IN THE MATTER OF

MODULE 6 OF THE UK COVID-19 PUBLIC INQUIRY

ROYAL COLLEGE OF NURSING OPENING SUBMISSIONS

1. The Royal College of Nursing ("RCN") extends its thanks for the opportunity to participate in and contribute to the UK Covid-19 Public Inquiry ("the Inquiry") in respect of the Module 6 hearings which will consider the impact of the Covid-19 pandemic on the Care Sector in England, Wales, Scotland and Northern Ireland.

2. As the Inquiry will be aware, the RCN is the representative voice of nursing across the four nations of the UK and is the largest professional union of nursing staff in the world. It is a registered trade union with over half a million registered nurses, student nurses, midwives, nursing support workers and healthcare associates. Members work across NHS hospitals and specialist health facilities, in care and nursing homes, the community and independent healthcare sector, amongst other settings. For the avoidance of doubt, our below submissions will focus on RCN members working within the Care Sector. The RCN notes from the Provisional Outline of Scope that the Inquiry recognizes that the focus of this Module is not to be limited to 'care homes' as commonly understood, but is to include adult care and residential homes and care provided in people's own homes. The RCN's members work across the entire breadth of such provision, including providing care to members of the population on a daily basis in patient's own homes.

3. The RCN continues to offer its condolences and its heartfelt thoughts to everyone who has lost loved ones during the pandemic. It will never forget the sacrifice of healthcare professionals, including those who passed away as a result of the pandemic and those who continue to feel the impact on their health as a consequence of Covid-19 including Long Covid. The RCN is committed to continuing to advocate for and support those of its members that were impacted by the pandemic.

4. This submission sets out some of the RCN's key concerns in respect of the impact of the pandemic on the Care Sector in the four nations.

Overview of RCN Membership and Roles in the Adult Social Care Sector during Covid-19

5. As of 01 March 2020, more than 30,000 RCN members worked in the Care Sector. This included nurses, nursing support workers and students working in care homes and home services. The majority of our members working in care homes and home services were employed in England (78.86%), with 10.19% employed in Scotland and 5.51% employed in each of Northern Ireland and Wales. Of the members that we hold ethnicity data for, 14.42% identified as Asian, 12.77% identified as Black and 58.09% identified as White. Members working in care homes and home services encompass a wide range of age groups from those <20 years old (3 members) to those more than 65 years old (2102 members, 6.96 %). The age groups most represented in our membership data for these settings as of 01 March 2020 were aged 55-59 (14.52%), 50-54 (14.28%) and 45-49 (13.45%) respectively.

6. The Covid-19 pandemic highlighted the critical role that nursing plays in protecting, improving and sustaining health and wellbeing. This includes working in care homes, the homes of those receiving care, and throughout communities, providing safe and effective health and care services as well as addressing the wider determinants of health.

7. As the above demonstrates there were significant numbers of RCN members working within the Care Sector, many very experienced practitioners in their 50's and many from minority ethnic backgrounds. The Inquiry will by now be very familiar with the challenges and risks to their own health faced by staff working within NHS hospital environments. If anything, those working in the less well-resourced care sector, sitting outside the reach of NHS Trust management, facilities and equipment, faced even greater challenges.

Summary of the RCN's work in relation to the Care Sector

8. The RCN is a recognised expert in its field and has contributed to numerous consultations and published open letters and position statements throughout the pandemic to escalate urgent issues affecting those nursing in the Care Sector up the government's agenda, including: testing for care home staff; discharge of patients from hospitals to care homes; enabling visiting in care homes; pay for social care workers when unable to work because of Covid-19; and eligibility of workers from the Care Sector for furlough support while shielding. The RCN highlighted the need for

clarification of infection prevention and control ("IPC") guidance to take account of healthcare workers in community settings, including the Care Sector, called for the use of individual dynamic risk assessments to enable visiting in care homes and campaigned against "locked in staffing arrangements" for care home staff.

9. Some examples of the RCN's work in relation to the Care Sector during the relevant period included: providing clinical advice and guidance, influencing and campaigning, responding to consultation documents in relation to the UK Government and Governments of the devolved nations, engaging with relevant clinical and government advisory groups and undertaking member engagement including member surveys and research. Further details are set out in the statement of Claire Sutton, Head of Independent Health and Social Care ("IHSC") Sector at the RCN.

10. Given the breadth of the experience of its members and the expertise within the RCN itself it hopes that, looking to the future, it will have a central role to play in the planning and preparations that need to be made to ensure, so far as it is possible to do so, the health and wellbeing of the recipients of care and all those who work within the health sector, including all those in the Care Sector both in respect of potential future pandemics as well as on a business as usual basis.

Workforce capacity in the Care Sector

11. Years of under-investment in community care and care home sectors meant social care was left exposed when the pandemic hit.

12. For too long, local authority commissioned care has not been treated as an equal partner to the NHS. Planning and budgeting decisions for health and social care services across the NHS and local authorities have not been made in an integrated and cohesive way, based on an understanding of population demand and modelling of the resources, including the workforce required to meet that demand.

13. Social care is an incredibly important yet often overlooked pillar of public service. Social care services have experienced years of underfunding, despite needs increasing within the population. This has led to widespread unmet needs and a high level of complex care being delivered by services. As is well known, demand for social care will continue

to grow. By 2035 (only 10 years from now) the Care Sector may require an extra 490,000 jobs in England alone.

14. Overall funding for social care must be sufficient to provide fair pay, terms and conditions for all nursing staff. This is key to improving recruitment and retention of nursing staff in social care settings. Investment levels must also fund staffing for safe and effective care in all social care settings. In 2021, registered nurses working in social care had the highest turnover rates of any job role in social care at 38.2%, which is much higher than counterparts working in the NHS who had a turnover rate of 8.8% as at March 2021.

15. The nursing workforce is at the heart of health care in all settings. Nursing is uniquely positioned, as a profession, to support the public, drive prevention and play a part throughout an individual's entire care journey - from diagnosis, in crisis, and in ongoing treatment and management of a health condition enabling individuals to lead independent lives, right the way through to end-of life care. When the nursing profession is under resourced, and under intolerable pressure, there isn't a single part of any health and social care system that isn't affected.

16. Any unfilled nursing post in the UK, in any setting, compromises the quality of care received by patients and clients, and compromises their safety. There is a clear body of evidence to this effect, for example, *Hogne Sandvik and Steinar Hunskaar,* Staff retention and mortality, BMJ 2024;387 that shows a direct link between nursing staffing levels and poor patient safety outcomes.

17. The RCN has consistently highlighted over a number of years the absence of effective workforce planning for nursing. The impact of this manifested in high levels of vacant posts, escalating expenditure on agency staff, and an inability to advance the strategic transformation of health and social care services because of shortages within the community care nursing workforce, upon which the refocusing of services is largely dependent.

18. Chronic staff shortages have impacted the system’s ability to cope both with the pandemic as well as ongoing service demands. Prior to the onset of the pandemic there were an estimated 122,000 vacancies across the entire adult social care workforce. The majority of the vacancies (77,000) were for care worker jobs. Policy makers in UK

Government hid behind a narrative that the pandemic was to blame for the ongoing collapse of the health and social care sector, refusing to acknowledge the extent of the existing workforce shortage prior to entering the pandemic. This failure in accountability and transparency further damaged an already depleted system and workforce, the effects of which cannot be remedied quickly enough.

19. Our members told us repeatedly through the pandemic that staffing levels in the Care Sector were challenging and, in many instances, unsafe. During the pandemic, staff shortages were exacerbated by sickness and nurses having to shield, putting further pressure on an already stretched workforce and leading to stress, burnout and moral distress for those who had to fill the gaps. It was not unusual for nurses to find themselves being the sole nurse on duty with responsibility for the provision of care to all the patients within their care home. The Inquiry are due to hear evidence from Reverend Charlotte Hudd whose statement to the Inquiry paints a vivid picture of the difficult circumstances our members faced. Given the increased acuity of patients and the need to don and doff PPE when caring for Covid-19 positive patients, nurses working in adult social care were placed in an invidious position, having to make decisions about who they would prioritise giving care to. RCN members continue to report feeling overstretched and undervalued today.

20. More than half of social care is funded by the public purse and with funding pressures on commissioners, significant cost pressures are subsequently placed on employers. The nursing workforce is then viewed as a cost burden rather than a workforce to be invested in to promote the effective reward and recognition for the skills and accountability of nursing as a safety critical profession.

21. The failure of the UK Government to tackle the issues facing the nursing workforce, including in recruitment, retention and burnout remains a serious risk to the country's ability to robustly tackle future pandemics. Currently, in England, there is not yet a credible system for understanding workforce shortages and responding to increasing demand in both population and service. Persistent, systemic workforce issues put nursing staff and patients at risk – this was even more evident during the Covid-19 pandemic.

22. The RCN is calling for a strong legislative underpinning of Government accountability for workforce planning and supply across health and social care. In England and

Northern Ireland, there is no law related to nurse staffing (unlike the Nurse Staffing (Wales) Act 2016, and the Health and Care (Staffing) (Scotland) Act 2019). The RCN is calling for legislation in each UK country to guarantee nurse staffing levels across all sectors and settings.

Impact on nurses, end of life care and Long Covid

23. Since nursing staff played a central role in the provision of healthcare services in the Care Sector during the pandemic, it is essential to place consideration of the impact on them at the heart of this module. The RCN's members were impacted in terms of the work they had to do, day in and day out, what support was available to them in order to facilitate that work and the toll that work took on their physical and mental health. Many nurses continued their professional commitment to those that they cared for despite the risks to them, including those who were pregnant or clinically vulnerable. The impact on nursing staff included suffering from Covid-19 themselves, often on multiple occasions. Many continue to suffer from Long Covid.

24. Throughout the pandemic, the RCN engaged with its members through existing interactive support services via a call centre and online platform known as RCN Direct ("RCND"). The RCN received approximately 28,604 contacts from members on Covid-19 related issues during the period March 2020 to the end of June 2022. From these member contacts, much of the impact felt by RCN members was documented contemporaneously. Nurses and healthcare workers in all settings reported amongst other things that they were:

    a. Attending work despite not feeling well enough to perform their duties.
    b. Being asked to work in conditions they considered to be unsafe.
    c. Isolating themselves from their families in order to protect them.
    d. Not having adequate access to PPE.
    e. Feeling anxious, depressed and stressed.
    f. Experiencing symptoms indicative of probably PTSD.

25. Nursing staff from ethnic minority groups, as in the general population, suffered poor outcomes of Covid-19 infection, exacerbated by existing structural inequalities and institutional bias within the healthcare system.

26. Evidence shared with the Inquiry by the RCN from its members in the Care Sector highlights the feelings of fear, panic and dread and their sense of vulnerability, as well as the emotional and physical toll of dealing with death, pain and suffering daily at levels they had never experienced before. Examples of concerns raised by RCN members included:

    a. *"We have dealt with changes in routine, guidance, the struggles with staff morale, keeping our patients safe etc, but now we are having to deal with Next of Kin demanding weekly visits that we can't facilitate safely at the numbers required while still maintaining stringent infection control, I'm trying to juggle too many demands and the fear of Covid getting in because of a wrong decision or a failure in our procedures ..... or simply the increase in footfall"*

    b. *The sense of the unknown, with case numbers increasing so too does anxiety levels. No clear Governmental advice."*

    c. *"Working in a nursing home during the past week, I have experienced great team spirit among those I have worked with but in addition to this there has been many emotions displayed. Staff are fearful for the residents, there is not Covid-19 in the home at present but what if it gets into the home, the main concern is protecting the residents but also themselves and their colleagues…The most challenging bit is communicating with relatives as when there is a shortage of staff due to people being off then the priority is the delivery of care and sometimes there is little time to contact the relatives which then leaves a guilty feeling."*

    d. *"Feel under pressure so much paperwork to complete. Constant changing guidelines to ensure residents and staff are kept safe. Clear communication. Staff under extreme pressure."*

    e. *"…A few days later we began to notice a cough develop. Immediately the management had the resident swab tested and had our fears confirmed that it was a positive COVID case. Immediately all contingency plans were put in place but unfortunately the virus had spread to a further 7 patients. As this is a large nursing home of 83 residents and over 100 employees the decision was made to swab test all residents and staff in which I assisted the management team in doing so. Thankfully all tests came back with negative*

results. Unfortunately, over the course of time 10 residents had passed away within the home, some coronavirus related some not. These patients had to pass away without their loved ones by their side and we as a team had to become their families and be with them during their final hours..."

27. Social care staff shared their experience of working during the pandemic with the RCN and a common theme evident within their responses was their fearfulness for the patients and relatives of patients at end-of-life care. Many of the member's stories indicated that it became their role to provide critical emotional and social support to patients due to their relatives not being present. There are stories about staff stepping in for families at the end of life and how they maintained dignity at the end of life. Below are a sample of stories which relate to this theme:

    a. *"What I as a nurse struggled with most was when we had people approaching the end of their life, we were the only source of comfort and support they had in between attending to our other residents. We were the only ones allowed to be there to hold their hands, to tell them it was going to be okay and we also had the duty to convey information to family members who were left helpless at home, standing at their loved ones windows in all weathers, not being able to say a proper goodbye to tell them they loved them and hug them one last time."*

    b. *"Having to cope with supporting staff, families and deaths of numerous patients. Verifying numerous deaths over a two-week period and seeing coffins in double figures in total. Flashbacks, battlefield and having to break news to all these families. Listening to the heartbreaking voices saying their last goodbyes including grandchildren, husbands, wives, brothers, sisters, aunts, uncles and the list goes on saying goodbye to their loved ones. Tears trickling down my face but trying to be strong for the staff and their families."*

28. It is well known that nursing staff across the UK carried the heavy burden of the Covid-19 pandemic. The RCN Research Society's survey into the impact of Covid-19 on the nursing and midwifery workforce was conducted between April and August 2020 and found that Covid-19 was causing a significant detrimental impact on the mental health and wellbeing of the workforce. The results were drawn from a large cross-section of the nursing and midwifery workforce rather than any area.

29. Alarmingly, this survey found that nearly 30% of survey respondents reported experiences indicative of a probable PTSD diagnosis three months after the peak of the first wave. The survey also demonstrated that particular factors such as redeployment to new areas without adequate training and inadequate infection control training were associated with adverse psychological effects.

30. In an effort to combat the impact of the pandemic on the mental health of health and care workers the RCN also developed a Healthy Workplace Toolkit, containing pandemic-specific guidance in relation to workplace health, safety and wellbeing. The toolkit was published online and made available to members in June 2021 including those working in adult social care.

31. Members contacted and continue to contact RCND in large numbers with queries about Long Covid. Although exact figures are not known, the prevalence of Long Covid amongst staff working in healthcare care is significantly higher than in the wider population. The Office for National Statistics reported that deaths involving Covid-19 among adult social care workers were higher than the rates of death involving Covid-19 among those of the same age and sex in England Wales. This rate was also higher than the death rate for health care workers.

32. Many RCN members who contracted Long Covid via exposure to Covid-19 at work have either already lost, or are now at risk of losing, their employment due to ongoing health issues and the lack of workplace support to enable them to remain in employment. Further, the impacts of the pandemic have been unequal across the population, exposing long-standing structural inequalities that have impacted RCN members.

33. Support for these staff members needs to continue and the impact of Long Covid, in terms of increased long-term absence, needs to be factored into workforce planning for those working in the Care Sector.

34. Although keen to get back to work, many RCN members have found workplace support lacking and reasonable adjustments difficult to secure. Many have therefore faced reduced pay, and some have lost their jobs. These issues cause further distress for those who are already debilitated by the condition.

35. To date, despite most European countries and many countries globally classifying Covid-19 as an occupational disease, the UK Government is yet to follow suit.

The decision to discharge residents from hospital to care homes without testing

36. RCN members had concerns about the arbitrary discharging, or prevention of discharge of patients from hospitals into care homes and particularly for people returning to their own homes. This was driven by Government policy. The RCN is of the view that the pandemic has emphasised the need to ensure the community care and care home sectors are properly represented in planning to scale up the nursing workforce for future pandemics to ensure a whole system approach. Historically there has been an artificial and unhelpful divide between social care and the NHS, with unequal access to resources, guidance and workforce. This had led to an unfair perception that adult social care is secondary to acute hospital care. This perception appeared to continue throughout the pandemic, with care homes feeling under pressure to take untested discharged patients to prevent the NHS from being overwhelmed but which, ultimately may have resulted in higher levels of deaths in care homes.

37. In the wake of cuts affecting resources, privatisation, outsourcing and central control the Covid-19 pandemic hit. Care homes, with or without nursing, are now largely outside the reach of NHS management and its economic structures. They became a place where patients came from, or to where they were discharged. When the reduced capacity of hospitals was threatened by Covid-19, hospitals were under pressure to address the lack of capacity by prematurely discharging patients to care homes, some as returners and some in new and hurried arrangements. '*Protect the NHS'* became a Government mantra, later becoming '*Save Lives'*.

38. It is accepted that the acute hospital environment is not beneficial for people to remain in longer than clinically necessary. There is an increased risk of infection and a growth of mental dependency. Physical abilities decline rapidly which result in an increased likelihood of falls and further injury. The discharge of a patient into a care home is, however, an extremely complex process. The care home must assess the individual's needs, ensure the home can meet the needs of the individual through physical and staffing resources, and discuss arrangements with family members and health professionals. Furthermore, discharge needs to occur on an appropriate day and if an individual needs to be transported to the home in an ambulance that needs to be

arranged as well. Often the discharge of a patient involves multiple professions. Therefore, communication needs to be consistent and free flowing throughout secondary, primary and social care. The requirement to discharge patients within short timeframes meant that this planning was difficult to effectively achieve.

39. The premature discharge of patients without appropriate planning including the lack of testing led to many patients with Covid-19 being discharged to unsuspecting and ill-prepared care homes, including those with a lack of facilities for the safe isolation of residents. The very people who would be most at risk and in need of acute and intensive care were being rapidly sent to much less well-equipped environments.

40. At the same time, the UK Government was providing data on cases and deaths due to the virus. However, for the first couple of months, such data was confined to those patients in a hospital setting, despite a very significant number of virus-related deaths taking place in care homes or in their own homes with hastily arranged care packages.

41. Care homes did their best to accommodate these unprecedented demands of the NHS. Some were in a better position to respond than others. But in most care homes space is at a premium, staffing levels are at, or below, a safe minimum and many depend on bank or expensive agency staff to supply peripatetic nurses and others. Where they had no nurses, demands on community care nursing services grew as homes began to discover some of their residents were developing symptoms of Covid-19. As these residents were often already frail, recovering from other illnesses and adjusting to life back in care homes, they were most at risk of dying.

42. Despite pleas for help with PPE and other resources to prepare care homes to manage rising rates of Covid-19 infections, the response was slow or non-existent. Policy on what preparations to make came from a central government, advised by SAGE, without regard for regional and more local circumstances.

<u>Availability of testing for recipients of care and nurses</u>

43. Linked to the above were concerns about the availability of testing. The RCN conducted a survey of members across the UK and all health and care settings between Friday 24 April and Tuesday 28 April 2020. The survey was completed by 22,043 respondents, of which 2,632 (12%) worked in the social care sector. This survey found that only 24% of

workers in the social care sector had been offered testing. Furthermore, of those who had been offered testing, a small but significant 9% of those working in the NHS and 16% of those in social care (almost double the number of their NHS colleagues) were unable to access the test. The most common reasons given for being unable to access a test included being unable to travel to the testing site, particularly for those without a car, as well as some being too unwell to travel or having no available time slots. The results reveal a disparity between the Care Sector and those working in the NHS, with 91% of those working in the NHS able to access testing when offered compared to the 84% in social care.

44. While access to testing was very limited across all sectors at this early stage, the increased proportion of those in the social care sector unable to access testing indicated that they faced additional issues that would need to be addressed.

45. In September 2020, the RCN was still receiving reports of significant problems in the availability of testing kits, with many employers not supporting members to access routine testing in care homes and some employers were struggling to resume routine testing. The RCN also received reports of difficulties accessing testing for members working outside of care home settings (such as domiciliary care), with members reporting having to travel for hours on days off or even take leave in order to access testing which was being mandated by their employer. There were also concerns over delays in receiving results from labs, with delays of 6-14 days becoming common.

Visiting restrictions

46. The RCN was concerned that the interpretation and implementation of guidance for care homes was not sufficiently monitored and resulted in significant variation. An example was visiting access, including for patients at or nearing the end of life. 'Lockdown' in care homes was poorly guided - a care home is someone's own home and should be considered in the same way to make sure that residents' ECHR rights are respected and upheld accordingly.

47. We published frequently asked questions for care home visiting which included consideration of the human rights of the care home resident and the need for a dynamic ongoing assessment of the risks of visiting which required the input of managers, residents and families, multi-disciplinary colleagues, nursing support workers and local

public health staff. We reiterated how risk assessments must also take into account national and local guidance.

48. We also published a position statement on 11 March 2021 which provided further background to the issue including the benefits of a partnership of care with friends and relatives and acknowledged the distress experienced by residents, who are frequently at the end of their lives, when face to face visiting is absent. The RCN's position emphasised a rights-based approach: there is a balance to be struck between the right to live your private life and develop relationships and the public health concerns. Most importantly, this balance is dynamic and will change based on the particular needs of residents, visitors and staff as well as the particular risks in a changing environment. The RCN called for employers to have policies in place to help nursing staff undertake these complex risk assessments as well as sufficient resources to allow measures identified in risk assessments to be put in place, including staffing and IPC resources.

49. Social care staff also had to deal with the demands from next of kin regarding visiting, which was not always possible, given low staffing levels and stringent IPC guidelines. Social care staff also reported that managing the changes to visiting restrictions added to an already high workload and led to fears of wrongly implementing guidance. Concerns were also raised about the possible impact of an increasing footfall on infection rates as visiting restrictions eased. Whilst the overwhelming majority of relatives and friends who wished to visit their loved ones were completely understanding of the extraordinary difficult circumstances around facilitating visits, some health and care workers reported feeling traumatised by forceful relatives on occasion.

50. After the first lockdown in March 2020, visiting restrictions in care homes began to ease and outside visits were introduced during the summer of 2020. The expectations of family members, however, had to be carefully managed. In some cases, this meant that visiting was initially limited to once a fortnight, which, understandably was difficult for relatives, who had not seen their loved ones for several months. The introduction of lateral flow tests for visitors by DHSC on 2 December 2020 and the anticipated approval of Covid-19 vaccines at the end of 2020, however, brought fresh hope that care homes would be able to introduce face to face visiting shortly.

Locked in staffing arrangements

51. The RCN became aware in the first wave of the pandemic that staff in care homes were being requested or in some cases coerced to comply with 'locked in' staffing arrangements to enhance the shielding of residents. These 'locked in' arrangements were over several days/weeks with staff having to share communal mixed gender sleeping arrangements very often in the resident areas of the care home.

52. The RCN strongly opposed the use of these arrangements as they implied blame on the staff for spreading the virus, increased staff exposure to Covid-19, and damaged the physical and mental wellbeing of staff as it did not allow them time to rest, relax, and spend time with family. Care homes also employ a high proportion of staff from ethnic minority groups who we were aware already faced increased risk from Covid-19, which these arrangements would exacerbate.

53. Care home staffing was already in crisis before the pandemic and these 'locked-in' arrangements further contributed to staff being deprived of breaks and expected to work hours exceeding those prescribed by the Working Time Regulations 1998.

54. The RCN's position was that greater emphasis should instead be placed on infection control guidance, adequate provision of appropriate PPE, testing, and sufficient staffing provision, as this would provide better protection for staff, residents, and visitors. This being yet another example of the lack of parity of treatment between RCN members working in NHS hospitals and those who chose to work in the adult social care sector.

PPE

55. Despite being most at risk from Covid-19, the lack of regard for older people's rights and specifically the rights of care home residents in the development and implementation of guidance are concerning. Lack of access to appropriate PPE, testing and guidance for care home staff exposed health and social care staff and those they care for, to unnecessary risk. It is important to note that many people within these settings will be older, and as such must not be discriminated against for equal access to protection based upon their age or disability.

56. The Inquiry will hear evidence from Revered Charlotte Hudd, a former Queen's Nurse who worked in the Care Sector during the pandemic. She recalls having to seal her only

surgical face mask in a small freezer bag when she stopped for lunch and put it back on after eating as the care home she was working in did not have enough stock to enable her to replace it with a clean, fresh mask. She also recalls how:

"*As time wore on, when external professionals visited the home, I was struck by the difference in the PPE they were wearing compared with what we had. Funeral directors would come to the door in their suit and tails and then would change into hazmat suits before entering. I was greeting them in a gown and a paper face mask. I suddenly felt vulnerable, and I realized they were being protected from me."*

57. It is the view of the RCN that a lack of clarity on the use of the term PPE, combined with a culture of assumptions that historical influenza guidance was adequate, placed health and social care workers at unacceptable risk in the workplace. Challenges around distribution and the inequality in supplies/distributions for social care and other non-NHS services were among the main issues. Due to those challenges, there were reports that RCN members had been required to reuse equipment, to use equipment previously marked as out of date, to refrain from wearing FFP3 masks and in the direst of circumstances, to fashion gowns out of old bedsheets in an attempt to protect themselves from Covid-19.

58. The RCN regularly expressed its concerns in correspondence to the UK Government and HSE regarding difficulties its members had in accessing supplies of PPE. Care homes were particularly impacted by a lack of PPE. Care homes are generally privately run. Consequently, they were initially responsible for purchasing their own PPE. Alongside the disruptions to the global supply and distribution chains, in the early stages of the pandemic, many care homes found that their usual supplier/s did not have sufficient stocks to supply them. They were also competing with better funded hospitals for PPE supplies.

<u>Infection, Prevention and Control ("IPC")</u>

59. Many RCN members worked in close proximity to patients who had or were suspected of having Covid-19, often in enclosed spaces with poor ventilation. This occurred in both hospital and non-hospital settings, including care homes and patient's own homes. Some members were recognised as being at an increased risk of contracting or developing more severe complications from exposure to Covid-19. The RCN expected

all employers to follow their legal duties under Health and Safety legislation in ensuring the health, safety and welfare of all their employees when they are at work including the carrying out of suitable and sufficient risk assessments, identifying who can be harmed and how, by a person with the competency to do so. However, RCN members raised concerns that risk assessments were not being undertaken.

60. The IPC guidance issued during the pandemic did not seem reflect the reality of health and social care worker's experience in the Care Sector nor their client's needs. There seemed to be a flawed understanding of how individuals who present with challenging behaviour could be safely managed in order to limit the risk of exposure of our members to Covid-19. Sometimes, those who are receiving care can display behaviour which is unpredictable by reason of their health condition. Some residents would seek closeness as a means of comfort, safety and reassurance. Sometimes closeness would also be necessary if health and social care workers were required to use a physically supportive intervention to de-escalate challenging behaviour. Sometimes residents experience excessive salivation due to their condition or the medication they are using so being physically close carried heightened risks of potential Covid-19 transmission. Physical contact is human; it provides adults with the feeling of support, guidance, reassurance and can enhance communication especially for those who struggle to understand verbal commands. Yet the IPC guidance often failed to take these practical considerations into account, leaving it difficult to implement and health and social care workers exposed to risk.

61. As a profession, health and social care workers deliver the vast majority of physical and psychological care to patients in all care settings. They have led the way in reducing the transmission of infection by prioritizing IPC measures in their clinical practice. These measures are fundamental to our profession which is uniquely placed to understand the importance of IPC methods to reduce the spread of infection and in so doing, to protect patients from avoidable harm. It is extremely disappointing that the voice of nursing was absent from discussions regarding the creation of IPC guidance for the Care Sector. Nurses need to be engaged and around the table to help shape and influence policy and communications that affect their patients and the communities they care for.

Vaccination as a condition of deployment

62. Like the wider population, health and social care staff are a diverse group and there are both physical and societal barriers for some on the take up for the vaccine. The RCN did not support staff being forced or coerced into having the vaccine, vaccination being used as part of staff contracts, a condition of employment or any part of employment contracts, linked to terms and conditions of employment or to pay.

63. A significant number of calls RCND received from members during the relevant period related to those who were concerned about the mandate, including those in the Care Sector where the mandate was initially imposed before being revoked by the Government. We heard from large numbers of members, particularly those working in care homes who were fearful for their jobs or that choosing not to be vaccinated would negatively affect their employment. For some, vaccination became a condition of their employment, meaning those who refused faced dismissal. For nurses on sponsored visas, this could lead to them losing their right to remain in the UK if they lost their employment. Other members were concerned that this may affect their entitlement to maternity benefits or their pension, or the Government Life Assurance program for nurses who die in service.

64. Some members were required to pay back sick pay or only receive statutory sick pay if they contracted Covid-19 while unvaccinated. Some even reported receiving no pay at all. Others were told that they would not be receiving any pay rises, bonuses, or promotions if they refused the vaccine. Agency workers, including those working in the Care Sector were particularly vulnerable to this. We received reports of agency workers no longer being booked for shifts and even having shifts cancelled as a result of their refusal to be vaccinated. This difficult issue is a further example of the challenges those much-needed staff in the social care sector faced and the disparity in treatment of those in this sector compared with their NHS colleagues.

Public Health England's "Guidance for social or community care and residential settings on Covid-19' published on 25 February 2020

65. The RCN has been asked about Public Health England's ("PHE") '*Guidance for social or community care and residential settings on COVID-19'*, published on 25 February 2020. The RCN's view was that this guidance did not seem to reflect a scenario

whereby the spread of infection in the community would occur, nor did it reference further guidance on escalation. The guidance stated: "*This guidance is intended for the current position in the UK where there is currently no transmission of COVID-19 in the community. It is therefore very unlikely that anyone receiving care in a care home or the community will become infected"*. This guidance was focused on hospital settings and seemed to seriously underestimate the potential for the virus to spread within the community including health and care facilities, which was surprising given the spread of Covid-19 in Europe at this point in time.

66. It may be that early Guidance such as this, coupled with the early mantra of 'Protect the NHS' did not fully reflect the potential impact of the virus in the community and in the adult care sector where so many of the most elderly and vulnerable patients were cared for.

Conclusion

67. In the context of the pandemic, the RCN's key focus was the protection of health and social care workers and patients from infection acquired as a result of work or receiving care. The protection of health and social care workers is critical not only to protect them from occupationally acquired disease, but also to ensure that staffing levels are maximised to avoid harm to patients through an under-resourced service. The Covid-19 pandemic taught us that the experiences of those working in the Care Sector were often not considered or dangerously overlooked. There were inadequate opportunities for those representing health and social care staff to feed into the development and delivery of guidance, particularly IPC guidance, despite learning from previous incidents of the need for this. Such a lack of opportunities resulted in guidance that was not fit for purpose and which did not address issues that clinicians and health and social care workers were facing on the ground. In turn, this had a detrimental and sometimes fatal impact on those who were on the frontline of care.

68. The RCN believes that the greatest lesson to be learned from the Covid-19 pandemic is to ensure that there is a suitably resourced, educated and trained healthcare workforce in place that can respond to the next challenge at speed. Staffing levels need to be based on workforce projections that reflect actual population need with safety-critical nurse-to-patient ratios enshrined in law. Without an adequate number of medical, clinical and health and social care workers, with the right mixture of skills and who are

able to deliver the appropriate standard of care to meet the demands of the four nations at the present time, in the absence of a pandemic, then there is a poor prospect of the demand created by a future pandemic being met.

69. Demand continues to outstrip workforce growth in the UK's health and social care systems. For too long, the RCN has been highlighting concerns about the lack of workforce planning and the gaps in the nursing workforce as a risk to patient safety. Safe and effective nursing staffing levels are critical for safe and effective patient care.

70. In our respectful submission, this is not just a lesson to be learned but also a warning that with the current level of staffing, the number of vacancies and the long-term effects of the Covid-19 pandemic, such as Long Covid, the UK Care Sector and its workers are struggling to meet the health and care needs of the population. Inevitably, as matters currently stand, their ability to do so will be compromised in the event of a future pandemic.

Dated 13 June 2025