership of the Royal Colleges of Physicians in 1979. I worked as a hospital doctor, as well as a researcher, in respiratory and internal medicine in various NHS hospitals notably the Royal Brompton in London and the Southampton University Hospitals. In 1986 I started a 4 year higher specialist training post in occupational medicine at the Institute of Occupational Medicine in Edinburgh. In 1990 I was appointed Senior Lecturer in Occupational and Environmental Health at the University of Edinburgh (as well as an honorary consultant with Lothian Health Board) where I stayed until I moved to Manchester.

I have researched extensively in occupational and environmental health/medicine/epidemiology and have published hundreds of papers as well as a text book of occupational medicine. A listing of my publications can be seen through this 'Google Scholar' link. Since 'retirement' I deliver occasional postgraduate lectures in the UK and on the European mainland, and am still engaged in some research and postgraduate supervision in occupational epidemiology.

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

I worked in the NHS during all the forty years of my salaried professional life. For more than thirty of those years I looked after the occupational health needs of health care workers (HCW), besides many other workers from time to time. This work included the assessment of risks to health from work, and giving advice on reducing such risks as well as on rehabilitation. I have undertaken wide ranging research on occupational disease, and on the risks to health from work including the anticipation and prediction of new hazards. My international work had included a 4 year leadership of a European collaboration called MODERNET (Monitoring Occupational Diseases and tracing New and Emerging Risks in a NETwork).

At the onset of the pandemic the General Medical Council restored my licence to practise as a specialist in occupational medicine (GMC Reg. No: 2401593; I had previously voluntarily relinquished this following my retirement). I then undertook a range of 'pro bono' activities relating to the pandemic. Thus, for example, as a member of the Covid-19 Control Measures Working Group of the British Occupational Hygiene Society (BOHS) (of which I am a Past President) we published its covid risk control matrix. In relation to the covid pandemic I also lectured to a range of UK and overseas audiences, as well publishing my opinions and research. These outputs are shown in the above cited link, and in the text below I have provided relevant links to publications of mine, often with other authors for whose contribution to the debate I am very grateful. Those hyperlinked articles in turn list and lead to other references containing important information.

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

As stated above: as a physician my specialist clinical expertise is in occupational medicine, including the management of risks to health from work; as a researcher I have expertise in epidemiology and other aspects of occupational and environmental health.

Although I am giving this evidence in a private capacity, for the avoidance of doubt I should state that currently:

- I hold a 'public office' in the UK as a member of the Industrial Injuries Advisory Council (IIAC) (and have been a member of other UK Government advisory bodies in the past). In March 2021, IIAC published a Position Paper on COVID-19 and Occupation.
- I am the Deputy Chair of the Occupational Medicine Committee of the British Medical Association.
- I am a member of the "Conseil Scientifique" of the "Réseau National de Vigilance et de Prévention des Pathologies Professionnelles" of the French " Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail ".

I do not have any conflicts of interest in giving evidence to the Inquiry.

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

In my view the NHS' provision of free health care for all 'from the cradle to the grave' is only a fraction of the implicit original (and hopefully enduring) vision and principles. The NHS aspires for equity and public involvement in the fostering of health and in the prevention of ill health, as well as in effective and safe health care. It should achieve international excellence in its service and in its research and training, as well as being an exemplar employer.

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

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

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

A_5.1 Thank you for the opportunity to give testimony in response to the inquiry's questions. The length and 'weight' of my responses vary. For example, in respect of this first question (regarding how the country's understanding of and respect for the role of 'key worker' has changed) I do not consider myself better qualified than other people attending the session.

As regards the first question, we argued in this BMJ opinion piece that workers in social care warranted comparable concern as NHS staff / HCW. Indeed in the context of the pandemic a key worker could range from a member of the traditional emergency services to a van driver delivering indispensable groceries or a bus driver (conveying other essential workers to their work).

A_5.2 NHS employers' published guidance on 30 April 2020 for NHS organisations to take appropriate measures to mitigate the risk of covid, including taking age, gender, underlying health conditions and ethnicity into account alongside other factors. Early in the pandemic, NHS England had recognised the evidence of disproportionate covid mortality and morbidity amongst black, asian and minority ethnic (BAME) people. However it did not adequately recognise that the principal determinants of risk (and differential in risk) arose from viral exposure, and inadequacy of protection at work rather than age and ethnicity. Neither the "Risk Reduction Framework" for NHS staff at risk of covid infection nor Public Health England (PHE) guidance took sufficient account of relevant past research and precautionary guidance in their recommendations to reduce exposure to the virus. They ignored evidence or guidance existing prior to the pandemic, such as from the Health and Safety Executive (HSE) or from previous SARS coronavirus or similar outbreaks, and which would have mandated respirators (e.g. FFP3) as Respiratory Protective Equipment (RPE) for jobs such as front line NHS and social care workers who were likely to look after infected patients. As was noted early in the pandemic public servants and scientists had the evidence based foresight in 2008 to show the suitability of FFP3 respirators and the inadequacy of 'surgical masks' to protect against viral aerosol. They even forewarned that "the widespread use of respirators might be difficult to sustain during a pandemic unless provision is made for their use in advance."

My colleagues and I opined that DHSC/PHE pandemic policy was influenced by a need to "rationalise the rationing" of such personal protection. In the context of frontline staff a prime example of this was the presumption, essentially lacking objective evidence, that the main or only risk of airborne exposure to NHS staff arose from so called 'Aerosol Generating Procedures' (AGPs) such as tracheal intubation, bronchoscopy and artificial ventilation of patients. PHE guidance (rightly) advised the wearing of fitted filtering facepiece respirators (e.g. FFP3) for such exposures. Yet then it only provided for 'surgical masks' in the routine face to face care of infected patients who were exhaling airborne virus while coughing, talking and even breathing (in spite of the pre-pandemic precautionary guidance, 'lessons' and research cited above). Hence I had little doubt at the onset of the pandemic that thousands of workers were not being adequately protected from serious risk to their health.

A_5.3 The question implies (rightly) that risk management should be constantly updated based on the search for new evidence. However it bears reiterating that, as argued above, the shortcomings are not simply those evident 'with the benefit of hindsight'. In a recent editorial we said that "The greatest concern in primary prevention of covid-19 at work has probably been the persisting underestimation of the risk of airborne spread and hence the inadequacy of precautionary protection, in spite of past lessons." As we had said in a British Medical Journal editorial, the PHE guidance was weaker than that of the European Centre for Disease Prevention and Control which, in February 2020, stated that the minimal composition of a set of personal protective equipment (PPE)

for the management of suspected or confirmed cases of covid included (as RPE) a FFP2 or FFP3 respirator (valved or non-valved version), with face masks to be used 'in case of shortage'. In fairness it has to be conceded that PHE guidance in respect of PPE was similar to that of the World Health Organisation (WHO) at the start of the pandemic, although my colleagues and I have intimated that WHO may have had to cater for resource constraints in countries less fortunate than ours. However in December 2020, WHO interim guidance had shifted to acknowledge that respirators (FFP2/3) may be used by health care workers when providing care to covid patients in settings other than so-called AGPs "if they are widely available and if costs *(sic)* is not an issue". Yet in spite of the now overwhelming evidence of airborne spread of covid, the government (through DHSC and PHE) continues to eschew better precautionary provision and did not widen the scope of PPE in the second wave even though the country now has a glut of PPE - as we said in our letter to The Lancet. However, relatively late in the pandemic, and even then to a limited degree, the HSE's "COVID-secure" campaign has started to address the need to improve ventilation in workplaces.

A_5.4 All employers have a legal responsibility to make a "suitable and sufficient" risk assessment in respect of all employees. "The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work." Few would argue that the pandemic risks were so high, and the nature of frontline work so critical that detailed and comprehensive assessments were warranted. For employers to merely say that they were 'following PHE guidance' does not constitute a risk assessment. Moreover as I have argued in response to question 5.2, PHE guidance provided inadequate protection relative to the guidance antedating the pandemic or the current medical, scientific and professional consensus. It is difficult to get a representative picture of the quality of the assessments of the risk to frontline staff in the country as a whole. Judging by their actions some Trusts are now adequately protecting their staff. However using a rhetorical question we posit that in respect of many frontline staff there are still unjustifiable shortcomings in risk assessment and in protective measures.

As we argue in the next issue of the British Medical Journal, workers (usually through their safety representatives) are legally entitled to be consulted about the risks to their health at work and the risk assessments and control measures which are consequently envisaged. This is particularly important to give a voice to, and empowerment of workers. Anecdotal information suggests that in many workplaces such consultation with workers is conspicuous by its absence.

Besides taking all reasonably practicable steps to protect all workers in a group from exposure to the coronavirus, employers have a legal obligation to consider the susceptibilities of individual employees. Most frontline staff in the health care sector and in the emergency services have access to competent occupational health services (OHS) to give individual advice. Application of risk matrices by suitably qualified OHS staff such as specialist occupational physicians should then result in recommendation of individually specific risk mitigation (such as provision of a powered respirator, or exceptionally redeployment). However the pressures on OHS during the pandemic have been unprecedented and the evidence from trade unions would be of value as regards the extent to which their members perceive themselves to be adequately covered.

A_5.5 The Trade Unionists at the session are probably better placed than me to address to what degree outsourcing, employment conditions and low pay may have had an impact on the work of key workers. However poor employment conditions and low reward are recognised stressors and demotivators. Moreover poor employment conditions which may be associated with increased exposure to the coronavirus would of course increase the health risks - but these are already addressed in response to other questions.

A_5.6 Data ('RIDDOR statistics') from the Health and Safety Executive (HSE) (and the quality of which is critiqued below) show that over the period 10 April 2020 – 13 March 2021, 31,380 occupational disease notifications of covid in workers were reported to the HSE, including 367 death notifications. Out of these, 9,947 cases (including 139 deaths) were in 'human health activities', with similar numbers in social care. As we had summarised compared to nonessential workers, HCWs have a seven-fold increase in risk of severe covid (hospitalised or died); frontline, or patient-facing, HCWs have a three-fold increase in risk of testing positive for covid compared to the general population. The long term post-acute impacts directly arising from covid infection (e.g. damage to the respiratory and cardiovascular systems) are colloquially referred to as 'long' covid. As we have noted, about 10% of people infected with covid-19 may have significant post-acute or chronic symptoms persisting beyond 12 weeks. Moreover frontline work during pandemic has had significant psychological consequences such as "burnout" and these are also subject to much study.

A_5.7 Socio-economic factors, notably deprivation, as well as ethnicity are associated both with an increased likelihood of exposure to the virus causing covid, and with the risk of death or other adverse outcome after becoming infected. This complex relationship has been recognised by the IIAC position paper on covid-19 and occupation. For example Office for National Statistics (ONS) data show that the age standardised mortality rate for deaths involving covid in the most deprived areas was more than double the rate in the least deprived areas. As stated, deprivation as well as ethnicity may also be associated with increased occupational exposure and so these factors may confound each other in epidemiology. As I presume that trade union panellists would attest, workers on low pay or in precarious employment would have found the pandemic more difficult for instance if required to self isolate.

A_5.8 In a recent editorial (already referred to) we consider "Covid-19 and workers' protection: lessons to learn, and lessons overlooked." Besides primary prevention, which has already been discussed, workers require support in rehabilitation from "long covid" , and several services and clinics have already been established although the provision is still in evolution. Moreover, as already stated, frontline staff in particular need support for the psychological consequences (e.g. burnout and post traumatic stress) of contending with the covid burden.

A_5.9 Employers are under a statutory obligation to report cases of covid-19 in workers for whom a 'reasonable judgement' can be made 'on the balance of probability' that they contracted the disease from work. The legal provision for this arises from the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The report is made to the enforcing authority, usually the Health and Safety Executive (HSE), which then collates (and should investigate) these reports which have been used to help answer question 5.6. However, as we have argued in an Editorial in the British Medical Journal the HSE guidance is flawed, and significant numbers of cases are not reported and so opportunities to investigate and learn lessons have been missed.

The HSE has more experience and expertise relevant to the investigation of covid at work than other bodies (specifically the coronial service) - as I showed in an Occupational Medicine paper. The HSE only received a yearly average of the 100 reports of disease caused by biological agents prior to the pandemic (but as per its criteria, HSE investigated all of them). Following a Freedom of Information request HSE disclosed that as of the week ending 12th March 2021, 466 HSE investigation cases had been raised following covid RIDDOR reports (183 of which relate to fatal

reports). Out of the 466 investigation cases (which may have dealt with more than one report), 303 investigations were conducted remotely and 14 involved a site visit while 149 investigations are ongoing. One case has resulted in an Improvement Notice, 3 in written correspondence and 9 in verbal advice. Therefore the HSE has investigated only a small fraction of the covid RIDDOR reports. In my opinion this, on top of the already limited HSE reporting guidance, constitutes a very serious failing in investigating covid contracted from work, and has missed opportunities to learn lessons and save lives (especially in the second wave).

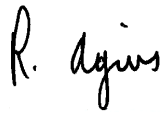
PHE has also collected data on hundreds of workplace outbreaks. However it is not clear whether the PHE has pursued these to the extent necessary to learn lessons about specific measures to prevent further outbreaks for example through work practice, engineering controls (notably ventilation) or RPE.

A_5.10 In the first instance the Health and Safety Executive (HSE) had a role in preparing for a pandemic. In my opinion the HSE scientists and public servants fulfilled this role in advance of the pandemic very well (I have already intimated this in my response to question 5.2 in respect of their prior guidance and research). It is to their credit that they achieved what they did in spite of governmental disinvestment in institutional resilience, such as a halving of HSE's budget over a decade. Sadly, as I argued in the first editorial I wrote in the pandemic, it would not have provided the HSE with much encouragement when the Secretary of State for Health & Social Care dismissed the need for investigation by HSE of cases of covid in health care workers presumed to have been contracted at work (in spite of this being legally mandated). During the pandemic the HSE has not asserted the relevance of their prior research findings and their precautionary guidance for worker protection against biological agents, but simply endorsed 'PHE guidance'. Moreover as stated in my reply to the previous question, the response by the HSE in investigating occupational covid has been lacking, and as I said in another editorial, published data have been missed in the first month of the pandemic. However in that editorial I also opined that the additional funding allocated to the HSE to meet the pandemic challenge "bears no relation to the scale of the task in hand".

On the 11th February 2021 the Scientific Advisory Group for Emergencies (SAGE) reported that since June 2020, HSE had conducted spot check exercises via telephone interviews with 92,000 businesses and in 93% obtained satisfactory assurance, with only 193 eventually needing formal Enforcement Notices. When I reviewed information from the HSE website on a sample of 100 Enforcement Notices, most concerned cleaning, handwashing, sanitation, and 'social distancing' and only one related to RPE.

The HSE is conducting or has commissioned important and relevant research (e.g. regarding occupational transmission of covid and its control) out of its relatively modest budget. However, as stated earlier in this testimony, the HSE has not adequately asserted precautionary measures based on its past research and guidance, and has only investigated a miniscule fraction of the cases reported to it by law.

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



19 April 2021

SIGNED Raymond Agius MD, DM, FRCP, FRCPE, FFOM **DATE**

Please return to inquiry@keepournhspublic.com

Thank you
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Secretary to the panel
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