IN THE MATTER OF

Witness Name: Claire Sutton
Statement No.1
Exhibits: 1 - 273
Dated: 21 May 2025

MODULE 6 OF THE UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF CLAIRE SUTTON

I, Claire Sutton of the Royal College of Nursing ("**the RCN**") of 20 Cavendish Square, London W1G 0RN, will say as follows: -

1. I make this statement, about the RCN's views on the publicly and privately funded adult social care sector ("**the Care Sector**"), in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 12 September 2024, in relation to Module 6 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

2. I make this statement on behalf of the RCN and confirm that I am duly authorised to do so.

3. Nursing staff across the UK carried the heavy burden of the Covid-19 pandemic, working in hospitals, care homes, general practice, the community and beyond. Our nursing community responded to the global health crisis in the UK in extraordinary ways, coming out of retirement, putting aside their studies and being redeployed to specialised clinical areas. Nurses were at the forefront of the battle against Covid-19, and we will always remember the commitment to their patients and the sacrifice of those who have sadly passed away. We must never forget the dedication shown by health and social care workers to their patients, recipients of care, and their profession.

4. I am a Registered Nurse (Adult), having qualified with DipHE Nursing Studies in 2013 from Edge Hill University. My career to date has seen me working as a nurse across a number of independent health and social care settings including in nursing homes as well as in independent health providers. I have also worked in digital clinical safety and in a digital transformation role, supporting social care providers to utilise technology. Since August 2022 I have held my position as Transformational Lead for the Independent Health and Social Care ("**IHSC**") Sector at the RCN. My role sees me lead a team of 12 IHSC Lead Nurse posts based in Wales, Scotland, Northern Ireland and each of the nine RCN England regions.

The role, aims and functions of the Royal College of Nursing

5. The RCN was founded in 1916 as the College of Nursing Ltd as a professional organisation with just 34 members and was granted a Royal Charter in June 1929. The RCN is also a Special Register Trade Union under section 3 of the Trade Union and Labour Relations (Consolidation) Act 1992.

6. The RCN is the world's largest professional body and trade union for nursing, with a membership of over half a million registered nurses, midwives, health visitors, nursing students, nursing support workers and nurse cadets. The RCN's members work in a variety of hospital and community settings in the NHS and independent sector. While over 300,000 members are employed in the NHS, a significant and growing number of our members work in independent health and social care. This diverse group includes all nursing staff employed in settings outside the NHS, including those working in adult social care such as care homes and those working in private hospitals. For the purposes of this statement the term "social care worker" refers to anyone providing care as part of employment within the Care Sector, including registered nurses and nursing support workers.

7. The RCN supports members across all four countries of the UK and internationally, and has offices in Scotland, Northern Ireland, Wales and nine regions across England. These offices support the activities of local RCN branches, as well as learning representatives, stewards and safety representatives in their area. Each of the four countries is led by a country Director, who sits on the RCN's Executive Team. The RCN Executive Team is responsible for delivering the RCN's strategic and operational plans.

8. As a member-led organisation, the RCN works collaboratively with its members to ensure that the voices of nursing, their patients and recipients of care are heard. The RCN promotes patient and nursing interests on a wide range of issues, including pay and terms and conditions, health policy and workforce strategy. It does this by working closely with the Government, UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

9. 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 **[CS/001 - INQ000574650]**. 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. We do not hold membership data on disability. By the end of June 2022, membership of those working in care homes and home services had increased by approximately 850 **[CS/002 - INQ000574651]**.

<u>The RCN's role in relation to nurses in the adult social care sector during the Covid-19 pandemic.</u>

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

11. Throughout the pandemic and more widely, the RCN provides support services and runs a call centre where nursing staff across the UK can seek advice and access the RCN's specialist representation. Since the start of the pandemic, the RCN received over 28,604 calls from its members on issues to do with Covid-19, including more than 3,700 calls from members working in the Care Sector, a notably higher figure (relative to the number of members) than calls from other sectors. This gave the RCN a clear insight into the day-to-day experiences of nurses and other allied health professionals directly relevant to Module 6. We also instigated an RCN Care Home Network in April 2020 to provide members with an opportunity to share best practice, raise concerns and support peers.

12. The RCN compiled extensive guidance and advice, both in anticipation of, and in response to, key emerging issues. This included Covid-19 guidance on DNACPR and verification of death **[CS/003 – INQ000525196]**, which would apply to care homes as well as hospital settings, frequently asked questions for care home visiting **[CS/004 – INQ000574525]** and the Covid-19 workplace risk assessment toolkit applicable to all health and social care settings **[CS/005 – INQ000114307]**.

13. 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 **[CS/006 – INQ000553909]**.

14. The RCN responded to a number of consultations including: the Department of Health and Social Care's ("**DHSC**") consultation on extending free PPE to the health and care sector to take account of primary and community care **[CS/007 – INQ000525185]**; the UK Government's proposal to stop movement of staff between care settings **[CS/008 – INQ000525187]**; the Migration Advisory Committee's

review of the impact of ending freedom of movement in the adult social care sector **[CS/009 – INQ000525182]**; and the DHSC open consultation "Making vaccination a condition of deployment in older adult care homes" **[CS/010 – INQ000492120]**.

15. In Northern Ireland, the RCN responded to the proposal for the "Safe at Home" model pilot study **[CS/011 – INQ000553314]**. In Wales, the RCN called on Care Inspectorate Wales to assure the quality and safety of care homes for older people during the pandemic **[CS/012a – INQ000525176]** and requested assurances from the Welsh Government that those being admitted to a care home from hospital test negative for Covid-19 prior to transition **[CS/013 – INQ000525175].** The RCN also called for lessons to be learned from the impact of the pandemic on Scotland's care homes **[CS/014 – INQ000525180]**. RCN consultation responses are discussed in greater detail throughout the statement.

16. The RCN undertook regular surveys of its membership including a UK-wide online survey on staff testing in April 2020 **[CS/015 – INQ000525315]**. The results revealed a disparity between access to testing for those working in the NHS compared to the Care Sector. Results of two online RCN surveys on PPE indicated that social care workers in care homes were less likely to have access to appropriate PPE and were more likely to feel pressurised into caring for individuals with Covid-19 without adequate protection. These surveys are discussed in greater detail at paragraph 209. The RCN also collected qualitative data about nurses' experiences of the pandemic, for example through "SenseMaker" **[CS/016 – INQ000328831]**.

17. The RCN Research Forum designed and led a national study exploring the Impact of Covid-19 on the Nursing and Midwifery workforce ("**ICON**") **[CS/017 – INQ000525205]**. This national 4-country survey was administered at three distinct points in time: prior to the Covid-19 peak, during the Covid-19 peak, and in the recovery period following Covid-19. Our findings have informed national health and social care policy. By way of example, commenting on the key implications of the results for the nursing and midwifery workforce, Ruth Harris, Professor of Health Care for Older Adults in the Florence Nightingale Faculty of Nursing, Midwifery & Palliative Care at King's College London said:

> *"These initial findings show that individuals do not feel adequately prepared for the pandemic and are concerned about the risk to themselves and their families. They also highlight a need for ongoing training and confidence building*

and that optimising healthcare worker testing may reduce the number of missed shifts due to self-isolation."

18. Dr Keith Couper, Assistant Professor in Emergency and Critical Care at the University of Warwick and project lead said:

"The responses from this first survey show there is a need to provide supportive interventions during and after COVID-19 to support individual's psychological and physical needs. Healthcare employers should advocate self-care and provide a psychologically safe workplace where individuals can openly discuss their concerns. Urgent research is needed to develop and evaluate interventions to support individuals."

19. Although the majority of responses [77%] for the ICON study came from those working in the NHS, the study was available to any member of the nursing and midwifery workforce in the UK, both within and outside the NHS and included responses from those working in the Care Sector. Furthermore, as discussed throughout the statement, concerns about testing, access to adequate PPE and psychological well-being were applicable to social care workers as well as nurses and nursing support workers in the NHS.

20. The RCN also played a key role in furthering scientific understanding through research to inform UK health and care guidelines. For example, the RCN commissioned an independent review of guidelines for IPC health care settings in the UK **[CS/018 – INQ000114357]**, and an evaluation and messages for future infection-related emergency planning. The guidelines applied to all hospital and community settings, including the Care Sector.

RCN liaison and communication with the UK Government and Devolved Administrations

21. Although the RCN was able to engage with the UK Government and each of the devolved administrations, the nature and level of governmental participation with the RCN varied between the four nations and at different stages in the pandemic.

22. The RCN initially encountered difficulties communicating with the UK Government. By way of example, and as discussed at paragraph 130c, in the early stages of the pandemic **[CS/019 - INQ000328862]**, we attended a briefing with the

Deputy Chief Medical Officer ("**DCMO**"), Jenny Harries, regarding policy changes around pregnancy and Covid-19. We were advised at the meeting that the RCN invitation may have been made in error. As a professional body and trade union, however, we have a duty to inform this risk group, particularly our pregnant members, including those working in the Care Sector. We therefore reiterated our request for greater co-operation and challenged the suggestion that pregnant health and social care staff should not be offered full protection due to concerns about reducing the workforce. As a result, it was agreed that pregnant women should be advised not to work in a direct patient-facing role and that redeployment should be considered.

23. The lack of opportunity to engage with the UK Government in relation to the development of IPC guidance was particularly concerning for the RCN. This caused a number of difficulties for those working in the Care Sector. By way of example, as discussed at paragraph 13, initial IPC guidance did not consider the Care Sector which left those working in the sector and those they cared for in a vulnerable situation. Members expressed confusion and difficulties regarding IPC requirements on discharge of patients from hospital to care homes [paragraph 169]. IPC guidance lacked sufficient detail around risk assessments to determine what PPE to use in the absence of adequate ventilation [paragraph 177]. Furthermore, guidance published by the UK Health Security Agency (**"UKHSA"**) 'Personal protective equipment: resource for care workers working in care homes during sustained COVID-19 transmission in England.' discouraged those working in care homes from wearing FFP3 masks **[CS/020 – INQ000525317]** [paragraph 181].

24. An example of positive engagement between the RCN and UK Government was early collaboration with DHSC and the NMC on plans to establish a Covid-19 temporary emergency register ("**the temporary register**"), applicable to both the NHS and Care Sector. As discussed at paragraph 77, we consider that the establishment of the temporary register was quick and effective.

25. In Wales, initial engagement with the Welsh Government was not always forthcoming. By way of example, as discussed at paragraph 85 the plan to include nursing students on the temporary register resulted in some difficulties and confusion. The RCN considered that many of these issues resulted from the failure of Health Education and Improvement Wales ("**HEIW**") to consult or engage with the RCN **[CS/021 - INQ000328820]**.

26. Similarly, as discussed as paragraph 130b, RCN Wales was compelled to write to the Welsh Government seeking clarification of reissued shielding advice, of which the RCN had not received prior notice **[CS/022 - INQ000328861]** so that we could inform our members, including those working in the Care Sector.

27. Engagement with the RCN improved in Wales when the Welsh Government set up "cell" groups for a number of activities, including the procurement and provision of personal protective equipment **("PPE").** In our experience, this initiative worked relatively well.

28. We consider that our levels of government engagement were generally excellent in Northern Ireland. This was, however, invariably due to a proactive approach by the RCN. As discussed at paragraph 44, the RCN was invited to meetings with the Northern Ireland Department of Health, which facilitated solutions for ongoing challenges, including those in the Care Sector, such as the availability and standard of PPE and the lack of testing.

29. A further example of positive engagement in Northern Ireland, discussed in more detail at paragraph 45, is the extensive engagement between the RCN Independent Sector Nurse Managers Network ("**ISNMN**") and Department of Health, Health and Social Care Trusts and the Regulation and Quality Improvement Authority, particularly during the early stages of the pandemic which allowed the concerns of our members working in the Care Sector to be raised. Whether this high level of engagement translated into effective and timely influencing outcomes, however, was not always clear.

30. In Scotland the RCN engaged extensively with the Scottish Government through lobbying activities. We were also invited to sit on a number of advisory groups and attended regular meetings with the Scottish Government. Broadly it is our view that engagement between the RCN and Scottish Government resulted in positive outcomes, including those for the Care Sector. By way of example and as discussed at paragraph 191 a social care triage hub was established in or around 25 March 2020 in Scotland, in response to concerns around PPE supply, expressed by the RCN and others. The RCN and other stakeholders were also able to contribute to proposed updates to PPE guidance and a dedicated phone number

for staff to report difficulties with PPE distribution following requests from the RCN.

31. Engagement between the RCN and Scottish Government, however, was not always effective. As discussed at paragraph 191, the RCN was excluded from the development of clinical guidance in Scotland via the clinical cell. Although the CNO in Scotland agreed that the RCN should have input, **[CS/023 - INQ000417597]** this did not happen. We viewed this as an absence of nursing expertise in shaping the guidance, driven by representation from medical professionals. Given the predominance of nurses and nursing support workers in both the NHS and Care Sector, who would be required to use the guidance, this was concerning.

32. As discussed above in respect of Northern Ireland, it was not always possible to determine whether high levels of engagement translated into effective and timely influencing outcomes. It is apparent, however, from the above examples and as discussed throughout the statement, that a lack of engagement with the RCN often resulted in confusion for our members who were required to apply guidance issued by the UK Government and Devolved Administrations. Furthermore, excluding the RCN from guidance planning sometimes meant that the Care Sector was not initially considered or that guidance was inappropriate for this sector.

England

33. The RCN attempted to engage with the UK Government throughout the pandemic, both publicly, for example through published open letters and working behind the scenes to promote the needs of our members and health and social care workers in general as well as patients and the general public.

34. The RCN had direct lines of communication with senior health and social care leaders including the Secretary of State for Health and Social Care, the Minister for Care and Chief Nursing Officers. Dame Donna Kinnair, the former RCN Chief Executive and General Secretary, escalated concerns directly with such individuals throughout the currency of the pandemic by email correspondence, telephone calls and attendance at formal meetings. Formal correspondence between the RCN and Secretary of State for Health and Social Care, CNO for England and IPC decision making bodies was also a mechanism for raising formal issues and occurred on a regular basis.

35. By way of example, Dame Donna Kinnair met with Helen Whately MP, Minister for Care on 21 April 2020. The meeting focused on the impact of Covid-19 on the workforce and patient care, in particular care homes. Key points discussed included: the need to secure access to adequate and correct supplies of PPE; testing of health and social care workers including the accessibility of testing services; access to infection prevention control advice and the return of nursing staff to the register during the pandemic. Dame Donna Kinnair raised substantial concerns about: 'lock ins' for staff at care homes; the need for IPC training and the reporting of nursing deaths. Similarly, Dame Donna Kinnair raised concerns about the approach taken by the UK Government to testing in care homes with CNO England on 20 April 2020 **[CS/024 – INQ000612631]**

Wales

36. RCN Wales was in frequent contact with the Welsh Government during the pandemic. The RCN raised issues of concern and provided expert advice to government on the management of the pandemic. The operational issues of managing health and social care services within and outside of hospitals (e.g. prisons, community services, primary care) and outside the NHS, for example care homes, were of concern. Our members required accurate and up-to date information regarding the legal position on restrictions, advice on professional practice and ensuring access to the right equipment.

37. In this period, the Director of RCN Wales held a seat on the Welsh Partnership Council group with the First Minister, which met every week for discussion and briefing purposes and, in addition, had formal quarterly meetings with the Minister for Health and Social Services. Monthly meetings were held between the Director and the CNO for Wales and with the Chief Executive of NHS Wales. Telephone contact was maintained at least weekly with the Special Adviser of the Minister and the office of the CNO.

38. The RCN had a seat on the monthly meeting of the Welsh Government Nosocomial Committee. There were also weekly meetings with Welsh Government Officials to discuss general issues relating to Covid-19 and the workforce but also fortnightly meetings with Welsh Government Officials to discuss vaccinations and testing.

39. Formal correspondence between RCN Wales and the First Minister, Minister of Health and Social Services, Chief Executive NHS Wales, CNO, and health boards was also a mechanism for raising formal issues and occurred on a regular basis. Public policy briefings were also published by RCN Wales during this period which addressed specific matters of concern and contributed to public discussion.

40. RCN Wales met frequently with members of the Senedd during this period to brief on the situation as experienced by our members, answer questions and raise our concerns as needed. Meetings were held monthly with the spokespeople of the Opposition parties and the Chair of the Welsh Parliament Health and Social Care Committee. Events and seminars were also held at Parliament to provide information on matters of concern.

Scotland

41. RCN Scotland lobbied the Scottish Government on behalf of members from the outset of the pandemic, at times writing directly to Scotland's First Minister to raise concerns and to highlight areas requiring action. The RCN was given seats on:

- Workforce Senior Leadership Group - a multiagency group with Scottish Government officials
- The Care Home Clinical Professional Advisory Group – a care home specific group with a range of stakeholders
- The Care Homes Rapid Action Group
- HSC Winter Planning and Response Group - to plan for the 2021 winter surge
- Pandemic response in Adult Social Care Group

42. Regular meetings between the RCN Scotland Director and the Cabinet Secretary provided an opportunity for the RCN to raise member concerns directly with Scottish Government. The RCN Director also met the Scotland CNO regularly and RCN Scotland's two Associate Directors held weekly meetings with the Deputy CNO to allow more detailed discussion around key issues.

43. In addition to direct dialogue with the Scottish Government, RCN Scotland worked to highlight member concerns around safe staffing, access to PPE and staff wellbeing through the media, with Members of the Scottish Parliament and through joint working with key stakeholders including the Royal College of General Practitioners, the British Medical Association ("**BMA**") and Scottish Care. For example - on 30 March 2020 RCN Scotland penned a joint letter with the Royal College of General Practitioners Scotland and Scottish Care to the Cabinet Secretary for Health and Sport calling for a consistent approach regarding the level of PPE required across both acute and community settings **[CS/025 – INQ0000589804]**.

Northern Ireland

44. From the outset of the pandemic the RCN in Northern Ireland was in frequent contact with the Office of the First Minister and Deputy First Minister ("**OFMDFM**") and the Minister for Health. Regular communications were also maintained with the CNO, the Public Health Agency ("**PHA**"), the Regulation and Quality Improvement Authority and the Chief Medical Officer ("**CMO**"). In addition, the RCN, alongside the other health trade unions, attended weekly meetings with employer representatives and Department of Health officials. These meetings provided an opportunity to raise issues and seek solutions to the many ongoing challenges, including those in the Care Sector, such as the availability and standard of PPE and the lack of testing.

45. In Northern Ireland the RCN, through the ISNMN, provided support to registered nursing homes and raised issues on behalf of the sector with the Department of Health, Health and Social Care Trusts and the Regulation and Quality Improvement Authority. During the early stages of the pandemic, members of the ISNMN engaged extensively with RCN staff, resulting in enhanced communication with the Department of Health. However, measuring how this engagement contributed to positive outcomes or tangible actions remains difficult.

46. Correspondence was also forwarded to the Health and Safety Executive for Northern Ireland regarding the inadequate availability of PPE and the absence of fit testing for FFP3 masks **[CS/026 – INQ000400948]**.

47. The RCN launched a Northern Ireland helpline for members, and it was via this channel that concerns and realities for frontline staff were heard, and the RCN was able to respond and influence on their behalf.

48. RCN personnel were also closely involved in a number of relevant advisory groups. These included the National Clinical Cell Frontline Subgroup; the Care Task Force Group; the Rapid Learning Initiative into the transmission of Covid-19 into and within care homes in Northern Ireland and Enhancing Clinical Care Framework in Northern Ireland Care Homes. The RCN also contributed to NI Assembly Committee for Health: Inquiry report on the impact of Covid-19 in Care Homes (2020) **[CS/027 – INQ000256510]**.

Pre-pandemic capacity of the adult social care sector in the UK

49. 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 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 workforce, required to meet that demand. This has undermined the integration agenda and the focus on prevention and early intervention which could reduce the pressure on the NHS and resilience on costly treatment services.

50. Social care is an incredibly important yet often overlooked pillar of public service. Social care services had 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. The Institute for Fiscal Studies in its 'English local government funding: trends and challenges in 2019 and beyond' paper reported that council service spending is predominantly focused on social care services, leading to cuts in other areas such as transport and housing. There was a need for additional, sustainable and long-term investment in the social care sector. Specific attention should be given to learning disability services, mental health services, and the needs of both old people and children and young people within social care.

51. 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.

52. As funding pressures have grown, many local areas have had to raise the threshold for people accessing care. This means that only those with the most severe and enduring care needs are able to receive support. For many, this leaves families and carers filling the gaps of care services. People may also be likely to turn to other frontline services such as general practice or A&E when they need support, placing additional pressure on an already stretched health service. Some councils had reported that they were failing to meet their statutory adult social care duties. This was extremely concerning.

53. Although the 2020 spending review did include additional funding for social care, including the ability for local authorities to increase the social care precept, it did not go far enough. We had seen these piecemeal increases to social care funding before. They did not allow decision makers to take a long-term strategic view.

54. We recommended that the UK Government introduce a long-term funding settlement for social care settings in all parts of the UK, based on a robust assessment of population needs. Overall funding for social care must be sufficient to provide fair pay in addition to fair terms and conditions for all nursing staff. Investment levels must also fund staffing for safe and effective care in all social care settings. Funding should consider wider health promotion and prevention, which nursing staff are key to and which can allow earlier identification and intervention for individuals.

Workforce capacity and vacancy rates, including recruitment and retention issues

55. 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, 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 care system that isn't affected.

56. 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, for example, *Hogne Sandvik and Steinar Hunskaar,* Staff retention and mortality, BMJ 2024;387 **[CS/028 – INQ000525179]** that shows a direct link between nursing staffing levels and poor patient safety outcomes.

57. The RCN has consistently highlighted over a number of years the absence of effective workforce planning for nursing **[CS/029 – INQ000114252 pp.11-13] [CS/030 – INQ000114302] [CS/031 – INQ000114303] [CS/032 – INQ000114304] [CS/033 – INQ000114306]**. 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 nursing workforce, upon which the refocusing of services is largely dependent. 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 **[CS/034 – INQ000114416 pp.3] [CS/035 – INQ000103564]**. The majority of the vacancies (77,000) were for care worker jobs. The vacancy rate for care workers (9.0%) was also higher than for other direct care-providing roles, including senior care workers (5.7%) and personal assistants (8.2%). Registered manager vacancies (11.4%) were double the average of other managerial roles (5.3%), equivalent to around 2,900 vacancies at any given point in 2018/19. Vacancy rates for regulated professions were the highest of all job role groups (9.4%). The registered nurse vacancy rate was particularly high, at 9.9%.

58. The pre-existing nursing workforce vacancies across the UK faced increased risk to recruitment and retention during and after the pandemic. Insufficient sustainable nursing supply to meet the needs of the population undoubtedly lead to risks in service quality, and to patient care and outcomes. Although the former UK Conservative Government committed to recruiting 50,000 more NHS nurses for England by 2024, this is understood to be for the NHS alone and failed to consider the social care sector. Any increases in nursing staff working in health services anywhere in the UK during the relevant period included registrants who had joined or returned to the NHS since the start of the Covid-19 pandemic as part of the response needed during this time, and there was a high risk that this would not be sustained.

59. The 2020 RCN Member survey **[CS/036 - INQ000176038]** indicated that almost half (49%) of those who work in independent/private sector social care reported that staffing levels had worsened during the pandemic compared to 39% of those working for NHS trusts/boards.

60. Recruitment and retention are a particular problem for the nursing workforce in social care. 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. The number of registered nurses working in social care continued to decrease year-on-year between 2012/13 and 2019/20, and in 2021 was down 1,800 jobs (5%) on the previous year. Registered nurses were one of the only jobs in adult social care to see a significant decrease over this period down almost 17,000 jobs, or 33% since 2012/13 **[CS/035 – INQ000103564]**.

61. The number of unfilled posts in the adult social care sector in England continues to be a concern and suggests that the perceived risk to adequate recruitment and retention has transpired. Figures from October 2024 suggest that the number of vacant posts in this sector now stands at 131,000, an increase of 7.38% since before the pandemic and equating to a vacancy rate of 8.3%, higher than both the NHS (6.9% as at March 2024) and the UK economy as a whole (2.8% as at February - April 2024) **[CS/037 – INQ000572390]**. The previous UK Government and those across the UK have despite this failed to publish fully funded health and care workforce strategies to ensure sufficient demand-led workforce planning to meet the needs of the population both during the pandemic and in the future.

62. Staff vacancies in care services 2021 published by the Care Inspectorate and Scottish Social Services Council in November 2022 shows the percentage of care services reporting vacancies has increased by 11 percentage points from 36% in the previous year (2020) and vacancy rates in some local authority areas were higher than others. The parts of the workforce facing most challenge in filling vacancies were care at home services, care homes for older people, housing support and care homes for adults. The more common reasons for vacancies not being filled included that there were too few applicants, too few applicants with experience and too few qualified applicants.

63. The number of vacancies reported in the Social Care Wales workforce data collection report 2021 was 2,676. An additional 1,675 posts were being 'held vacant' by employers **[CS/038 – INQ000574662]**.

64. In Northern Ireland, social care vacancies as at 31 March 2020 were at 7.8% in accordance with workforce data published by the Department of Health Northern Ireland.

65. The RCN highlighted particular concerns for recruitment, training and retention social care in a submission to the Health and Social Care Committee Inquiry on 22 March 2022 **[CS/039 – INQ000418109]**. We were clear that international recruitment should not take place at the expense of appropriate education, development and investment in the domestic nursing workforce and that international recruitment must be part of a transparent UK Government strategy to grow and develop a sustainable health and care workforce. Given the vulnerabilities of the social care sector, we recommended that the sector should be better supported to further draw upon the international workforce in the short-term.

66. Demand for social care will continue to grow - by 2035 the Care Sector may require an extra 490,000 jobs in England alone, equivalent to 29% growth **[CS/040 – INQ000525188]**.

67. The RCN has identified several factors driving registered nurses to leave the health and social care sector. The 2021 RCN employment survey revealed how registered nurses, health care support workers, students and nursing associates working across all areas of health and social care found almost six in ten respondents (56.8%) were considering or were planning to leave their current post. Similarly, 52.0% of respondents working in care homes indicated that they were thinking about or actively planning to leave their job. 16.0% of respondents working in care homes were undecided or unsure **[CS/041 – INQ000525159] [CS/042 – INQ000525186]**. The main reasons given for thinking about leaving were feeling undervalued and feeling under too much pressure.

68. Long working hours have been a problem for the nursing profession across all parts of health and social care for many years. 67.3% of respondents working in the independent care home sector reported working additional hours at least once a

week and only 10.4% indicated that they never worked beyond their contracted hours.

69. To address recruitment and retention issues in social care, the sector needs increased long-term investment. Funding for the social care sector must be sufficient to provide fair pay, terms and conditions for all nursing staff, to encourage recruitment and retention, and must be included in Government accountability for assessment and planning of the health and care workforce. The next iteration of the NHS People Plan, and a people plan for the social care sector must prioritise the need for the UK Government to hold accountability for assessing the health and social care workforce and delivering a strategy for workforce planning and supply.

70. 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.

71. A lack of collective bargaining means that the employment terms and conditions across social care are variable, which can affect terms and conditions including pay, unsocial hours payments, pension, maternity pay, annual leave and occupational sick pay. This fails to deliver contractual and employment conditions fit for attracting and retaining the right numbers of nurses and nursing support workers within the sector. Pay is often set just above legal minimum wage levels, terms and conditions of employment are poor, and training and CPD opportunities may also be limited or non-existent. It is the RCN's position that regardless of where a registered nurse or nursing staff member is employed, they should at least have parity with Agenda for Change pay, terms and conditions.

72. The RCN raised these issues via consultation responses including RCN's submission to the Migration Advisory Committee's call for evidence on the Shortage Occupations List in June 2020 **[CS/043 – INQ000525192]** and the Public Services Committee's session on Lessons from Coronavirus to discuss the nursing workforce in June 2020 **[CS/044 – INQ000525193]**. In July 2020 the RCN provided evidence to the Public Accounts Committee inquiry into the NHS nursing workforce **[CS/045 – INQ000525194]**. On 16 September 2020 the RCN made a submission to the Commons Health and Social Care Committee Inquiry on Workforce Burnout and

Resilience in the NHS and Social Care Sector **[CS/046 – INQ000418108]**. In winter 2020, the RCN provided a written response to the Department of Health and Social Care's consultation on the proposal to regulate staff movement between care settings **[CS/008 – INQ000525187]**. The RCN had significant concerns about the Department's proposals to regulate movement between care settings, as we anticipated that the regulations would have a significant impact on social care staff, on staffing levels in social care settings and in other public services, as they were based on out-of-date evidence. Similarly in December 2020, RCN Scotland responded to the Scottish Government's Independent review of Adult Social Care in Scotland. In February 2021 **[CS/047 – INQ000525206]**, the RCN responded to NHS England's consultation on building a strong, integrated care system across England **[CS/048 – INQ000525189]**.

73. The RCN does not retain data regarding the bed capacity of adult social care.

The scaling up of the nursing workforce

74. Years of under-investment in the community and care home sectors meant social care was left exposed when the pandemic hit. In order to address this major gap in the workforce, the adult social care action plan, published by DHSC on 15 April 2020, set out an ambition to attract 20,000 people into social care over the following three months. However, the National Audit Office Report '*Readying the NHS and adult social care in England for Covid-19*', published 12 June 2020, to which the RCN contributed, reported that the DHSC did not know how it was progressing against that goal; there appeared to be no mechanism available to assess whether the target would be achieved **[CS/049 – INQ000114319 pp.12]**.

75. Registered nurses, midwives and nursing associates across the UK are required to be registered with the Nursing and Midwifery Council ("**NMC**") in order to practise. The Coronavirus Act 2020 introduced powers for the NMC to establish a Covid-19 temporary emergency register applying to both the health and social care sectors. This enabled nurses who had left the register within the last three years and nursing students in the final six months of their programme to temporarily register if they chose to do so.

76. There was a lot of activity across the UK on developing the details of these plans at the start of the pandemic, crucially after measures had already been

announced, which resulted in a period of confusion, anxiety and uncertainty for members. Plans to rapidly scale-up the nursing workforce nationally had not been worked out in detail in advance.

77. The RCN was supportive of the creation, and later expansion, of the temporary register for nurses by the NMC. It is the RCN's view that the implementation of the temporary register was quick and effective. However, it was not clear how those choosing to return to practise or join the temporary register from overseas would be robustly supported and supervised to ensure that they were able to practice safely, especially in the context of an already stretched workforce.

78. The RCN worked with the NMC and other organisations including the Department of Health and Social Care to produce a joint statement providing further details on expanding the workforce and the proposed temporary register ("**the Joint Statement**"), which was released on 19 March 2020 **[CS/050 - INQ000470413] [CS/051 - INQ000232032]**. The RCN sought to make it clear that this was a voluntary scheme, and that staff and students must be appropriately supported, including appropriate terms and conditions, full employment status and protection, supervision and training.

79. On 2 April 2020, a further update to the Joint Statement on expanding the nursing and midwifery workforce in the Covid-19 pandemic was issued by the NMC **[CS/052 - INQ000300100]**. The statement identified two additional groups of people who the NMC would invite to join the temporary register: overseas applicants, including both nurses and midwives, who had completed all parts of their NMC registration process except the final clinical examination (OSCE), and nurses and midwives who had left the register within the last four or five years, including those who had left the register and had started but not completed a Return to Practice programme.

80. As of July 2020, there were 14,243 people on the UK wide Covid-19 temporary register made up of three main cohorts: those who had left the permanent register in the last three years (66%), those who had left the permanent register in the last three to five years (16%) and eligible overseas registration candidates (18%).

Scotland

81. RCN Scotland acknowledged, in its briefing for the Scottish Government Debate 'Suppressing Covid: Next Phase' in May 2020, that the response to the call for nurses and other health professionals to re-register, and for students to join the workforce early, had been overwhelming – but that many were not being called upon to work **[CS/053 - INQ000328817]**. Anecdotal evidence suggested that mobilising the student workforce in Scotland had got off to a slow start. Informal intelligence would appear to suggest that delays arose from: matching responders to need depending on their area of practice/expertise, especially in social care where responders may not have worked previously and where there was no existing central system that could identify need because of the nature of providers; protecting vulnerable adult checks, although turnaround time remained fast, taking on average 48 hours for clearance; ensuring students were treated appropriately given their unique status and agreeing pay and terms and conditions for responders. On 17 April 2020 guidance was issued to NHS Scotland Health Boards by the Scottish Government **[CS/054 - INQ000452514]** to help support the deployment of students and returners recruited through the Covid-19 accelerated recruitment portal.

82. RCN Scotland was clear that where final year students opted to join the Covid-19 temporary register, they must be paid at Band 5 level. The RCN sought clarity from the Scottish Government on the position for students who chose not to join the Covid-19 temporary register and opted to continue their final year placements as students, recognising that they would have a significant contribution to make in that capacity. The RCN also queried the extent of any financial support. The RCN insisted that 'early student registrants' should not enter the workforce as registered nurses until they had completed their programmes in full, had been assessed and were able to join the full register. If required, students must be supported to return to their full pre-registration degree on a supernumerary basis after the emergency measures came to an end.

Wales

83. Following the release of the Joint Statement on expanding the nursing workforce on 20 March 2020, Helen Whyley, the Executive Director of RCN Wales, wrote to, amongst others, the CNO for Wales and the Director of Nursing at HEIW,

requesting an urgent meeting to discuss the implementation of the Covid-19 temporary register in Wales **[CS/055 - INQ000328818]**.

84. On 3 November 2020, a letter from Vaughan Gething documented a meeting with Helen Whyley that had taken place on 8 October 2020 **[CS/056 - INQ000328819]**. Part of the discussion touched on the workforce implications of a possible resurgence of the levels of the virus that winter. The Minister indicated that officials were working with NHS Shared Services to see what roles those staff who were on the Covid-19 temporary register might fill. They were pleased to note that many of the overseas trained staff who were on the temporary register were completing their requirements and registering fully.

85. It is the view of the RCN that measures were poorly implemented in Wales:

a. It was initially unclear what was going to happen to nursing students who chose not to opt into the Covid-19 temporary register since normal clinical placements were suspended.
b. Academic expectations placed on students working full-time in the NHS were unrealistic.
c. Contracts had been issued to some students and not to others.
d. Each university appeared to be interpreting the "Nursing and Midwifery Student Support Guidance during Covid-19 Outbreak" issued by HEIW differently. This related to the option given to 2nd and 3rd year nursing students to extend their clinical placement to a maximum of 80% (retaining 20% for academic time) by providing frontline care. Students choosing to do so would be paid at a Band 3 or 4 level depending on their completed time on their degree program. However, some nursing students experienced delays in the issuing of the relevant contract which in turn led to delays in payment. Additionally, feedback from student members indicated a lack of parity around training and support, frustrations at timelines being postponed, and confusion as to whether and how students could be placed in other parts of the UK outside of Wales.
e. There was a delay in some nursing students receiving notice of their placement.
f. The position of death in service benefits for students was initially unclear. All universities had set up student helplines, however, as there was so little clarity around the contracts and processes this was causing more confusion. RCN

Wales recommended that there should be one central point for student queries.

g. There was much confusion around the NHS induction programme for students opting in. The original understanding was that there would be an All-Wales programme that would come from NHS Shared Services and HEIW. However, this had not happened, and some Health Boards had developed their own induction programmes, and some had expected students to start without one.

h. Arrangements for students from England studying in Wales and arrangements for students from Wales studying in England were unclear.

86. Many of these issues resulted from the failure of HEIW to consult or engage with the RCN. RCN Wales had written to the Chief Executive of NHS Wales on 05 May 2020 regarding this lack of communication **[CS/021 - INQ000328820]**.

A summary of the RCN's significant concerns in respect of key decisions made by the UK Government and the Devolved Administrations regarding the adult social care sector during the pandemic

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

87. The RCN had significant concerns in relation to the decision to discharge residents from hospital to care homes without testing.

88. 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'*.

89. On 19 March 2020, the UK Government published the document "COVID-19 Hospital Discharge Service Requirements" applicable to the Care Sector. The guidance provided that "*acute and community hospitals must discharge all patients as soon as they are clinically safe to do so. Transfer from the ward should happen within one hour of that decision being made to a designated discharge area.*

Discharge from hospital should happen as soon after that as possible, normally within 2 hours."

90. 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 such a short timeframe meant that this planning was difficult to effectively achieve.

91. 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.

92. 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, these were confined to those patients in a hospital, despite a very significant number of virus-related deaths taking place in care homes or in their own homes with hastily arranged care packages.

93. Care homes did their best to accommodate these unprecedented demands of the NHS. Some were in a better position to respond than others. Those outside the hotspots of London and Northwest England had a little more time to prepare. 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 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.

94. When the scale of the deaths within care homes became more widely known, the Prime Minister appeared to attempt to shift blame onto inadequacies in those homes.

95. 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.

96. Initially, if testing was done it was confined to one-off snapshot tests of residents who had symptoms and were at risk. NHS discharged care home residents were not tested for Covid-19 status before 16 April 2020. A national strategy to support formal testing of symptomatic residents and care home workers commenced on 15 April 2020. Testing of whole care homes with known Covid-19 infections began on 15 May 2020. The extension of testing to include voluntary screening for asymptomatic infection for adult care home residents under 65 was announced by the DHSC on 08 June 2020.

97. In Wales, testing for frontline NHS staff began on 7 March 2020 and by 18 April was available for all 'critical workers' which included those working in adult social care. Symptomatic residents and those returning from hospital became eligible for testing on 22 April.

98. In Scotland, no Covid-19 testing was routinely available for care home staff in March 2020, but targeted surveillance testing was being conducted nationwide which could include care homes where there had been an outbreak. On 21 April, testing was expanded to include symptomatic care home residents as well as Covid-19 patients discharged from hospitals to care homes.

99. In Northern Ireland, testing by appointment for health and social care staff started on 4 April 2020. On 27 April 2020, testing was extended to all staff and residents in care homes where an outbreak was identified, as well as for all new admissions to a care home, whether from hospital or from any other setting.

100. In Wales, on 16 April 2020 **[CS/012a – INQ000525176]** we asked, in an open letter to the Chief Inspector that Care Inspectorate Wales launch a review into the actions taken, and not taken, in relation to care homes. We believed that a retrospective account would undoubtedly identify significant lessons for us all about best practice, best policy and avoidable harm. This seemed to be a very appropriate exercise to undertake considering the remit of the Inspectorate and its strategic ambition to be an "*expert voice to influence and drive improvement*". The safety of our members in the community was very important. It was vital that our nursing staff felt safe to care for residents in a hygienic environment, having followed the appropriate guidance. This was also true for care home residents. Residents should feel safe, protected and comfortable in their home. The RCN were particularly concerned about the decision taken by both CQC and Care Inspectorate Wales to temporarily suspend its routine inspections of care homes in March 2020 to allow care home providers to focus on infection containment. Inspections are crucially important to maintaining standards and protecting residents. Whilst halting routine inspections during the height of the pandemic was appropriate and necessary, this also restricted CQC's and Care Inspectorate Wales' ability to carry out its statutory responsibilities, as they were unable to physically examine what was going on in care homes.

101. On 22 April 2020 we received a response that indicated that although it was not within the gift of Care Inspectorate Wales to secure testing, the Inspectorate had been seeking testing for people living in care homes and care home staff for several weeks **[CS/056 a – INQ000525177]**. The letter acknowledged that access to testing was particularly important prior to people being discharged into care homes. Care Inspectorate Wales also confirmed that they recognised providers may have to operate in different ways due to the pandemic for example with lower staffing levels, reduced activity programmes or recruit staff without full recruitment checks and full induction. It was not their intention to be critical of providers who breach these regulations as long as there is evidence this was done in the best interest of

people. They maintained however that if any RCN members had concerns about the safety and well-being of people living in a care home in which they are working they must report it to CIW immediately in line with their professional code.

102. On 3 July 2020, Helen Whyley wrote to Dr Andrew Goodall, Director General Health and Social Services and Chief Executive NHS Wales, after being given the opportunity to comment on the document NHS Wales Covid-19 Operating Framework – Quarter 2 (20/21) **[CS/013 – INQ000525175]**. The RCN was pleased that there was still a focus on older people in care homes and that their needs were being met. We felt, however, that we were missing an assurance that any older person being admitted to a care home or returning from hospital would have tested negative for Covid-19 prior to their transition.

103. In the interim, we received the following queries from members who had contacted the RCN interactive support services, consisting of a call centre and online platform, known as RCN Direct ("**RCND**") where members could seek advice and access specialist representation. They raised the following concerns:

a. *Unfortunately I work for a private nursing home and we are not that protected as the nurses from NHS. Unfortunately, where I'm working we don't have much materials and enough hand gel and we are admitting people from hospital and sadly we don't have much information about them, sometimes not even a discharge letter.*

b. *A patient came into the home who had tested positive for Coronavirus - member and other staff were advised the 2nd swab was clear, however discharge notes from the hospital did not mention this. They got in touch with the hospital to be told the 2nd swab had not come back but they then had the results this week which showed positive.*

c. *There is information on the daily logs that one of the residents came back from hospital with a discharge letter saying that a Covid test was done, came out negative but with GP recommendation to be treated like a positive person. I didn't have the correct PPE even with the guidance that was out at that time. Most of the staff were in self-isolation, with mild symptoms. But I was the only one ending up in hospital. We also lost about 13 residents.*

d. *Hospitals will send patients who have tested positive to Covid-19 to care home to create room for more beds but what happens to nurses and care staff without adequate PPE?*

e. *Member works with these patients who come directly from hospital. Member has had a Covid patient who has since died and another suspected case who is being nursed in a separate room. There is no PPE provided unless there is a suspicion of Covid. Staff have face to face and hands-on contact with these patients.*

Availability of testing for recipients of care and nurses

104. In our March 2020 briefing to MPs and members of the House of Lords on the Coronavirus Bill 2020 **[CS/057 – INQ000525312]** we called for the testing of health care professionals to be undertaken across all settings without delay. This would prevent staff being required to self-isolate as a precaution and lessen staffing issues in an already depleted sector.

105. 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 **[CS/015 – INQ000525315]**. 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 and of those, 8% had not needed it when it was offered. 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 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.

106. 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 did indicate that they faced additional issues that would need to be addressed.

107. On 16 April 2020, RCN Wales wrote to the Care Inspectorate Wales **[CS/012a – INQ000525176]** to raise serious concerns around the access to PPE and testing for care home staff. We asked in particular whether testing had begun for care home

residents as well as staff. We called for this to be done if testing was not already being undertaken as it would help limit the spread of the virus. We also specified that this testing should be conducted in the home as it would not be appropriate to require vulnerable patients to go to a hospital setting for testing. We received a response on 22 April 2020 **[CS/056 a – INQ000525177]** which explained that Care Inspectorate Wales was not able to secure testing but acknowledged that it had also been pushing for increased testing for residents and staff, as well as for those being discharged from hospitals into care homes.

108. In May 2020, RCN Scotland responded to the Health and Sport Committee's Covid-19 testing survey **[CS/058 – INQ000525178]** and called for routine asymptomatic testing of workers, residents and patients in the health and social care systems.

109. RCN Wales wrote to the Welsh Minister for Health and Social Services on 16 September 2020 **[CS/059 – INQ000525173]** to raise serious concerns over the availability of Covid-19 testing as key workers still did not always have timely access to testing even by this stage.

110. In September 2020, the RCN was still receiving reports of significant problems in the availability of testing kits **[CS/060 – INQ000525316]**, with many employers not supporting members to access routine testing in care homes and some employers were struggling to resume routine testing. There were also concerns over delays in receiving results from labs, with delays of 6-14 days becoming common.

111. On 6 November 2020, RCN Northern Ireland wrote to the PHA, CNO, and Chief Social Work Officer **[CS/061 – INQ000525163]** to raise concerns around the newly announced shift from fortnightly to weekly testing of care home staff. The RCN's Independent Sector network raised concerns that the testing regime was labour-intensive and placed an additional burden on already overworked care home staff. In the same correspondence, the RCN's Independent Sector network also raised a perceived inequity between Health and Social Care Trust employees who supported care in nursing homes or in hospitals who were not having to undergo weekly testing while those in care and nursing homes in the independent sector did.

112. A response letter was received from the Department of Health on 27 January 2021 **[CS/062 – INQ000574487]** which acknowledged a considerable change to the landscape faced by care homes in the management of Covid-19, particularly the roll out of a programme of vaccination for residents and staff which was continuing at pace since the letter was received. Furthermore, the challenges involved in setting up and maintaining the programme of regular testing was not underestimated by the Department, the further package of additional funding to support the care home sector recently announced by the Minister had an element paid directly to care homes to ensure they could support the continuance of the regular programme of testing and that the Department remained fully committed to supporting care home providers to implement this important programme of testing.

113. The RCN also received reports of difficulties accessing testing in social 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.

114. The RCN's member survey across the UK and all health and care settings was conducted between Friday 24 April and Tuesday 28 April 2020 **[CS/015 – INQ000525315]**. As stated at paragraph 105 of the statement, the survey was completed by 22,043 respondents, of which 2,632 worked in the social care sector.

115. At the time of the survey the testing position across the four nations was as follows:

a. In England, testing had been extended to frontline NHS staff on 27 March 2020, and on 15 April 2020 care home staff and symptomatic care home residents. On 28 April 2020, the final day of the survey, testing eligibility was expanded to include anyone with symptoms who was over 65 or who could not work from home, and to social care workers and care home residents even if they had no symptoms.
b. In Scotland, testing was available to symptomatic staff and expanded to include all symptomatic residents of care homes as of 21 April 2020.
c. In Wales, frontline NHS staff became eligible for tests on 7 March 2020. On 18 April 2020, the testing regime was increased to cover 'critical workers' which included both health and social care workers. On 22 April 2020, the Minister for Health and Social Services clarified that all symptomatic care home

residents and those returning from hospital were eligible for testing as were symptomatic care home workers. Testing was further extended on 2 May 2020 to all residents and staff (whether symptomatic or not) in care homes with outbreaks.

d. In Northern Ireland, testing by appointment for health and social care staff started on 4 April 2020.

116. Of the respondents to the RCN's survey on testing, 66% required testing or had previously required it but only 25% had been offered it and only 18% had been offered it when they needed it. The main reasons why respondents had not been offered testing were that their employer or manager were not currently offering testing, that they didn't display enough symptoms to be eligible, and almost 20% reported not knowing why they weren't offered testing.

117. Access to testing when offered was also a small but significant issue, with 16% of respondents in the Care Sector not having been able to access the testing that was offered. The main reason given by members for this was that respondents were not able to travel to the testing centre as they did not have a car or that it was too far to travel.

118. 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.

119. The RCN raised its concerns regarding testing in various consultation responses. For example, on 18 May 2020 RCN Scotland responded to two questions posed by the Scottish Parliament Health and Sport Committee in relation to testing for Covid-19 **[CS/063 – INQ000574659]**. The RCN asked for routine testing of all health and care workers and care home residents. We noted the increasing divergence in testing policy between the Scottish and UK Governments and believed that the Scottish Government needed to match England on the extent of testing. In England, social care workers and residents in care homes, with or without symptoms, were being tested both to investigate outbreaks and as part of a rolling programme to test all care homes. In July 2020, RCN Wales supplied a written response to the Inquiry into Covid-19 and its impact on matters relating to the Equality, Local Government and Communities Committee's remit in which we

noted that testing for care workers was considerably lower than that offered to corresponding staff in the NHS **[CS/064 – INQ000525174]**.

The impact of shielding on workforce capacity in the adult social care sector

120. Low nursing staffing levels during the pandemic impacted patient care and staff morale and contributed to increased numbers of nursing staff considering leaving the profession. Elevated staff sickness levels (in addition to those self-isolating and shielding) during the pandemic further exacerbated the workforce shortages and had a direct impact on the sustainability of services and the ability of staff to deliver safe and effective care, placing patients at risk of missed episodes of care. Nurse-to-patient ratios were diluted, impacting the level of care that could be provided. Members had to adapt to new ways of working at a rapid pace and often without adequate support. This put additional pressure on nursing staff, contributing to increased levels of anxiety and burn out. 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. 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.

121. Inextricably linked to workforce capacity, was the financial provision for those working in adult social care. The 2020 RCN Member survey findings, which included responses from those working in social care highlighted the impact of the pandemic on personal lives with 48.2% of respondents from all sectors reporting having worries about their own financial circumstances **[CS/036 - INQ000176038]**. Financial concerns were particularly acute among younger nursing staff: 57% of respondents aged 44 or younger stated they were worried about their financial situation as did 76% of black respondents and 74% of Asian respondents. In the social care sector, the figures were even higher, with 89% of Black and 78% of Asian respondents saying they were worried about their financial circumstances **[CS/065 – INQ000587565]**. As highlighted at paragraph 9, many of our members working within the social care sector are from ethnic minority groups.

122. As early as March 2020, the RCN became aware of members being asked by their employer to remain at work instead of self-isolating. This would have put their

colleagues, patients, and anyone else they came into contact with at risk and was entirely inappropriate.

123. The RCN advised its members to follow self-isolation guidance and inform their employers that they were following UK Government guidance. We expected all employers to ensure that all self-isolating staff were paid in full so that they would suffer no financial detriment when taking action to protect themselves, their colleagues, and their patients **[CS/066 - INQ000328836]**. We opposed any use of waivers or exemptions from self-isolation guidance **[CS/067 - INQ000328835]**.

124. The possibility of only receiving statutory sick pay (**"SSP"**) for Covid-related absences clearly created the risk of acute financial distress for nursing staff who would be receiving a very significant pay cut while on sick leave. The RCN submitted that changes to the rules on SSP in the Coronavirus Bill were a step in the right direction. However, the RCN called for the government and employers to ensure that staff who were absent from work due to Covid-19 received full occupational sick pay from day one, and that staff in all health and social care settings did not suffer any financial detriment while absent from work during the pandemic **[CS/066 - INQ000328836]**.

125. It was also of concern to the RCN and its members that on 15 April 2020, HM Treasury sent a Direction ("**the Treasury Direction**") to HM Revenue and Customs ("**HMRC**") which stated that, where SSP was payable or liable to be payable in respect of an employee, then the employer was not eligible to claim against the Coronavirus Job Retention Scheme ("**CJRS**") until after the entitlement to SSP ended. The Statutory Sick Pay (General) (Coronavirus Amendment) Regulations 2020 had extended the entitlement to SSP to include an individual who was self-isolating. This suggested that staff were eligible for SSP if they were shielding. The Treasury Direction appeared to prevent employers from placing shielding staff on furlough and claiming against the CJRS. Without additional financial support (for example from the CJRS funding from HMRC), many independent employers including those working in the social care sector would only pay SSP to those who were isolating. At just over £95 per week, this would be financially crippling for many in the extremely vulnerable group, who were required to shield, placing them in a worse position than others for whom employer funding through the CJRS furlough scheme was available. This situation inadvertently placed a group of extremely vulnerable health and care staff and other workers at greater risk of infection – as

those individuals faced a choice between financial dire-straits or putting their health and others' health at risk by continuing to work.

126. These concerns were raised by the RCN in a letter to the Chancellor of the Exchequer sent on 15 May 2020, which called for clarification and, if necessary, amendment to the Treasury Direction **[CS/068 - INQ000328837]**. To the best of our knowledge, the RCN did not receive a response from the Chancellor regarding this letter.

127. In July 2020, the RCN and other health unions were successful in securing full sick pay for almost 15,000 workers employed by Four Seasons Health Care ("**FSHC**"). The RCN, GMB and UNISON agreed with FSHC that all staff at the company's care facilities would receive full pay for any Covid-19 related absence and that all staff at 185 facilities who had tested positive for Covid-19 would have pay backdated to April 2020. Together, the three health unions worked with the care home operator to improve working conditions using the Government's Adult Social Care Infection Control Fund.

128. In an attempt to help those nursing staff facing financial difficulties, the RCN Foundation (an independent charity whose purpose is to support and strengthen nursing and midwifery), launched a Covid-19 support fund to finance awards for nurses, midwives and health care support workers in economic difficulty. Funding was awarded for a number of purposes, including to assist with living costs of those unable to work if they were self-isolating, living costs for those whose financial situation was directly impacted as a result of the virus, and financial support for families of health and care staff who died from Covid-19 to pay for funeral costs. The fund delivered a tangible benefit for health and care staff affected by the pandemic. The charity, which was set up following a £5 million pound donation from TikTok, made grants to 20 health and social care organisations and supported over 9,000 individuals.

<u>The impact on vulnerable members</u>

129. We received a high volume of calls from members who were vulnerable, including due to pregnancy, and who were concerned about the impact of their vulnerability on their ability to work. The following are typical examples of enquiries from those working in the Care Sector:

a. *Member is 17 weeks pregnant. Work have said she will need to stay off for 12 weeks as no suitable alternative work can be offered nor working from home Member has been told to use annual leave, once this has been used she will be paid SSP.*

b. *All staff received an email saying as of the 11th Jan anyone who has not been vaccinated and has covid symptoms will not be paid unless they have a medical condition. Member has asthma, however has continued to work and to look after covid residents. Member is currently at home after contracting covid for the second time. Member is worried she won't be paid.*

c. *Member is 17 weeks pregnant. Working at a Care Home. Member received a letter from her midwife saying she needs to self-isolate. Manager said the employer will only pay after 28 weeks. She either has to come to work, or self-isolate up to 28 weeks unpaid.*

d. *Member has asthma and recent respiratory issues. Member had covid symptoms 2 days before annual leave and manager has written to member to say that this time will be recorded in line with sick policy but the 12 weeks where member should shield won't be. Manager is putting pressure on member to obtain a sick note for shielding period so that she receives SSP - employer have said they won't pay her without a sick note. GP is clear that member should shield, has put this in writing but has refused to give sick note - member spoken to and seen GP several times about this. Member is very worried and stressed especially about the financial impact.*

e. *I have type 1 diabetes and I am a nurse working in a nursing home. We have a few residents who have tested positive for Covid 19, I am worried about coming in to contact with Covid and contracting it. I have had a risk assessment done, however there are times when I am the only nurse on duty and if there is an emergency situation I would obviously have to attend, so could potentially be coming into contact with an individual with suspected or confirmed Covid. I would like advice please on what to do.*

130. The RCN voiced these concerns on behalf of its members as follows:

a. In July 2020, the RCN developed a set of frequently asked questions on shielding to steer its members through the government guidance in each of the four countries **[CS/069 - INQ000328860]**.

b. On 24 December 2020, RCN Wales wrote to the Welsh Government Minister for Health and Social Services seeking clarification of reissued shielding advice, of which the RCN had not received advance notice **[CS/022 - INQ000328861]**.

c. On 16 March 2020, the RCN attended a briefing with the DCMO, Jenny Harries, regarding policy changes around pregnancy and Covid-19 **[CS/019 - INQ000328862]**. We were concerned to note that the Royal College of Midwives was not on the call, apparently having been omitted in error by the CMO's office. The RCN reiterated its request for greater co-operation and challenged the suggestion that pregnant health and social care staff should not be offered full protection due to concerns about reducing the workforce. It was agreed that pregnant women should be advised not to work in a direct patient-facing role and that redeployment should be considered.

d. The RCN produced a position statement advising members with asthma, who had not been contacted to the contrary, to follow the standard social distancing rules **[CS/070 - INQ000328863]**.

Visiting restrictions

131. 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.

132. We published frequently asked questions for care home visiting **[CS/004 – INQ000574525]** 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. Risk assessments must also take into account national and local guidance.

133. We also published a position statement on 11 March 2021 **[CS/071 – INQ000525313]** 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 position statement indicated that visiting decisions should be made based on an individual dynamic risk assessment which considered the needs of residents, visitors and staff. The RCN expected all care home employers to have local policies in place to assist nursing staff in undertaking these complex risk assessments.

The Deprivation of Liberty Safeguards

134. The RCN was also concerned about downturn of challenges to the Deprivation of Liberty Safeguards ("**DoLS**"). DoLS are an amendment to the Mental Capacity Act 2005 to ensure people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. The downturn in challenges to DoLS authorisations was concerning because the increased vulnerability and isolation of residents during a pandemic required scrutiny.

Vaccination as a condition of deployment

135. Like the wider population, health and 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.

136. 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. We also highlighted employment support available to RCN

members in the formal process of being redeployed or dismissed due to not being vaccinated.

137. We warned both in our consultation response and subsequent press releases **[CS/072 – INQ000492202]** that making vaccinations mandatory risked creating division where there should have been conversation, and that support and education would be more effective in increasing uptake across health and care staff. The RCN was clear that the government and employers must continue to engage with the small minority who have chosen not to have the vaccine so that their concerns could be heard and that they could be supported in understanding the importance of the vaccine to help them make that vital choice.

138. Results from the Covid-19 vaccination beliefs study **[CS/073 – INQ000492116]** showed those health and social care workers who felt under greater pressure from their employers to receive the vaccine were more likely to decline it. Feeling pressurised had damaging effects, eroding trust and negatively affecting relationships at work, and often exacerbated Covid-19 vaccination concerns and hardened stances on declining vaccination.

139. On 13 August 2021 the RCN attended a meeting with NHS England and Improvement (**"NHSE/I"**) to discuss operationalising vaccination as a condition of deployment into care homes prior to a letter and frequently asked questions being sent out to the sector **[CS/074 – INQ000492206] [CS/075 – INQ000492207]**. Jennie Hall, Director of Nursing and Clinical Delivery Covid-19 Vaccination Programme and Tom Simons, Chief HR and OD Officer led the meeting. NHSE/I stated that the DHSC was clear about expectations of employers to work with employees and that NHSE/I was aligning with this. NHSE/I indicated that the aim of the documents were to help employers to work sympathetically with employees and the RCN felt that the tone of the guidance was helpful. Whilst we supported approaches which improved better access to vaccines for everyone, we had concerns about the general messaging and perception of care home staff around the policy. We were particularly concerned about the potential impact on the recruitment and retention of Care Sector staff as well as the possible impact on the care of residents.

140. On 9 November 2021, the Government laid the draft Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No. 2) Regulations 2021 before Parliament. It did so under the draft affirmative procedure, which means

the regulations must be approved by both Houses before they can be brought into force. The regulations, if affirmed, would place a requirement for all those working in residential care settings registered by the Care Quality Commission ("**CQC**") and who have face-to-face contact with service users, to provide evidence that they had been fully vaccinated against Covid-19, although again there would be exemptions for certain staff. The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 subsequently came into force on 11 November 2021. The Government described the four-month gap as a "grace period" for the policy to be implemented

141. A few days prior to approval of the regulations, the Minister of State for Care Gillian Keegan, announced a second public consultation on whether or not to extend the requirement for mandatory vaccination beyond residential care settings to any other CQC regulated activity in health and social care, subject to certain exemptions and conditions. The RCN again expressed concerns about mandating vaccines and whether it would ultimately improve uptake. By June 2021, only 65% of older adult care homes in England were meeting the minimum level for staff uptake (as reported in the National Audit Office report: the rollout of the Covid-19 vaccination programme in England dated February 2022). We suggested the focus should be on communicating the benefits of vaccination rather than making them mandatory and involving staff in the decision making and taking account of their views. This was communicated in the RCN's response to the DHSC consultation on making vaccination a condition of deployment in the health and wider social care sector **[CS/076 – INQ000492120]**. The RCN urged caution, not only because of the impact a mandate would have on those who were not yet vaccinated, but also due to the risk to service capacity in light of existing workforce challenges.

142. On 6 January 2022, the RCN received official notification from DHSC **[CS/077 – INQ000492209]** that the 12-week grace period for unvaccinated health and social care workers would begin with immediate effect, with 1 April 2022 being the date that the regulations would be enforced. Shortly afterwards, we provided a workshop for RCN representatives to help them answer member queries on the issue.

143. In January 2022, the RCN called on the Health Secretary, Sajid Javid, to delay the implementation of the mandate. Nursing staff were working under sustained pressure and needed to be supported, not threatened with the loss of their job. The

RCN called on the Government to recognise that the implementation of the mandate would be an act of self-sabotage during a nursing staffing crisis.

144. On 09 February 2022, DHSC published an open consultation on revoking vaccination as a condition of deployment across all health and social care in England. This followed the Government's announcement on 31 January 2022 of their intention to revoke the regulations. The RCN in its response dated February 2022 **[CS/078 – INQ000492167]** supported the revocation of the regulations. Unfortunately, the ultimate climbdown by government came too late for staff who had already lost their jobs.

145. Many health and social care workers, some who had worked in their roles for decades contacted the RCN to express their concerns about the mandatory vaccinations. It is apparent from the concerns raised by members to RCND **[CS/079 – INQ000612622]**, that in many instances employers did not engage with health and social care staff in a positive way, but rather coerced or threatened staff with loss of employment. This had at times a devastating impact on the well-being of health and social care workers who had worked tirelessly throughout the pandemic and in many instances for decades before that.

146. There were many reasons why health and social care workers were hesitant about being vaccinated. Aside from perceived Human Rights issues and the question of individual choice, those who had experienced complications from previous vaccines or those with underlying health conditions were concerned about possible health effects. Many members felt strongly conflicted, as they did not want to leave their profession but also did not want the vaccine.

147. 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.

148. 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.

149. In response to these concerns, we raised the threats of dismissal at both a Social Partnership Forum ("**SPF**") Covid contacts meeting on 26 January 2021 and at weekly vaccination meetings for Social Care with the DHSC in January 2021 **[CS/080 – INQ000492212]**. We also wrote to specific employers, explaining that this was a very unhelpful approach in encouraging whole sector uptake.

150. Employers often set short deadlines for members to become vaccinated or face dismissal, and those who were in the process of seeking medical exemptions were particularly affected by this as the exemption process often involved delays or other barriers.

151. This was especially problematic for members whose health records were in other countries as they were unable to provide evidence that would be accepted by a GP in the UK in order to grant them an exemption. Difficulties or confusion were also experienced when exemptions were obtained overseas, which UK employers were not always willing or able to accept.

152. Members living outside of England also experienced difficulties in obtaining exemptions, such as nurses living in Scotland, where mandatory vaccination was not the policy and GPs therefore did not need to give exemptions.

153. Because the mandate only applied in England, there was confusion about its application to health and social care workers working for English organisations on Scottish premises. We also heard concerns of members who did not feel it was fair that they were required to be vaccinated when health and social care workers elsewhere in the UK were not.

154. Members also raised various issues relating to maternity and the vaccine. We heard from pregnant health and social care workers, some of whom were at the

early stages of their pregnancy and did not wish to inform their employers until later, as well as those already on maternity leave. Some also did not want the vaccine because they were concerned about potential impacts on fertility, particularly those already undergoing or considering IVF or other fertility treatments.

155. Those on maternity leave were concerned that their employer may require them to get vaccinated even while they were not actively working. Those who were breastfeeding sometimes felt pressured to be vaccinated despite feeling that it was not in their baby's best interests.

156. Some members felt intimidated and bullied for choosing not to have the vaccine or having contra-indications to do so. We received reports of some members being in effect "named and shamed" for not being vaccinated and some who felt that they were being discriminated against.

157. Although care home workers were targeted for mandatory vaccinations, members commented that not all care home residents or visitors were vaccinated, which appeared illogical. Another anomaly raised by members was that at the time of the initial mandate, some NHS staff were not required to be vaccinated even though they were caring for vulnerable patients.

158. The issue of vaccination choice, however, was not clear cut. Some members were clear that health and social care workers had a responsibility to be vaccinated and expressed discomfort working with colleagues who were not vaccinated as this they felt put them and patients at risk. However, other vaccinated colleagues were also concerned about the impact on staffing if all unvaccinated staff were dismissed following the mandate.

159. Nurses did not take the decision to decline or postpone vaccination lightly. Consequently, some nurses felt that they had no choice but to take the ultimate decision to leave nursing due to the pressures on them to be vaccinated against their wishes.

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

160. 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*" **[CS/081 – INQ000114411 pp.4]**. 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. It seems that earlier PHE guidance from January 2020 – '*Novel coronavirus (2019-nCoV): interim guidance for primary care*' – did acknowledge that people could potentially present in the community thereby potentially spreading the infection. The guidance stated: "*It is possible that novel coronavirus (2019-nCoV) may cause mild to moderate illness, in addition to pneumonia or severe acute respiratory infection, so patients could potentially present to primary care*". It is not clear why this risk was then downplayed in the February 2020 guidance **[CS/082 – INQ000114313]**.

A summary of relevant RCN published guidance

161. The RCN published a large amount of guidance to support its members during the pandemic as discussed throughout the statement. Much of it was relevant to members working in both the health and social care sector. By way of example, early in the pandemic we provided Covid-19 guidance on do not attempt cardiopulmonary resuscitation ("**DNACPR**") and verification of death **[CS/003 – INQ000525196]**. The guidance advised that all healthcare establishments have policies in place around cardiopulmonary resuscitation ("**CPR**") and these should still be adhered to. This would be applicable to settings in the Care Sector as well as the NHS. The RCN expectation was that conversations relating to DNACPR recommendations should be part of a wider person-centred conversation with each patient, along with the wider team caring for the patient, where this was possible and appropriate to do. It was recognised that this may not be practical or possible to do in an emergency.

162. Nurses with appropriate competency can verify death. In normal circumstances, we would expect there to be confirmation within the patient record that death is expected, or that medical staff would appreciate nurse verification of death or for there to be a DNACPR recommendation. However, there is no legal requirement for this and, given the situation as it was, we recognised that there may not always be such records in place. We expected nurses verifying death to be trained and supported in the procedure and in the aftercare required by families and staff.

163. The RCN developed its own Covid-19 respiratory risk assessment resource for its members to align IPC principles and Health and Safety requirements and to provide clarity of the position of Health and Safety legislation which remained current throughout the pandemic. It did not represent new guidance and was developed as a practical informative tool relevant to NHS and care home staff and employers. Developed with a range of stakeholder organisations, the RCN's Covid-19 workplace risk assessment toolkit was launched on 23 December 2021 to members and non-members **[CS/083 - INQ000114284] [CS/005 - INQ000114307] [CS/084 - INQ000328953]**. The toolkit highlighted the legal duties of employers to protect their staff and reflected UK legislation on risk assessment, such as the Management of Health and Safety at Work Regulations and the Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended) (**"COSHH"**) applicable in all health and care settings wherever care is provided such as care homes and people's own homes. It allowed health care staff and employers to make evidence-based decisions about the correct level of PPE, including respiratory protective equipment ("**RPE**"), needed to keep staff safe. The toolkit underwent extensive review by specialists prior to launch and was well-received by stakeholders. The assessment of respiratory risk and necessary RPE was particularly important for the Care Sector given the difficulties many care staff experienced in accessing adequate RPE during the pandemic, as discussed in greater detail later in the statement, the disproportionate impact that Covid-19 had had on health and social care workers from ethnic minority backgrounds and the high numbers of our members working in the Care Sector from these communities as highlighted previously.

164. The RCN also developed guidance specific to the Care Sector. By way of example, we published a position statement on staff living in care homes on 14 May

2020 **[CS/006 – INQ000553909]**. The RCN was alarmed 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.

165. The position statement discussed the reasons for our opposition to the arrangements including the underlying suggestion that Covid-19 could only be introduced to the home by a member of staff, which implied a blame culture. We were also concerned about the increased exposure and the potential for infection of staff, which given the lack of access to adequate PPE in care homes, particularly in the early stages of the pandemic, discussed in further detail later in the statement, the high proportion of workers from ethnic minority backgrounds employed in the sector and the disproportionate impact of Covid-19 on this community was particularly concerning. This approach had not been adopted in hospital settings, where spread of infection was also a concern and the RCN failed to see why it should be considered appropriate within care homes.

166. The RCN was of the view that greater emphasis should be placed on adherence to infection control guidance; adequate provision of the appropriate PPE, (including training in donning and doffing), Covid-19 testing for all staff and residents; staffing provision that could meet the current demands of the service; suitable rest break facilities, and the availability of private changing, showering and staff laundry facilities.

Infection Prevention and Control

Ventilation in care settings

167. 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.

168. One member working in a care home during the pandemic contacted RCND, our member support service, and reported that management had removed all portable fans and were unable to provide portable air-conditioning units due to Covid-19 restrictions. The member reported that as a consequence staff were working in "*30-degree heat in PPE*" which resulted in symptoms of heat stress.

Isolation of recipients of care following discharge from hospital and/or a positive Covid-19 test

169. Members reported a number of issues in relation to the discharge of patients from hospitals into care homes with positive Covid-19 tests. By way of example members reported confusion about the guidance on testing prior to discharge, discharging a Covid-19 positive patient back to a care home, lack of space for isolation of symptomatic patients and safety concerns around patients with dementia who were required to self-isolate. A selection of their concerns is captured below. Those with quotation marks are direct quotes from written correspondence from members, whereas those not in quotation marks are the RCND call operator's contemporaneous summaries of concerns raised by members as recorded in RCND's call logs:

a. *Possible Covid resident, Member came on shift last night - one resident returned from hospital without a swab being done before the resident was discharged. Resident refused a swab at the hospital. Resident in isolation for 14 days in separate room in the Care Home. Resident has dementia. Member is concerned for staff and resident safety* – Raised by a member working in a care home in Scotland, August 2020

b. *"Just to let you know I have been exposed to attending Covid positive resident discharged from the hospital over the last week of March. We were not provided with sufficient PPE to protect ourselves. I was down with covid symptoms, even attended A&E due to breathlessness."* – Raised by a member working in a care home in England, May 2020.

c. *"We sent a resident to hospital clear of virus (tested on admission). Our testing of residents and staff proved all negative. In the week of admission this 90yr old resident with diabetes has contracted Covid. Hospital wants to send her back....as an old-fashioned nurse I cannot understand why they would send a positive case to a virus free environment. We have successfully shielded our residents. They have obviously not done the same and their isolation of covid cases has also failed. Where do we stand?"* – Raised by a member working in a care home in England, June 2020.

d. *Member concerned about discharge of resident from hospital to care home. Has only been in hospital 3 days. Staff understanding is that resident should be tested negative twice before being discharged. This is based this on a comment made by Matt Hancock in a press conference. Nurse in charge has said that the resident has been tested negative. Member has no faith in this. There has been a total lack of communication in the home. The manager stays in her office, there are no staff meetings* – Raised by a member working in a care home in England, May 2020.

e. *Care home provider is moving in residents to their empty beds - can they do this as it puts member at risk of infection. Residents who go into hospital for day treatment - shouldn't they be isolated for 14 days afterwards* – Raised by a member working in a care home in Scotland, June 2020.

RCN member's lived experience and the SenseMaker tool

170. RCN Northern Ireland and RCN Scotland sought to capture the lived experience of being a nurse during the pandemic using the SenseMaker tool **[CS/085 - INQ000328827] [CS/086 - INQ000328828] [CS/087 - INQ000328829] [CS/088 - INQ000328830]**. Nurses were asked to share a story from their recent experience and to answer some follow-up questions related to their specific experience.

171. The SenseMaker project also allowed the RCN to analyse the issues that nursing staff had to face during the pandemic and enabled the organisation to support members during these challenging times. The Northern Ireland results were distilled into the RCN report 'SenseMaker: the lived experience of nursing in Northern Ireland during a pandemic 2020/2021' **[CS/016 - INQ000328831]**.

172. With a backdrop of uncertainty and ever-changing guidelines for nurses to incorporate into their own working practices and communicate to patients, families of patients, and members of their own team, some of the stories describe oscillating between information overload and information vacuum. This included those working in adult social care. The quote below is from a nurse working in Northern Ireland in 2021.

a. *"Bombardment of, or lack of information following COVID-19 vaccines and now positive residents and staff. Having to support both residents, staff and the families with little to no guidance and maintaining safety within the workplace. A level of uncertainty and lack of education…same for care home sector. Not only is there still the day to day running of the care home to maintain, with now increasing numbers of staff off isolating and lack of support from the trust due to likely the same issues."*

Personal Protective Equipment

173. Throughout the pandemic, RCN members raised concerns about their experience of the pandemic in the Care Sector via RCND. Examples included:

a. *"We are not being provided with masks as they still are not sure. What are we nurses and carers to be doing? Can there be a protocol that all nurses and carers regardless of which sector they belong to are asked to wear PPE strictly. Please, we are at high risk. We want to serve others but also protect ourselves."* – Raised by a member working in a care home in England, March 2020.

b. *"Due to masks going missing at my place of work we are now limited to one each per 12 hour shift. Will the masks still be effective for this amount of time."* – Raised by a member working in a care home in England, August 2020.

c. *The member has been told that the home is going into quarantine for at least 2 weeks. They have asked staff if they can stay in work for the lockdown and they will get paid for 18 hours. The member has a small son as well but if they cannot go in they stay at home. There are no cases of the virus in the home* – Raised by a member working in a care home in England, March 2020.

d. *"I work for a care home and there is nothing in place to protect us during this pandemic. There is no senior leadership in place, no PPE, no instruction on how to deal with this pandemic or what to do if one of our residents gets symptoms of Covid-19."* – Raised by a member working in a care home in England, March 2020.

e. *"Today I was called to managers office regarding an email I sent to human resources because of infection control. Manager said that it wasn't my business and I was wearing a mask and she said to take it off or leave the home. I said I wasn't going to take mask of so I left home. What can I do now?"* – Raised by a member working in a care home in Northern Ireland, March 2020.

f. *"I have been informed that there will be masks delivered to the [nursing] home but staff are not to have these unless there is concern of an outbreak within the [nursing] home. I was not sure if these should be given beforehand to prevent any outbreak as the past week patients have coughed and spat on me."* – Raised by a member working in a care home in Scotland, March 2020.

g. *"I'm an Advanced Nurse Practitioner who visits nursing homes and would like to raise my concern about a lack of PPE/ face masks available to my colleagues who work in the nursing homes. There has been one confirmed case of Covid-19 in a resident who is now in hospital but there are 15 other residents who are symptomatic and who won't be tested. The staff only have gloves and aprons but no masks and cannot get any anywhere. The situation is extremely unsafe."* – Raised by a member working in a nursing home in England, March 2020.

h. *"I work in a frailty assessment team, currently we see patients in the community i.e. in patients own homes and care homes for admission avoidance. We currently have no PPE and are expected to assess patients that could be suspected [of] Covid-19. I feel [I] would be putting myself and other patients at risk. These concerns have been raised to managers who have insisted we just continue as normal."* – Raised by a member working in a frailty assessment team in England, March 2020.

174. Clarity on when or how PPE should be used effectively to keep staff and patients safe, had been missing. Initial UK IPC guidance (version 1, March 2020), published after severe acute respiratory syndrome (**"SARS**") CoV2 was downgraded as a high consequence infectious disease (**"HCID"**) failed to reflect the standardised adoption of a precautionary approach to the protection of health and social care workers. A precautionary approach or principle emphasises taking preventative action when faced with potential harm even if scientific evidence is incomplete or uncertain. The Interdepartmental Liaison Group on Risk Assessment **("ILGRA")** suggests that the precautionary principle should be invoked when: there is good reason to believe that harmful effects may occur to human, animal or plant health or to the environment; and the level of scientific uncertainty about the consequences or likelihood of the risk is such that the best available scientific advice cannot assess the risk with sufficient confidence to inform decision-making. The guidance was confusing, and contradictory as evidenced by the following: 2.1 Routes of transmission states "*Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak*". SARS remained classified as an airborne HCID, and although a decision had been made to downgrade SARS CoV2 the route of transmission remained as airborne. The reference to predominance of droplet and contact spread via the rapid review of evidence (Scotland) did not concur with existing PHE guidance on Middle East Respiratory Syndrome coronavirus (**"MERS")** coronavirus (**"CoV"**) and an absence of hard scientific evidence or proof of droplet /contact spread as the predominant mode of spread between people.

175. The RCN considered the introduction of language into pandemic guidance such as the 'hierarchy of controls' on the use of PPE, to be both confusing and inappropriate in a situation where evidence and views on transmission routes was divided and many employers were unfamiliar with the language.

176. The RCN views the limited reference within IPC guidance to Health and Safety legislation and risk assessment process insufficient. Combined with no implementation plan, this guidance was of limited value to managers and employers with no experience of applying the hierarchy of controls in a situation where staff were exposed to a respiratory hazard of this magnitude.

177. The RCN had further concerns relating to a widely accepted view that ventilation was poor in most care homes as a result of an inability to open widows and a lack of mechanical ventilation. Stronger visibility and detail on Health and Safety requirements and how to manage the selection of PPE in situations where ventilation was known or suspected to be limited should have been developed or, as a minimum, embedded in IPC guidance. There was no indication at this time that members of the HSE were involved in or supported the development of IPC guidance.

178. Health and Safety requirements would be informed through implementation of Health and Safety regulations, namely COSHH. In this instance the hazard was the SARS CoV-2 virus, the cause of Covid-19 disease. As an infection transmitted via the airborne route, as previously described in RCN Module 3 evidence, the implementation of COSHH requires a risk assessment by the employer, identifying the hazardous substance, mode of transmission and suitable control measures, which can then be used at the point of care by health and care workers to select the level of PPE, including RPE as required.

179. The RCN considered the IPC guidance inadequate as it did not, in our opinion, reinforce the need and compliance for risk assessment based on COSHH to determine what PPE to use in the absence of adequate ventilation, a key determinant and risk for transmission of SARS-CoV-2. Instead, the IPC guidance focused on individual decision making based on risk assessment including the consideration of ventilation quality, by driving selection of PPE based on droplets and an absence of airborne risks outside of high-risk scenarios such as aerosol generating procedures (**"AGPs"**) rarely undertaken in care home settings. The RCN expected clear alignment of Health and Safety requirements in IPC guidance with unambiguous explanations of how IPC guidance would enable compliance with legislation in place to protect healthcare workers. The short reference to the need to comply with Health and Safety requirements without the detail and suitable explanation to those using the guidance who had limited experience in applying COSHH to biological hazards and the lack of an implementation plan within the guidance resulted in confusion among staff, including managers, on how to select and procure the correct level of PPE required in the context of care delivery.

180. At the beginning of the pandemic, despite early IPC guidance acknowledging the airborne route of transmission, it was subsequently stated that respiratory secretions containing the virus travelled over short distances as droplets and settled quickly under gravity and this was the dominant route of transmission. These droplets can contaminate the close environment of an infected person. Consequently, physical distancing, fluid resistant surgical face masks (Type 11R) to protect workers against exposure to physical droplets, and hand hygiene were regarded as the most important infection prevention measures in clinical guidance. Airborne transmission and the implications of this appear less important, and the role of respiratory protection was disregarded unless under specific situations such as AGPs.

181. Of significant concern at the time was guidance published by UKHSA 'Personal protective equipment: resource for care workers working in care homes during sustained COVID-19 transmission in England'. This guidance discouraged those working in care homes from wearing FFP3 masks as "*most care home workers are not expected to undertake aerosol generating procedures*" **[CS/020 – INQ000525317]**.

182. The airborne route of transmission in the view of the RCN also had significant implications for patient safety and the risks to patients who could easily acquire Covid-19 in health and care settings. UK infection prevention and control guidelines to prevent the spread of Covid-19 in health care settings and the rapid reviews of the literature undertaken by Health Protection Scotland on which it was based, identified and maintained droplet spread as the major route of infection and promoted hand hygiene as a key infection prevention measure, based on early advice from the World Health Organisation ("**WHO**"). This, as previously stated, is not in line with existing and current IPC advice (in England) on the management of MERS CoV, a member of the Coronavirus family.

183. The transmission of SARS CoV-2 occurs in the same way in care homes as in hospital settings. Early UK wide IPC guidance published March 2020, **[CS/089 – INQ000325350]** was developed for NHS settings with limited reference to care homes beyond the principles of standard infection control precautions. At this time the Government response had moved from a 'contain' to 'delay' phase in recognition

of escalating spread of infection in the UK with increased infection within wider communities, outside of hospital settings, highly anticipated.

184. Care home settings differ from hospitals in many ways and the direct application of hospital-based guidance without proportionate consideration of care home needs was considered inappropriate by the RCN. Previous guidance developed by PHE for care home settings had referred to the unlikely impact on this sector and focused on basic IPC interventions reflecting common seasonal infections and not the reality of an airborne infection with increased mortality risks for elderly and vulnerable populations.

185. The care home sector was unprepared psychologically and physically for the reality of residents and staff becoming infected and how this might be managed in a largely unqualified workforce with limited IPC expertise/education, resources and equipment, including the use of PPE. Guidance for care homes focused on broad actions such as social distancing, signs and symptoms of infection and the discharge of residents from hospitals to release NHS bed capacity. IPC guidance was limited (Annex E) **[CS/089 – INQ000325350]** with information on respiratory protection restricted to FRSM provision and no reference to Health and Safety and COSHH requirements to guide the use of RPE when caring for a resident with Covid-19.

186. The disconnect between IPC guidance developed for the NHS and the reality of the needs of community and care home settings was a cause of concern to the RCN. Updated PHE guidance 6th April 2020 **[CS/090 – INQ000574647]** advised the use of 'Aprons, gloves and fluid repellent surgical masks' where close personal contact (for personal hygiene, washing etc) was required which forms a large part of the care worker role in care homes. PHE guidance 'Covid-19 - How to work safely in care homes', published April 2020 **[CS/091 – INQ000303275]**, provided specific guidance on the use of PPE in care homes and for those providing residential supported living during the 'sustained transmission' phase of SARS CoV-2. The guidance was aligned to NHS IPC guidance at the time.

187. The positioning of IPC guidance on the use of PPE failed to describe and reinforce the need for risk assessment and led guidance users to a 'one size fits all'

approach to the detriment of risk assessment and local decision making in the context of care provision and environmental constraints including a lack of ventilation where this occurred.

188. As a key element of IPC guidance designed to protect both health professionals and patients, the RCN is unclear why, in the absence of any evidence regarding the predominant route of transmission of SARS-CoV2 via large droplets, this was changed and amended from statements included in IPC guidance in the early phase of the pandemic. This IPC guidance change directed health professionals to use surgical masks in place of RPE, ignoring the advice contained within existing PHE MERS CoV guidance (2016). SARS CoV2 remained a class 3 biological hazard, as defined by HSE's Advisory Committee on Dangerous Pathogens following downgrading of the virus as a HCID in March 2020. The RCN considered this classification as warranting a different approach to the selection and use of PPE, specifically RPE, taking into account COSHH, than was advised in IPC guidance at that time. At a time when consensus had not been reached by the scientific community as a whole on the transmission dynamics of SARS-CoV2 the RCN expected a more precautionary approach to be adopted, rather than the position of 'no evidence', to justify no change to IPC guidance.

189. Guidance for PPE for all health and care workers supporting the pandemic response was predominantly focused on hospital settings at the expense of health and care staff working in community and social care settings. By way of example, draft revisions to the PPE guidance in secondary care produced by PHE were circulated by the Academy of Medical Royal Colleges to the RCN on 28 March 2020. The RCN was astonished at the limited nature of the draft revisions of PPE guidance in that it continued to apply to acute hospitals only. The RCN highlighted the absence of consideration for those nurses and health care assistants working in the community to the CNO for England via email on 28 March 2020 **[CS/092 - INQ000328932]**.

190. The quality of PPE was also an issue for the Care Sector. The RCN heard reports directly through RCND and via RCN social media from members working in adult social care about the quality of PPE as documented below. Issues raised included a general lack of appropriate PPE. We also received concerns about the provision of reusable material masks instead of FRSMs or FFP3 masks, lack of

instructions in English on PPE received and PPE past its expiry date, by way of example, out of date goggles as referenced below. Examples within quotation marks are directs quote from written correspondence from the member, whereas those without quotation marks are the RCND call operator's contemporaneous summary of concerns raised by the member as recorded in the RCND's call log:

a. *"I work as a bank nurse between two homes. One of the homes has not got paper masks. We are told to barrier nurse*[1] *but do not have correct PPE equipment, putting residents and ourselves and our families at risk. Even if we had the basic PPE equipment, it does not provide adequate protection."* - Raised by a member working in care homes in England in March 2020

b. *Manager made a comment that instead of masks staff could wear pantyliners.* - Raised by a member working in a care home in one of the four nations in March 2020.

c. *Response to PM letter post – "Would be nice if he would ensure care homes were sent decent PPE it's not just NHS staff who are still required to go to work."* - Raised by a member working in a care home in one of the four nations in March 2020.

d. *Member has guidance from PHE saying should have fluid resistant masks - doesn't think they have these, very thin masks and writing on box in Chinese* - Raised by a member working in a care home in England in May 2020.

e. *Manager's mother made fabric face masks which all staff were made to wear Member discussed these masks with colleagues and highlighted that homemade masks weren't protecting them or service users and they should have surgical masks at least. Member was then called later and questioned over what he said. Member highlighted his concerns and manager said that masks had been ordered. Member has been placed on supervision as a result of speaking up even after he quoted NMC code and raising concerns…* - Raised by a member working in a care home in England in May 2020.

[1] Barrier nursing is a broad term that is often used alongside the terms source or protective isolation, with the aim of reducing the risk of spreading infections to others or to protect the individual themselves. In social care it may involve placing the resident in a single room or dedicated area that facilitates physical separation from others. As an infection prevention and control intervention It may also require the use of specific PPE.

f. *"Hi, I need some advice please, as our care home, haven't got proper face masks and concerned about this they have given us all (someone who made ones cloth with elasticated strings on…)"* – Raised by a member working in a care home in Wales in April 2020.

g. *Member works in Care Home - Staff have 3 surgical masks for a 12 hour shift – to be used by 1 nurse and 2 HCA's caring for the 3 patients. When not using the mask it has to be stored in a box and disposed of at end of shift. The goggles used have an expiry date of 2016. There is no hand gel left in the care home. Member's colleague has spoken to manager and been told this is all acceptable."* – Raised by a member working in a care home in England in April 2020.

191. In Scotland, in response to concerns around PPE supply, expressed by the RCN and others, a social care triage hub was established in or around 25 March 2020 and new supply routes for primary care and hospitals were set up from 30 March 2020. PPE guidance for health and social care staff was repeatedly updated, with input from the RCN and other stakeholders, including a PPE Clinical Oversight Group established by the Scottish Government. A dedicated phone number was also set up for staff to report problems with PPE distribution, following requests from the RCN for an additional mechanism for staff to raise concerns. The RCN queried, via then RCN Scotland Director Theresa Fyffe, how nursing was represented in the development of clinical guidance via the clinical cell. Fiona McQueen, CNO for Scotland, acknowledged in her email correspondence **[CS/023 - INQ000417597]** that she was fighting a medical dominance and agreed that the Royal Colleges should be involved in the development of clinical guidance although this did not come to fruition. The RCN took this to mean that there was an absence of nursing expertise in shaping the guidance, which was instead being driven by representation from other medical professionals.

192. In England, issues around the provision of PPE for both health and social care sectors were evident from the early stages of the pandemic. On 23 March 2020 **[CS/093 - INQ000417657]**, Dame Donna Kinnair wrote to the UK Prime Minister setting out the serious concerns of RCN members regarding the lack of PPE available for health and social care staff, including those working in care homes. To

the best of our knowledge, a response was not received in relation to this correspondence.

193. On 29 March 2020 the RCN responded to a request via the Academy of Medical Royal Colleges to provide feedback on a rapid review of guidance on personal protective equipment in secondary care **[CS/094 – INQ000418802]**. The RCN was very concerned that suggested changes only related to secondary care as RCN members working in community settings, which would include the Care Sector, were reporting low levels of confidence in PHE PPE guidance as well as limited availability of PPE.

194. A request to respond to further changes to the use of PPE outside of secondary care was received from the Academy of Medical Royal Colleges at 21.28 on Sunday 29th March and the RCN responded at 11.32 on Monday 30th March 2020 **[CS/095 – INQ000574517]**. The RCN response highlighted that the proposed table did not reference the independent sector within 'Recommended PPE for primary, outpatient and community care by setting' and that the guidance should be extended to social care settings. We also took the opportunity to reinforce the position that independent settings, including care homes, were undertaking both NHS activity and their own business.

195. On 31 March 2020, Dame Donna Kinnair **[CS/096 - INQ000328917]** wrote to HSE urging them to take action over inadequate supplies of PPE including that in care homes. The response received on 02 April 2020 **[CS/097 - INQ000417540]**, indicating that all reasonable steps were being taken to address PPE supply issues, did not allay our concerns. Similarly, the RCN were frustrated about the inspection and enforcement of health and safety breaches more generally. HSE stopped carrying out routine inspections in March 2020 and instead, suggested it would work closely with organisations to provide advice on workplace issues, signposting to relevant guidance and encouraging businesses to follow it. Under the Health and Safety at Work Act 1974, employers have a duty to ensure, as far as practicable, the health, safety and welfare of their employees at work. In practice, the ability to respond to concerns being raised appeared limited as there was little in the way of enforcement to prevent employers from failing to follow measures. The RCN was concerned by the failure of enforcement agencies to take action against employers who were putting the health and safety of their employees in jeopardy. The RCN

expected robust enforcement action to be taken by HSE and local authorities against employers whose actions put employees and patients at risk.

196. On 3 April 2020 we raised concerns about availability of PPE in care homes with PHE **[CS/098 – INQ000574649]** and the Minister of State for Social Care **[CS/099 – INQ000574485]**. We offered our assistance in ensuring that our members, staff and residents of care homes were protected.

197. As discussed in greater detail at paragraph 209, the RCN undertook two extensive surveys of its members working across all health and social care sectors in April and May 2020, about the use and availability of PPE in health and care settings **[CS/100 - INQ000114401] [CS/101 - INQ000328873] [CS/102 - INQ000427462].** In England these survey findings were shared with a number of relevant stakeholders including the Department of Health and Social Care (**"DHSC"**), the UK Prime Minister, via his Special Adviser **[CS/103 - INQ000328874]** the HSE **[CS/104 - INQ000417594]** and NHS England and NHS Improvement **[CS/105 - INQ000427471].**

198. The HSE acknowledged the survey results on 17 April 2020 **[CS/106 - INQ000417596]**, advising of the commitment of the HSE and other regulators in ensuring access to appropriate PPE for health and social care staff.

199. NHS England and Improvement in its response queried the shortage of respirator masks or gowns and requested more data which we subsequently provided **[CS/105 - INQ000427471]**.

200. We raised concerns about PPE procurement for both health and social care staff during a conference call with the Cabinet Office and NHS England ("NHSE") and NHS Improvement ("NHSI") on 08 July 2020 **[CS/107 - INQ000328880]**. To the best of our knowledge, the conference call only had England representatives present. This took place as a result of member concerns raised following the publication of an interim PPE procurement structure **[CS/108 - INQ000417641]**.

201. Members had raised concerns at the apparent lack of clinical presence in the structure, the lack of detail on the links with the 'Clinical and Product Assurance' (**"CAPA"**) function of NHS Supply Chain, and the lack of transparency on the

evolution of this work. Whilst the focus remained on procuring PPE that met technical standards, member concerns focused on the equivocal need for clinical acceptability of products to support its safe and effective use.

202. Meeting attendees acknowledged that local procurement was a challenge. A decision-making committee **("DMC")** had been established to assess products where questions had been raised about their suitability for health and care settings. We were informed that this DMC was made up of technical assurance individuals and regulatory bodies. We requested a nursing presence via a specialist procurement nurse on the DMC to support decision making. Whilst we understood that there was no specialist procurement nurse, three nurses were present on the DMC.

203. By way of follow up to the conference call on 08 July 2020, we emailed NHSE/I on 16 July 2020 and forwarded a number of member concerns we had received regarding PPE procurement **[CS/109 - INQ000328900] [CS/110 - INQ000427455] [CS/111 - INQ000427444] [CS/112 - INQ000427445] [CS/113 - INQ000427446]** We reminded NHSE/I that there were a number of experienced RCN members who would be happy to support evaluation of PPE procurement either via the DMC or as part of various groups looking into different aspects of current and future procurement of PPE. This was based on previous RCN involvement in procurement and clinical evaluation methodologies of consumables used by nurses to deliver patient care. To the best of our knowledge, this offer was not taken up.

204. In Northern Ireland, nursing home staff were advised of the imminent pandemic in February 2020 and urged to prepare accordingly. Nevertheless, the lack of clarity surrounding the pandemic challenged RCN members' ability to organise suitable and sufficient PPE. Furthermore, it became apparent that care homes struggled to access PPE from the announcement of the pandemic (17 March) until approximately 7 April 2020. This situation highlighted a pressing need for increased Executive intervention. Consequently, the ISNMN became more proactive in voicing its concerns, mainly through the RCN Northern Ireland lead nurse for the IHSC. In response to these challenges, the Executive began engaging more closely with the network, inviting participation in the Rapid Learning Initiative (Department of Health, 2020), which focused on the realities of the wider challenges in nursing homes during the pandemic.

205. It is worth noting that the pandemic highlighted the existing problems within the adult social sector, which effectively became a crisis on top of an existing crisis. This was acknowledged by the Health Minister who indicated his intention to conduct a root and branch review of the relationship between the mainstream Health and Social Care service and the independent sector, including potential evaluation of the merits of effectively "nationalising" the sector. Although this review has never materialised. The improved collaboration between the two sectors was a turning point in the network's level of activism and the Department's ability to respond to the needs of the sector. It vitally addressed the needs of nursing home staff and patients and built enhanced relationships between the care homes and external stakeholders.

206. In summary, the Department of Health, Chief Nursing Officer, Public Health Agency, and the Health and Social Care trusts collaborated with the RCN to address members' concerns regarding access to PPE. This engagement led to improved access to PPE, which had been limited during the initial stages of the pandemic. Increased escalation ultimately enabled nursing homes to obtain the necessary types and quantities of PPE. However, the guidance and resources provided were slow to arrive and were often challenging for the nursing homes to navigate.

207. In December 2020, we responded to a request from the Northern Ireland Audit Office to submit evidence (via a questionnaire) to inform its inquiry into the availability and use of PPE during the pandemic **[CS/114 – INQ000525153]** The resulting report was eventually published in March 2022 **[CS/115 – INQ000417702]**

208. In Wales, there were initial difficulties engaging with the government before 'cell' groups were set up to engage with the RCN and other stakeholders, including on the topic of access to PPE. These focussed initially on the NHS before including care homes as well. RCN Wales tried to press for information and answers about the PPE supply to care homes as well as the NHS. Helen Whyley wrote letters to various stakeholders including the HSE **[CS/116 – INQ000417623]** and individual Health Boards **[CS/117 – INQ000417546]** to raise issues about the supply of PPE not just in the NHS but also in social care, however it very much seemed that care homes were a second thought after the NHS in Wales.

RCN PPE Surveys 2020

209. The RCN undertook two extensive surveys of its members working across all health and social care sectors in April and May 2020, specifically about the use and availability of PPE. The first survey, titled 'Personal protective equipment: use and availability during the Covid-19 pandemic' **[CS/100 - INQ000114401]** received responses from 13,605 members, of which 1,341 responses were from across the social care sector as a whole. 76% of respondents from the social care sector worked in nursing homes, 15% worked in residential homes and 9% worked for care agencies. Of those 1,341 responses, 58% had felt pressured to care for a patient without adequate protection as outlined in the PPE guidance at the time. 74% of respondents had raised concerns about PPE, but only 18% of those reported that their concerns had been addressed fully, with 51% having been partially addressed and 31% not at all. Most of those who raised concerns did so with their manager, either verbally (74%) or in writing (8%), with 13% raising them formally with someone more senior. The remaining 6% raised their concerns either through filling out an incident/near miss form or equivalent or with the RCN or other trade union.

210. The majority of the respondents in the social care sector (89%) did not work in areas where high risk procedures including AGPs were conducted. For those respondents, only 28% reported that they had enough FRSM's to use including 17% who had enough but were concerned about the supply for their next shift. For those working in areas where high risk procedures were conducted, only 20% reported having sufficient FFP3 or FFP2/N95 masks as recommended for supporting these high-risk procedures.

211. These results reveal a significant disparity between social care staff and those in healthcare settings. Across all responses in non-high-risk areas, 49% said they had enough FRSMs in their last shift compared to the 28% in social care, and for high-risk areas 64% had access to FFP3 or FFP2/N95 masks compared to 20% in social care settings. While a small proportion of around 15% reported that they did not carry out aerosol generating procedures or other high-risk procedures that required FFP3 or FFP2/N95 masks, this still left a significant number of nursing staff without proper protection against infection.

212. 39% of respondents in social care settings who do not conduct high-risk procedures had been asked to re-use single use equipment, a comparable figure to those across all sectors who do not conduct high-risk procedures. The survey was open to all RCN members across all health and social care sectors.

213. Training on what PPE to wear was also less available in social care, with 52% of respondents in social care reporting having received training on what standard PPE to wear and when, compared to 58% across all sectors.

214. The second survey, titled 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic' **[CS/101 - INQ000328873] [CS/102 - INQ000427462]** received 5,023 responses in total of which 555 were from workers in social care. These results indicated an improvement in the supply of PPE to the Care Sector as 69% of those who did not conduct high risk procedures now had access to FRSMs, although that included 20% who were concerned about the supply of FRSMs for their next shift. This also still lagged behind the overall figure of 82% across all sectors.

215. The responses reveal a similar improvement for those who did conduct high risk procedures, with 54% now reporting sufficient access to FFP3 or FFP2/N95 masks, which also remained lower than the 75% across all sectors. The proportion of those having been asked to reuse single-use PPE had increased as well to 44%, which was now higher than the 39% of all respondents outside of high-risk areas.

216. The provision of training on what PPE to wear and when had also improved to just under 60% but this too remained noticeably lower than the 67% across all workers outside high-risk environments.

217. In this survey, 40% of respondents in social care said they had felt pressured to care for a patient with possible or confirmed Covid-19 without adequate protection compared to 34% of all respondents.

218. 58% of those working in social care reported having raised concerns about PPE with 27% reporting their concerns were addressed fully, 27% reporting that they weren't addressed at all, and the remainder reporting that they were addressed partially. These proportions were similar to those of all respondents.

219. Both PPE surveys revealed a concerning disparity between members working in social care and those in other settings, with those in social care reporting less access to essential PPE in both surveys despite overall access improving between the first and the second.

220. These survey findings were shared with a number of relevant stakeholders including the Department of Health and Social Care ("**DHSC**") **[CS/103 - INQ000328874]**, the UK Prime Minister (via his Special Adviser) **[CS/103 - INQ000328874]**, the Scottish Cabinet Secretary for Health and Sport **[CS/118 - INQ000328878]**, members of the Welsh Senedd **[CS/021 - INQ000328820]**, Audit Wales **[CS/119 - INQ000427472] [CS/120 – INQ000574488]**, the HSE **[CS/104 - INQ000417594]** and NHS England and NHS Improvement **[CS/105 - INQ000427471]**. The HSE responded on 17 April 2020 **[CS/106 - INQ000417596]**, acknowledging the survey results and noting that HSE was working closely with other Government departments including DHSC, NHS and PHE to facilitate efficient procurement and distribution of suitable and effective PPE. NHS England and Improvement noted that there had never been a shortage of respirator masks or gowns and requested more data which was subsequently provided **[CS/105 - INQ000427471]**. The first RCN PPE survey was reported in an RCN Northern Ireland press release and web story and was subsequently extensively referenced and quoted in a report published in 2022 by the Northern Ireland Audit Office on the supply and procurement of PPE **[CS/115 - INQ000417702]**. To the best of our knowledge, a substantive response to these findings was not forthcoming from the other stakeholders.

221. The RCN raised its concerns regarding the provision of PPE in parliamentary submissions to the Health and Social Care Select Committees Inquiry on Coronavirus Preparations in April 2020 **[CS/121 – INQ000525191]**. In May 2020, RCN Wales supplied a written response to the Health, Social Care and Sports Select Committee Inquiry into the Covid-19 outbreak **[CS/122 – INQ000525311]** in which we asked the Welsh Government to review the distribution arrangements for PPE in health and social care and ensure lessons are learned and future arrangements are more robust. This was particularly important to the Care Sector where care homes did not initially have access to the NHS supply chain which left both staff and residents in a precarious position. Similar issues were raised in the RCN's submission to the All-Party Parliamentary Group Coronavirus in September 2020 **[CS/123 – INQ000525181]** and in RCN's response to the Public Accounts Committee Inquiry on Covid-19 supply of personal protective equipment in December 2020 **[CS/124 – INQ000525184]**.

Fit testing of PPE

222. Given the learning from Ebola Virus Disease and MERS CoV around training on the use of PPE, the RCN was surprised that the UK was not better prepared for the Covid-19 pandemic. In addition to the shortages of PPE (as discussed elsewhere in this statement), there was also a shortage of the skills and equipment required to undertake proper fit-testing of RPE particularly FFP3 masks. This is surprising given the fact that fit testing of RPE was, and is, a legal requirement under COSHH and was a requirement under the Health and Social Care Act 2008 Code of Practice (England) (the "**Code of Practice**"), on the prevention and control of infections, which sets expected standards that all health and adult social care providers must meet.

223. A one-size-fits-all approach to the provision of PPE posed a problem for many frontline health and social care workers, as a number of brands were not producing masks to fit female faces causing many female nurses and doctors to fail fit tests.

224. For FFP3 masks, each brand is manufactured and therefore fits differently and users need to be tested separately for each brand in line with HSE requirements. This became an issue as the difficulty of procuring FFP3 masks meant that many health and social care providers had to use many different suppliers, significantly increasing the need for fit testing and use of valuable FFP3 masks to do this. Some members also reported that the supply of fit testing equipment became an issue.

225. The RCN sent an email to the HSE on 04 May 2020 highlighting member concerns regarding fit testing **[CS/125 - INQ000427437]**. In particular, members had reported that employers were deviating from published guidance when receiving masks from multiple different manufacturers. In their response dated 07 May 2020 **[CS/125 - INQ000427437]**, HSE confirmed that there was no derogation from the requirement to fit test and employers must discharge their duty by having arrangements in place to manage the risks that their employees and others are exposed to. The RCN received significant push back from senior nurse leaders on the practical implications of compliance with the need for fit testing indicating a lack of awareness and communication on this issue by HSE aligned to IPC guidance.

226. On 28 May 2020, the RCN and BMA sent a joint letter to the British Safety Industry Federation ("**BSIF**") on PPE for male and female users highlighting how nurses and doctors' safety was being fundamentally compromised by the lack of adequate and correct supplies of PPE **[CS/126 - INQ000097948]**. Members of both organisations were reporting that specialist FFP3 masks did not securely fit smaller, often female face shapes. This was despite 89% of the UK nursing workforce and 48% of doctors being female. Both the RCN and BMA urged the BSIF to future proof FFP3 provision to ensure that it fits both male and female users. A response was received on 18 June 2020 **[CS/127 - INQ000417569]** **[CS/128 - INQ000417570]** which acknowledged that one size does not fit all and several RPE manufacturers had the size range which they believed accommodated smaller face sizes but they had struggled to get these established as mainstream products within the NHS and healthcare.

227. There was mounting evidence of the unequal impact of Covid-19 on nursing staff from ethnic minorities as reported by survey respondents. The RCN's first PPE survey, published in April 2020 **[CS/100 - INQ000114401]**, revealed that, across all sectors, staff from ethnic minority groups were more likely to report that they did not have access to adequate supplies of PPE compared to their colleagues from white British groups. 47% of respondents from ethnic minority backgrounds across all sectors reported needing to use single use PPE more than once, compared to 35% from a white British background. Furthermore, 77% of respondents from ethnic minority backgrounds reported caring for patients without adequate protection compared to 44% of respondents from white British backgrounds **[CS/122 – INQ000525311]**. 21.03% of respondents working in adult social care reported being from an ethnic minority background.

228. Staff members from ethnic minority groups across all sectors reported feeling less confident in their employer's ability to protect them from exposure to Covid-19 in comparison to their white British counterparts: almost a quarter of ethnic minority staff did not feel confident at all, compared to around 1 in 10 white British staff. Although a high proportion of respondents across all sectors reported that they had raised concerns to their managers, these concerns were reported as not always addressed. Staff from ethnic minorities reported that they were less likely to have their concerns addressed in comparison to their white British counterparts. Very few reported confidential discussions about safe redeployment especially during the peak of the pandemic.

Training on PPE

229. During the response to the Ebola Viruses Disease (EVD) outbreak in West Africa 2014-2016, the RCN was invited to attend a world summit for nurses held in Madrid following the infection of a healthcare worker. Rose Gallagher attended on behalf of the RCN and produced a document in conjunction with Susie Singleton, Nurse Consultant Health Protection at PHE summarising their feedback and recommendations for the UK and wider learning for future incidents where PPE was required **[CS/129 – INQ000114366] [CS/130 – INQ000114368]** One recommendation, which was fed back directly to the Department of Health at the Ebola Stakeholder Group on 31 October 2014 identified that training, specifically around the use of PPE and RPE (and more particularly regarding the fit testing of FFP3 face masks), needed to be harmonised, quality assured and mapped to the legislative requirements contained in the Management of Health and Safety at Work Regulations 1999; the Personal Protective Equipment at Work Regulations 1992; the Safety Representatives and Safety Committee Regulations 1977; the Control of Hazardous Substances Regulations 2002; and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 across the UK. We noted that training needed to be adaptable for different settings and scenarios and should consider all staff groups. We recommended that template PPE training resources be produced, for regional adaptation and implementation, and that nursing reference groups, and other relevant stakeholder groups, be utilised to review and feed into the content of training packages.

230. The second RCN PPE survey, titled 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the Covid-19 pandemic' **[CS/101 - INQ000328873] [CS/102 - INQ000427462]** of which 555 responses out of 5,023 were from workers in social care, also highlighted a need for training on dehydration, fatigue and exhaustion while wearing required PPE. 17% of those surveyed indicated that they had not received this training.

Summary of advice given to RCN members about PPE relevant to the adult social care sector during the pandemic

231. The RCN advised members, via its dedicated PPE webpage, to not use PPE which was not fit for purpose, including PPE which:

- Did not fit correctly (for example, had a failed fit test).
- Did not meet the correct standard or specification (for example, was not CE marked to indicate that the manufacturer or importer affirmed the goods' conformity with European health, safety, and environmental protection standards or did not meet other required standards) which would include items recalled by the Medicines and Healthcare products Regulatory Agency (**"MHRA"**) or HSE, for example ear looped FFP3 masks. The RCN actively disseminated and communicated MHRA and HSE alerts on how to report RPE and PPE failures as provided by national agencies, to members.
- Had degraded material present.
- Was donated by a third party with no assurance that quality standards had been met.
- Was dirty or unable to be adequately decontaminated.

232. Members were encouraged to refer to local level policies on the use of PPE and to report any quality issues immediately to managers alongside completing a local incident form.

233. There were shortages of essential PPE across all health and social care settings, but care homes were particularly affected. Some social care workers in the Care Sector reported that they had no choice but to purchase their own where they could or accept donations which did not meet the required standards. While honourable and well-intentioned efforts were made by the public to produce PPE at home to support the pandemic response, the RCN was clear that PPE worn by care staff working in adult social care must at all times meet with required standards. As set out above, Health and Safety legislation continued to apply throughout the pandemic and we therefore discouraged acceptance of handmade PPE that did not meet those standards. **[CS/131 - INQ000328903]**

234. Another consequence of these shortages was that some managers in the Care Sector attempted to stockpile and preserve the PPE supplies they were able to acquire, and this led to reports from our members that they were being faced with disciplinary action for wearing PPE when seeing 'low risk' patients. The lack of visibility of the HSE and broader health and safety communications resulted in too

great a focus on IPC guidance that focused on risk assessments to mitigate transmission rather than blanket use of items like surgical masks for health and safety purposes. The RCN's view is that IPC guidance should complement and support compliance with Health and Safety legislation, not override it. The lack of recognition of airborne transmission of Covid-19 in the IPC guidance also posed a barrier to the use of appropriate PPE, specifically RPE to protect care staff working in adult social care.

IPC Guidance

235. While the RCN cannot comment on the decision to downgrade Covid-19 from HCID status, this decision did not justify the blanket decision in the IPC guidance to downgrade the PPE required to FRSMs only when caring for patients with Covid-19. Covid-19 was still classified as a Group 3 biological hazard, described in the HSE's list of biological agent as one that '*can cause severe human disease and may be a serious hazard to employees'*.

236. It is a legal requirement that suitable and sufficient workplace risk assessments are carried out and adequate control measures are identified as far as reasonably practicable. Individuals working in adult social care should have been empowered to decide what PPE they required based on both their own dynamic risk assessments and informed by their organisation's workplace risk assessment.

237. The reuse of single-use PPE as proposed by PHE was not supported by the RCN and posed a significant risk to health and care workers as well as their patients **[CS/132 - INQ000328904]**. Given the mounting concerns regarding limited availability of PPE, the RCN published advice to members regarding 'refusal to treat due to lack of adequate PPE' on 09 April 2020 **[CS/133 - INQ000328905]**. This advice offered a step-by-step guide to determine whether to refuse to treat. The guidance referred to the UK Infection Prevention and Control government guidelines and, in combination with the RCN's guidance document 'PPE – are you safe?' **[CS/134 - INQ000328947]**, which set out the steps that members should take to determine what they needed in order to be safe and how to escalate matters and document these for record keeping purposes if they had not been provided with the necessary equipment, training, information, or if they had any concerns relating to those. The guidance also suggested that the nurse should 'take part in identifying changes to the way that you work that reduce the risk to you short of refusing to

provide treatment at all'. It is clear that refusal to treat was a last resort only if all other measures had failed or were unavailable.

238. Early IPC guidance in particular gave little recognition to the associated health and safety obligations on employers in a pandemic situation, and while employers would be aware of their obligations, it would have been beneficial to make explicit reference to their application in a new and unprecedented situation.

239. The RCN was concerned that there was no visible HSE/HSENI input into IPC and other guidance that affected health and safety during the pandemic given the seriousness of the situation and the specific concerns over PPE. The UK IPC Cell that produced this guidance was not transparent and its terms of reference and membership were not publicly available, making it difficult to determine whether there was appropriate input into the guidance from health and safety organisations.

240. The RCN was also concerned about re-directed PPE to England from Devolved Nations. On 02 April 2020, RCN NI wrote to the First Minister, Deputy Minister and Minister for Health in Northern Ireland in strong terms, highlighting how Northern Ireland was being treated as an afterthought, particularly in relation to testing kits which were produced in Northern Ireland by Randox Laboratories as part of a UK-wide contract **[CS/135 - INQ000417519]**. Despite being manufactured in Northern Ireland, the kits were then shipped out of Ireland until such time as they made their way back to Northern Ireland under the UK supply chain. Of significant concern was that the Chief Executive of Belfast Health and Social Care Trust had been informed that a consignment of PPE destined for Northern Ireland had been "turned back". To the best of our knowledge, RCN Northern Ireland did not receive a response to this letter.

<u>The Independent Review of the UK IPC Guidance commissioned by the RCN</u>

241. The Independent Review of the UK IPC Guidance **[CS/018 - INQ000114357]** was commissioned by the RCN, conducted by Professor Dinah Gould and Dr Edward Purssell, and published on 28 February 2021. This review examined the rapid literature reviews undertaken by Antimicrobial Resistance & Healthcare Associated Infection (**"ARHAI"**) Scotland which formed the evidence base for the UK IPC guidance at the time. The Independent Review found that the rapid reviews were not conducted within the accepted procedures even for rapid reviews in

emergency situations, and that it had not been appropriately updated in the 11 months since its first publication.

242. In particular, the Independent Review found that the rapid review did not sufficiently consider evidence of airborne transmission and ventilation of health care premises despite research being published on these matters during the relevant time period. The Independent Review also found that insufficient consideration was given to evidence of aerosols generated by coughing and ordinary speech as it focused on aerosol generating procedures.

243. The Independent Review went on to conclude that the UK IPC guidance developed using this flawed review of the evidence had not been appropriately updated to address the developing situation, particularly on the use of respiratory protection. The UK guidance had not followed existing WHO guidance for emergency advice reviews and ensuing recommendations. The Independent Review recommended that a more thorough interim review should be conducted by a multidisciplinary team with multi-professional stakeholder involvement and peer review, which would continue to be updated monthly to respond to new knowledge.

244. Following its publication, the Independent Review was shared with various key stakeholders including the four CNOs **[CS/136 - INQ000417619] [CS/137 - INQ000417620]**, and a meeting was held between Rose Gallagher and the Deputy CNO for England, Sue Tranka, on 17 March 2021 to discuss it **[CS/138 - INQ000328927]**. At this meeting, there was significant push back against the findings of the Review and its recommendations by the NHS, suggesting that the RCN offered criticism but no solutions and that there already was communication and consultation by Steve Powis on IPC guidance. This was disappointing as commissioning the Review was a step that we took in part because the existing mechanisms for consultation had not sufficiently addressed our growing concerns over the IPC guidance and the lack of a response to our reasonable questions and requests for assurances from the NHS and Government. The Review itself was also generally well received by scientists, academics, and other external stakeholders.

Summary of concerns of the Adult Social Care Risk Reduction Framework

245. The RCN was asked to review draft versions of the Adult Social Care Risk Reduction Framework during May 2020 **[CS/139 – INQ000574495] [CS/140 – INQ000574498]**

246. The purpose of the Adult Social Care Risk Reduction Framework (**"The Framework**") was to help employers support more vulnerable workers in relation to Covid-19. The Framework was intended to allow workers to make decisions about their risks of infection and possible adverse outcomes from Covid-19.

247. The Framework included information and advice for employers and workers on the individual risk management process, including individual risk assessments and possible risk reduction measures as well as signposting to further sources of information. Possible risk factors highlighted for users of the guidance included: increasing age, ethnicity, sex, relevant health conditions for the clinically vulnerable and clinically extremely vulnerable and pregnancy. Possible risk reduction measures identified in the guidance included: redeployment, workplace adjustments such as reviewing the requirement to use public transport, supporting staff in following PHE and DHSC guidance on reducing workplace and workforce risk and occupational health advice and support.

248. We provided feedback to DHSC on the draft Framework on 22 May 2020 **[CS/141 - INQ000417632] [CS/142 – INQ000417589] [CS/143 – INQ000417590]**. We made a number of recommendations. By way of example, we highlighted the need for the provision of the same level of risk assessment and professional clinical support such as occupational health, expert infection prevention and control advice as well as the same hierarchy of control measures for those working in adult social care as available in NHS settings.

249. The RCN highlighted how it would like to see a strengthened focus on significantly improving wider control measures which included issues such as: working conditions, employment policies and systems that provide for greater safety, first-line protection and resilience. This included: accessible and private staff changing rooms with showers, in-house laundry facilities, provision of fit-for-purpose uniforms, proper rest breaks and facilities, safe working hours, full pay for any health-related absence, including time off to seek medical assistance and regular health assessments for shift workers. The RCN noted how these matters were fundamental for the health and safety of all and would significantly reduce the

vulnerability of any worker to illness and infection if carefully and effectively implemented.

250. The RCN opposed nursing staff being required to sign a waiver of their rights if they refused redeployment. In this respect, we suggested that our guidance on redeployment **[CS/144 – INQ000574660]** will be useful in order to fully understand our expectations in this area. We also recommended the guidance to include a statement about the health and safety risks and impact links associated with living-in and lock-in arrangements.

251. The RCN also noted that this resource was too limited in scope as it only addressed how to speak to staff with specific characteristics in risk assessments. The Framework did not make a clear commitment to the principle that staff should suffer no detriment if they are unable to continue in their role due to being at risk, nor did it mention the role that trade unions can play in all circumstances surrounding risk and risk assessments.

<u>A summary of key lobbying or campaigning the RCN undertook regarding IPC in the adult social care sector during the pandemic</u>

2020

252. In March 2020, the RCN wrote to the UK Prime Minister **[CS/093 - INQ000417657]**, the First Minister of Scotland, Nicola Sturgeon **[CS/145 - INQ000417556]**, the Welsh Minister for Health and Social Care, Vaughan Gething **[CS/146 - INQ000417538]**, and the First Minister of Northern Ireland **[CS/147 - INQ000417543]** to raise the lack of PPE available for frontline staff and the confusing guidance over what PPE to wear in which circumstances.

253. To the best of our knowledge, no response was received from the Prime Minister, but Nicola Sturgeon and Vaughan Gething both responded on 27 March and 14 April respectively and assured us that the Welsh and Scottish governments were making all attempts to secure sufficient PPE and distribute it to frontline staff **[CS/148 - INQ000417683] [CS/149 - INQ000417537]**. We received no substantive response from the Northern Irish government, but a teleconference was held on 1 April 2020 with the Executive Office, Health Minister, and CNO to discuss the matter. Despite searching, we have been unable to locate minutes from this meeting. After the conference the RCN wrote to the Department of Health to set out our concerns in writing as well**. [CS/150 - INQ000417680]**

254. The RCN responded to the 'Covid-19 – guidance on personal protective equipment in primary and community care' consultation on 30 March 2020 **[CS/151 - INQ000417700]**. Amongst other concerns, the RCN highlighted the absence of reference to those working in the independent sector, requested further clarity on the minimum PPE required in all direct care areas including eye protection, and raised concerns about the use of FFP3 masks and the need to replace surgical/fluid repellent surgical masks once moist.

255. On 31 March 2020 and 1 April 2020 respectively, Dame Donna Kinnair **[CS/096 - INQ000328917]** and Helen Whyley **[CS/116 - INQ000417623]** wrote to HSE urging them to take action over inadequate supplies of PPE. Helen Whyley expressed her concern that some NHS and social care employers in Wales were failing to follow their statutory obligations in relation to the provision of PPE. Similar correspondence was sent to all Health Boards in Wales **[CS/117 - INQ000417546]**, in which the RCN requested details be shared of the plans in place for the distribution of and access to PPE for nurses and healthcare support workers in each Health Board including those in community and care homes. A response from the HSE was received on 02 April 2020 **[CS/097 - INQ000417540]** and responses from individual Health Boards in Wales were received throughout April 2020 **[CS/152 - INQ000417547] [CS/153 - INQ000417548] [CS/154 - INQ000417549] [CS/155 - INQ000417550]** in which they sought to reassure the RCN that all reasonable steps were being taken but RCN concerns remained.

256. On 3 April 2020, the RCN wrote to PHE **[CS/156 - INQ000417681]** to raise serious concerns about the lack of access to sufficient or clinically adequate supplies or PPE and to Covid-19 testing. Without these essential safeguards, these workers were risking their own lives as well as the lives of their families and their patients. While the UK government had been clear that there was a well-stocked national supply of PPE, the reality of our members in care homes is that they weren't receiving the PPE they needed in the quantities that were needed.

257. Similar correspondence was sent to the HSE on 09 April 2020 by Theresa Fyffe on behalf of RCN Scotland **[CS/156 - INQ000417681]**, regarding the provision of PPE to health and social care workers. In their response, dated 15 April 2020 **[CS/157 - INQ000417682]**, HSE confirmed that they had been meeting with PHE

and NHSE about fit testing and regulatory requirements for FFP3 respirators, as well as the management of FFP3 products in the stockpile.

258. On 21 April 2020, the RCN submitted a consultation response to NHSE/I on its 'Guidance for infection prevention and control in health and care settings 2020' **[CS/158 - INQ000417602] [CS/159 – INQ000574520] [CS/160 – INQ000574658] [CS/161 – INQ000574519] [CS/162 – INQ000574516] [CS/163 – INQ000417685] [CS/164 – INQ000417584]**. A response was received on 22 April 2020 from NHSE/I, attaching the revised guidance and thanking RCN for its feedback **[CS/165 - INQ000417902] [CS/166 – INQ000384604] [CS/167 – INQ000417904]**.

259. On 23 December 2020, Dame Donna Kinnair, sent a joint letter along with Dr Chaand Nagpaul, Chair of the BMA, to Sir Patrick Vallance, the UK government's Chief Scientific Adviser **[CS/168 – INQ000114338]**. This was in response to the identification and communication of the new variant of SARS-Cov-2 at the Prime Minister's press briefing on 19 December 2020. In the letter, the RCN and the BMA expressed their concerns, and the concerns of their members, about the implications of the increased risk of transmission of the new variants to patients and staff through exposure at work in all health and social care settings. We asked that the precautionary principle be applied in terms of increased PPE, including a higher level of RPE for those working with patients suspected or confirmed as having Covid-19. This was to ensure not only compliance with Health and Safety legislation but to protect the workforce to reduce as far as possible sickness absence due to work acquired Covid-19. We also called for more emphasis and tailored guidance on effective ventilation within health and care environments, which was acknowledged to be poor for the purpose of diluting risks of respiratory infection and asked for the UK government to initiate a review of the effectiveness of ventilation in the health and care estate. On 13 January 2021, the RCN and BMA followed up on this letter directly with Professor Chris Whitty, inviting a more detailed discussion of the issues highlighted **[CS/169 - INQ000417648] [CS/170 - INQ000417643] [CS/171 - INQ000417627]**. Chris Whitty's office confirmed receipt on 13 January 2021 **[CS/172 - INQ000417690]**. We do not believe that a substantive written response was forthcoming.

2021

260. On 21 January 2021, the RCN and BMA wrote to the HSE with concerns about the ongoing threat posed to health and care staff following the identification of the

SARS-Co-V2 variant (VOC 2020/2101) **[CS/173 - INQ000417626]**. Both the RCN and BMA were concerned by data from NHSE which showed that the average number of health and care staff off with Covid-19 related absence in the first week of January 2021 had increased by 22% when compared to the last week of December 2020. Members of both organisations were also concerned that fluid repellent surgical face masks and face coverings, as advised at the time in most general healthcare settings, did not protect against more infective aerosols. The letter sought assurance that employers were carrying out suitable and sufficient risk assessments and called for a precautionary approach to be adopted. A similar letter was also sent to the Scottish Cabinet Secretary on 27 January 2021 **[CS/174 - INQ000417571]** and a response received on 12 February 2021 **[CS/175 - INQ000417684]**.

261. The HSE's response, dated 29 January 2021 **[CS/176 - INQ000417574]**, repeated that "*no changes to the recommendations, including PPE, have been made in response to the new variant strains at this stage, however this position will remain under constant review…Whilst HSE will not be undertaking a review, as this has already been done by those responsible for the guidance, we will continue working closely with DHSC and other government departments*". It provided links to ventilation guidance and pointed to its inspection of NHS trusts and four health boards across England, Scotland and Wales for managing risks arising from Covid -19.

262. On 28 January 2021, Dame Donna Kinnair followed up on this letter and wrote to the HSE and raised concerns regarding the adequacy of PPE **[CS/177 - INQ000417654]**. In particular, the RCN noted how the HSE guidance, published in 2008 regarding investigating the protection afforded by surgical masks against influenza bioaerosols, was predicated on influenza pandemic planning. The design and specification of fluid repellent surgical face masks would have since evolved and therefore the RCN asked for this research to be revisited and repeated utilising SARS-CoV2 as the live virus in place of influenza. The RCN believed a review of this research in the context of the Covid-19 pandemic would fill the existing evidential gap and support the development of guidance on PPE that was suitable and sufficient and offered the right level of protection to enable employers to meet their duties under COSHH.

263. On 18 February 2021, the RCN coordinated a letter to the Prime Minister highlighting concerns about the measures in place to protect health and care workers, specifically around better ventilation, PPE and awareness and research in relation to the IPC guidance **[CS/178 - INQ000114283]**. The letter was also sent to the devolved administrations. In the letter, we called for the IPC guidance to be amended to reflect and increase the level of respiratory protection as a precautionary principle for all health and care workers and update all guidance to reflect the evidence on airborne transmission ensuring representation from a truly multidisciplinary range of experts. We also called on the UK government to collect and publish consistent data on health and care workers who had contracted Covid-19 from likely occupational exposure. The letter was co-signed by a significant number of other organisations (representing professional bodies, unions and other Royal Colleges) that had come together in an informal alliance to seek to influence the UK government on these issues. In the letter we highlighted the fact that we felt it necessary to escalate our concerns to the Prime Minister because of a lack of sufficient engagement from UK government departments and agencies in addressing our concerns. We also reiterated our previous calls to adopt a more collaborative multidisciplinary approach to producing and coordinating IPC guidance. A response to this letter was not received until 7 May 2021 **[CS/179 - INQ000114417]**.

264. It was in light of the lack of response to the RCN's concerns over the inadequate protection offered by the IPC guidance over the winter of 2020-2021 that prompted the RCN to commission an Independent Review of the UK IPC guidance **[CS/018 - INQ000114357]**. Following the publication of the Review, we continued to call for a review of IPC guidance to take into account its findings and the growing evidence of airborne transmission.

265. On 12 March 2021, the RCN co-signed a letter (with Royal Colleges, professional bodies and trade unions) to the CMOs in each of the four nations calling for an urgent review of PPE and ventilation guidelines **[CS/180 - INQ000114297]**. In that letter, we requested a meeting due to the length of delay and, in some cases, entire absence in communications with senior leaders. We pointed out that the lack of response to many of our letters asking for changes to current guidance was not only professionally discourteous but also unacceptable. We received a very dissatisfactory response to this letter from Dr Gregor Smith (CMO for Scotland) on 25 March 2021 **[CS/181 - INQ000114412]** – the response was no more than a brief

acknowledgement of receipt. Further to our letter, Chris Whitty (CMO for England) agreed to a meeting to take place on 22 April 2021, but this was postponed by the DHSC on 20 April 2021 **[CS/182 - INQ000114426]**. RCN Wales did not receive a separate response from the CMO for Wales, which was not unexpected as the letter sent on 12 March was signed and sent by the RCN Chief Executive and General Secretary rather than the Director of RCN Wales. To the best of our knowledge, RCN Northern Ireland did not receive a response from the CMO in Northern Ireland.

266. On 3 June 2021, the DHSC held a PPE IPC guidance Stakeholder Engagement meeting (which was in place of the meeting with the CMO which was initially scheduled for 22 April 2021, but which now had a much larger cast of invitees). Rose Gallagher, the then RCN Professional Lead for Infection Prevention and Control and Matthew Barker, RCN Deputy Director of Nursing, attended this meeting on behalf of the RCN **[CS/183 - INQ000114332] [CS/184 - INQ000114333]**. The alliance prepared a presentation on protective solutions for airborne Covid-19 **[CS/185 - INQ000114414]** that they delivered at the beginning of the meeting and, in the spirit of transparency and collaboration, the RCN also sent in a number of questions prior to the meeting to be addressed in the scheduled Q&A session **[CS/186 - INQ000114261]**.

267. The meeting on 3 June 2021 was widely attended, including the National Clinical Director Infection Prevention & Control, NHSE, Deputy Director, PPE Policy, Briefing & Engagement, Chair of IPC Cell, Medical Director (interim), Public Health Wales, and Head of Healthcare Associated Infections and Antimicrobial Resistance Programme, DHSC, CNO for England, the CNO (interim) for Wales and Associate Nursing Officer Scotland.

268. The RCN internal briefing paper, following the meeting, documents that the meeting was a professional exchange acknowledging the differences in opinion and interpretation of evidence on both sides **[CS/187 - INQ000417668]**. The alliance openly challenged interpretation of DHSC representatives' evidence and rationale for the current status quo in IPC guidance and lack of alignment with the Centers for Disease Control and Prevention (**"CDC"**) and the European Centre for Disease Prevention and Control (**"ECDC"**) guidance. There was a consensus among alliance members that active listening had not occurred, the meeting offer had been tokenistic and answers to questions posed by the alliance required further written clarification. There was no resolution that occurred as a result of this meeting.

269. On 23 June 2021, Michael Dynan-Oakley (Deputy Director, PPE Policy, Briefing and Engagement at DHSC) wrote to the attendees of the IPC guidance stakeholder meeting **[CS/188 - INQ000114267]**. The letter purported to answer the questions that we posed in the Q&A section of the meeting but was again rather dismissive of our key concerns and did not provide any tangible means by which a wider range of stakeholders could support the revision of future guidance and resources.

270. On 8 July 2021, the RCN wrote to Mr Dynan-Oakley **[CS/189 - INQ000114265]** expressing disappointment with regards to his letter of 23 June 2021 **[CS/188 - INQ000114267]**. The questions the RCN and the broader alliance had posed were not answered adequately at the meeting or in the follow-up. We felt that the DHSC had failed to recognise the critical issue of short-range aerosol transmission of Covid-19. The RCN's letter stated that "*our members continue to report a loss of confidence in the UK IPC guidance, dissatisfied with a lack of consultation with stakeholders, in particular those represented at the meeting on 3 June*". The RCN was disappointed and surprised not to be offered a follow-up meeting as requested by the alliance.

271. On the same day (8 July 2021), the RCN wrote a joint letter with the AGP Alliance to Dr Jenny Harries **[CS/190 - INQ000300383]**, Chief Executive of the UKHSA highlighting the ongoing concerns regarding the need to recognise airborne transmission of Covid-19 outside of AGP's and the increasing evidence supporting this as a primary mode of transmission in all settings. To the best of our knowledge, we received no response from Dr Harries.

RCN's views on pandemic preparations

272. The RCN considers that the UK's pandemic preparedness was inadequate and disproportionately focused on influenza. There were multiple opportunities for lessons to be identified from prior major incidents such as the H1N1/09 influenza pandemic in 2009 **[CS/191 – INQ000035085]**, the MERS-CoV outbreak from 2012 onwards **[CS/192 – INQ000090431]**, and the Ebola Virus Disease outbreak in 2014-2016, and these lessons were available to draw on, specifically the importance and benefits of meaningful engagement with stakeholders from professional bodies who may have a role in intelligence gathering, communication or the wider pandemic

response. This specific point is also reflected in learning from Ebola Virus Disease on the value of regular and two-way communication and sharing of learning. The learning from these incidents does not appear to have been reflected in preparedness planning and an overt statement of the need to engage in and ensure transparency regarding multi-professional communication and integration into incident response groups is needed.

273. Pandemic preparedness focused only on influenza and was not a significant regular agenda item at meetings of the emergency preparedness, resilience and response ("**EPRR**") Clinical Reference Group ("**CRG**") as it was usually considered as an agenda item among other incident learning or planning, including terrorist incidents. The need to consider other potential infections with pandemic potential was made public by the CMO for England in July 2019 and this position was supported by the RCN due to the experience it gained through its planning to support Saudi Arabia with MERS-CoV. Additionally, disease X, a previously unknown infection with pandemic potential, was added as a new category to the WHO's emergency priority list in 2019. The UK, however, continued to focus on influenza despite the experience of MERS-CoV in the Middle East and SARS and the potential for a new coronavirus to emerge.

274. It is the RCN's view that the UK's preparedness and emergency planning was overly focused on planning for pandemic influenza. Other pandemic threats resulting in respiratory infections, such as coronaviruses, should have been given equal attention. It was the RCN's experience that, prior to the Covid-19 pandemic, the nursing profession was concerned that emergency planning and risk assessments were almost solely focused on flu. Whilst it was the case that a flu pandemic was identified as one of the most significant threats, the recent experience of MERS-CoV (and, earlier, SARS) had demonstrated that coronavirus diseases were also a serious and tangible threat that should have featured more prominently in the UK's preparedness plans. As has been demonstrated by the Covid-19 pandemic, it seems that there had been an assumption at the national level that the plans for dealing with a flu pandemic were adequate, or could be easily adapted, for other pandemic outbreaks. Our experience of Covid-19 shows that the emphasis in approach has to be very different for highly communicable respiratory diseases. It is the RCN's opinion, that this almost single-minded focus on flu was

very limiting in terms of the robustness and efficacy of the UK's planning and preparedness for pandemics of HCIDs that were anything other than flu.

275. The RCN is also of the view that pandemic planning was overly focused on the NHS at the expense of non-hospital settings. This seemed very imbalanced, given the fact that if infection prevention and control is not dealt with properly at the local level (i.e. in public health and primary care), then it is inevitable that the impacts of this will filter through to secondary health care.

276. Overall, our experience was that lessons we identified and shared from previous pandemics and outbreaks were not visible in the experience of planning and early phase implementation of pandemic plans. If they had been, the RCN would have been present as a stakeholder from day one and not fighting to get its voice heard and offer assistance. As discussed previously, the RCN's experience of the Covid-19 pandemic was that nursing was often excluded and previous lessons were not implemented, or even considered, as we were often not approached for information.

277. It is the RCN's view that the UK government did not adequately plan for or have the supply of PPE, specifically RPE, needed for a pandemic on the scale of Covid-19. To some extent, we believe this was due to the fact that the UK government's planning focused on dealing with a short-lived influenza pandemic which at the time was considered to be predominantly spread via respiratory 'droplets' and did not adequately consider what RPE and PPE would be needed if dealing with a respiratory disease pandemic more like SARS or MERS-CoV.

278. A report by the National Audit Office entitled '*The supply of personal protective equipment (PPE) during the COVID-19 pandemic*', to which the RCN contributed, points to some of the shortcomings of the UK government's approach to the supply and stockpiling of PPE prior to the pandemic. The RCN contributed findings from its membership survey, conducted from 10 to 13 April 2020, in relation to the experiences of nurses with regards to the supply of and access to PPE **[CS/100 – INQ000114401]**. A similar survey was again conducted from 7 to 11 May **[CS/193 - INQ000114402]**.

279. The shortages of PPE experienced in the first wave of the pandemic, revealed serious problems with how the UK stores and procures essential safety equipment and how it might manage in the scenario of a worldwide demand for PPE. Those working in care homes were particularly impacted by problems with stock availability and the slow distribution of PPE, despite the government and health agencies knowing they needed to equip services with PPE in the weeks before the crisis took hold. Existing stocks of PPE, based on modelling for an influenza pandemic, were insufficient and there was a lack of the correct RPE needed (i.e. FFP3 face masks). Without adequate and proper PPE, nursing staff put their own lives, the lives of their families, patients and recipients of care at risk. The adequacy of these supplies should have been based on the need to follow Health and Safety legislation, specifically COSHH, and should have taken into account infection control guidance which reflected the latest available scientific and clinical evidence from PHE.

280. During the first wave of the pandemic, from 19 March 2020 (when RCN records for Covid-19 enquiries begin) to 13 May 2020 (when lockdown restrictions started to be lifted), the RCN received 1,572 contacts from across all sectors through its contact centre from members raising issues in relation to PPE and health and safety concerns at work. Approximately 1,200 (76.34%) of these calls were from members working in the Care Sector, a notably higher figure (relative to the number of members) than calls from other sectors. Examples of issues affecting our members in relation to PPE are provided earlier in the statement.

281. Insufficient consideration was also given to how pandemic plans would need to be adapted to deal with a different respiratory associated pandemic, where the primary mode of transmission was not necessarily via 'traditional' droplet transmission. The emphasis on dealing with a flu pandemic seemed to limit the ability of the UK government to adapt its approach and be flexible in the face of mounting evidence from the frontline experience of the pandemic, especially in relation to the new variants of SARS-Cov-2, that airborne transmission needed to be properly factored into IPC Guidance concerning the level of PPE required for health and care workers exposed to patients with Covid-19. Development of the IPC Guidance should have involved the inclusion of a broader range of experts, drawing on expertise in sectors and disciplines outside of medicine and health care (i.e. engineers, ventilation experts and aerosol scientists). The RCN benefitted from the expertise of a wide range of specialists when producing its workplace risk

assessment toolkit. This is a key lesson which should be implemented in the development and production of future IPC guidance.

282. The Covid-19 pandemic has also shown that the social care sector had been, and in many ways continues to be, severely overlooked and underappreciated. It is clear that previous resilience planning, both nationally and locally, had not adequately incorporated the community and care home sectors. Those working in care homes were particularly impacted by stock availability and the slow distribution of PPE, illustrating that the sector was not sufficiently considered in resilience plans. The pandemic has highlighted the need for health and social care partnerships to consider and include all health and care facilities in their area, including independent sector care homes, in resilience and emergency planning.

RCN concerns about RPE

283. RPE is designed to protect the wearer from inhalation hazards (chemical or biological, for example) and must meet specific standards within the Personal Protective Equipment at Work Regulations 2002 ("**the PPE Regulations**") to ensure the item's effectiveness. This contrasts with 'source protection' where the wearing of a mask, commonly a surgical facemask or equivalent, protects the patient from infection by the wearer (healthcare professional or carer). It is the PPE Regulations and associated standards that ensure, providing the mask or respirator fits appropriately and the user is trained in its use, that hazards and respiratory risks are managed, and healthcare professionals are protected. Surgical face masks such as FRSM or Type 11R masks are classed as medical devices and must meet standards as directed by The Medical Devices Regulations 2002 ("**the Medical Devices Regulations**"). They do not, unless specifically confirmed by manufacturers, meet the standards of the PPE Regulations, and are designed to protect the wearer from physical contamination such as respiratory secretions/large droplets.

284. It is the view of the RCN that a lack of clarity on use of the term "PPE" and confusion over the definition and purpose of source control, combined with a culture of assumptions that historical influenza guidance was adequate and that IPC guidance prevailed over Health and Safety requirements including COSHH, placed healthcare workers at unacceptable risk in the workplace. The RCN spent a considerable amount of time lobbying for the UK health leaders and government to

update and strengthen IPC guidance, including repeatedly calling for RPE for frontline workers to prevent infection due to airborne transmission of SARS-CoV2.

285. **PPE stocks** - Existing stocks of PPE, based on modelling for an influenza pandemic, were insufficient. Without adequate and proper RPE, nursing and midwifery staff put their own lives, and the lives of their families, patients and recipients of care at risk. These supplies should have been based on HSE recommendations such as those made in the HSE's report '*Evaluating the protection afforded by surgical masks against influenza bioaerosols*' ("**the RR619 report**") concerning the need to comply with Health and Safety legislation, the adoption of a 'precautionary approach' to the protection of healthcare workers and taking into account infection control guidance which reflected the latest available PHE scientific and clinical evidence, not dictated by cost or opinion. It is our view that pandemic stock levels were vastly underestimated and that global demand, as expected in a pandemic, was not sufficiently considered.

286. The PPE stockpile was based on what would be required in an influenza pandemic under a reasonable worst-case scenario as set out nationally. It was not sufficient to manage the reality of the Covid-19 pandemic. The volume of PPE needed was much higher due to the extensive needs of nursing and other healthcare staff in work settings beyond hospitals, particularly for nurses working in community settings including care homes and due to disruptions to global supply and distribution chains. Shortages of fit test solution to support the use of PPE, specifically RPE by health and care workers was also problematic. The demand for PPE exceeded availability and this evolved over time and affected all care settings including adult social care. Different elements of PPE were impacted at different times and for a variety of reasons. For example, the provision of FFP3 masks was impacted not only by supply but by a shortage of fit testing solutions to support the safe use of such items. A shortage of PPE items subsequently led to the PHE publication of 'Considerations for Personal Protective Equipment in the Context of Acute Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic'.

287. PPE stored in the Pandemic Influenza Preparedness Programme ("**PIPP**") stockpile was insufficient in terms of the type and number of items required over a sustained incident period. This included a reliance on the assumption that surgical face masks would provide adequate protection for healthcare workers, with RPE such as FFP3 masks only being needed in certain circumstances. The PIPP

stockpile was based on influenza planning, not coronavirus, and did not appear to have considered learning from other coronavirus incidents. Shortage of fit test solutions also occurred indicating the amount required to support use of FFP3 masks had been underestimated.

288. IPC guidance, first published by PHE, failed to robustly acknowledge, and align with Health and Safety requirements from the earliest iterations of guidance based on SARS CoV-2 as a HCID. The RCN notes that in January 2020 the Wuhan novel coronavirus ("**WN-CoV**") which preceded the nomenclature of SARS CoV-2, was described as "*an airborne high consequence infectious disease ("HCID") in the UK*". This position supports RCN concerns referenced previously as to why influenza guidance, with a documented predominance of droplet transmission, was later adopted rather than existing guidance on the management of coronavirus such as MERS CoV. The guidance made only one reference to health and safety statutory requirements despite SARS CoV2 being classified as a HCID at the time. It stated "*The hospital should be mindful of its responsibilities to persons who are not employees, under the Control of Substances Hazardous to Health Regulations 2002 and The Management of Health and Safety at Work Regulations 1999*". This trait was continued once UK IPC guidance development was coordinated by NHSE.

289. On 28 January 2021, Dame Donna Kinnair wrote to the HSE and raised concerns regarding the adequacy of PPE **[CS/177 - INQ000417654]**. In particular, the RCN noted how the HSE guidance, published in 2008 regarding investigating the protection afforded by surgical masks against influenza bioaerosols, was predicated on influenza pandemic planning. The design and specification of fluid repellent surgical face masks would have since evolved and therefore the RCN asked for this research to be revisited and repeated utilising SARS-CoV2 as the live virus in place of influenza. The RCN believed a review of this research in the context of the Covid-19 pandemic would fill the existing evidential gap and support the development of guidance on PPE that was suitable and sufficient and offered the right level of protection to enable employers to meet their duties under COSHH.

Risk Assessments and IPC Guidance

290. Limiting stakeholder engagement impacts on the ability to review guidance and consider its implications and implementation across care settings. The RCN continuously raised its concerns that the IPC guidance was inconsistent with the

evidence on airborne transmission and was defective in terms of failing to reinforce the need for health and care employers to consult staff and undertake effective local risk assessments that reflected the needs for flexibility in infection control.

291. In the early months of the pandemic, national guidance and policy on PPE did not maintain pace with the changing risks and emerging realities of the virus. The RCN considers that the UK IPC guidance was slow to be revised and not standardised, with hospital and non-hospital settings provided with different guidance by different organisations in England. Leading on from this, it is unclear how literature reviews from Health Protection Scotland were commissioned and how information gained was scrutinised given its critical importance in shaping what became UK IPC guidance. The RCN considered it important that the most up to date data and knowledge on emerging variants such as increased transmission dynamics, be reflected in PPE guidance, or where evidence was not available, risk assessment via COSHH is promoted and a precautionary approach to the use of PPE considered.

292. As previously discussed, the RCN views references to Health and Safety legislation and the risk assessment process within IPC guidance as insufficient. Lack of understanding of the hierarchy of controls by employers and an absence of an implementation plan, meant that the guidance was of limited value to those who needed to understand and apply it.

293. The RCN's view is that IPC policies, as developed by the UK IPC cell from March 2020 (such as Version 1.0 of Guidance for Infection Prevention and Control in Healthcare settings) **[CS/089 - INQ000325350]** used language that influenced the use of PPE as directed by the IPC guidance, which led to a lack of prominence of the need for focused organisational and local decision-making informed by risk assessment under COSHH.

294. Version 1.0 of the UK IPC guidance (undated) **[CS/089 - INQ000325350]** is described as 'good practice' in the document however in reality this was viewed as mandatory. The reader is directed to Table 1 (page 24), 'Transmission based precautions: Personal protective equipment for care of patients with pandemic COVID-19' which advises the use of FFP3 masks only for AGPs or when present in an Intensive Treatment Unit or High Dependency Unit setting. It further states that in a general ward setting a surgical mask is sufficient, citing '*PPE for close patient*

contact (within 1 metre) also applies to the collection of nasal or nasopharyngeal swabs'. The guidance includes a very brief reference (two sentences) to care home settings, intended to assist with the implementation of standard infection control measure and transmission-based precautions, applicable in all care settings. There is, however, no overt reinforcement or reference to the need for risk assessment under COSHH taking into account Table 1 recommendations given close contact with patients or residents who may be coughing or expelling secretions as a result of nasogastric tube insertion, pharyngeal swab collection or other interventions. Such scenarios were a cause of concern to members as they clearly identified such situations as posing an increased risk for the transmission of infection in healthcare and to a lesser extent care settings where such procedures were generally carried out less regularly.

295. Some RCN members reported a lack of support when requesting RPE in circumstances when IPC guidance recommended surgical face masks as the IPC guidance was interpreted as unchallengeable. This combined with minimal visibility and alignment of health and safety statutory requirements and wider lack of local expertise in risk assessment of respiratory hazards left RCN members feeling unprotected and unsupported.

296. As previously discussed, a lack of PPE led some managers including those in the Care Sector to 'stockpile' and preserve PPE supplies. As a consequence, some RCN members in different settings reported that they were told they could face disciplinary action for wearing PPE to see 'low risk' patients or residents. Such scenarios represent a lack of understanding of fundamental health and safety responsibilities by managers in conjunction with IPC guidance inadequately reinforcing the need for local COSHH risk assessment as opposed to blanket use of specific items such as surgical face masks as described in IPC guidance. As described earlier in the statement, the lack of visibility of the HSE and wider health and safety communications resulted in a dominance of IPC guidance without a complimentary focus on health and safety requirements and aligned educational needs. This, we believe, led to confusion and an inadvertent prioritisation of IPC guidance content in the minds of managers who lacked experience to objectively interpret its application in the workplace. It is the view of the RCN that IPC guidance should be complementary to, and enable compliance with, Health and Safety legislation, not take precedence. The RCN's view is that the lack of recognition in the UK IPC guidance that SARS CoV2 could be spread via the airborne route, as

recognised in MERS CoV and SARS clinical guidance, outside of aerosol generating procedures, was also a major barrier to managers and employers adopting a proportionate and focused approach to the protection of health care workers in line with existing requirements.

297. Many RCN members worked in close proximity to patients or residents 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 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 were 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:

a. On 30 March 2020 a member contacted us from a care home in England as they suffered from asthma and the employer was ignoring requests for a risk assessment.

b. A member working in a nursing home in Wales contacted us on 15 July 2020 as she had been furloughed since March 2020 due to chronic health conditions and a weakened immune system but was being asked to go into work for Covid testing without a risk assessment and threatened with being reported to the health board if she refused.

c. On 8 August 2020, we heard from a member who reported that although a risk assessment had been undertaken, she felt that she was being pressured into working in an area that the risk assessment said she should not work in.

298. As previously discussed, the RCN subsequently developed its own Covid-19 risk assessment toolkit for its members working in both the NHS and care homes, which was launched on 23 December 2021 to members and non-members **[CS/083**

- INQ000114284] [CS/005 - INQ000114307] [CS/084 - INQ000328953]. The resource aligned IPC and Health and Safety requirements and provided advice on relevant Health and Safety legislation which remained in place throughout the pandemic.

299. Given the shortages of PPE experienced particularly during the early stages of the pandemic, PHE produced 'The Public Health England Acute Shortages Guidance' on 17 April 2020 which aimed to highlight the "*sessional use and re-use of PPE when there are severe shortages of supply. The considerations are to ensure that health and care workers are appropriately protected from Covid-19 where items of PPE are unavailable and should be considered as temporary measures until the global supply chain is adequate to meet the UK's needs*". This followed the decision to downgrade SARS CoV2 as an HCID. This decision by the UK government did not remove the need for nursing staff and other health professionals to have access to and use of PPE, including RPE in line with risk assessment and the classification of SARS CoV2 as a Group 3 biological hazard. A Group 3 hazard is described in the HSE's Approved List of biological agents, as a biological agent that '*can cause severe human disease and may be a serious hazard to employees*'.

300. As discussed earlier in the statement, the RCN considers that the decision to downgrade SARS CoV2 from a HCID on 19 March 2020 did not, in the view of the RCN, justify the blanket application of IPC guidance on use of FRSM when caring for patients with Covid-19 as described in NHSE and NHSI correspondence dated 20 March 2020 **[CS/194 - INQ000252604]**, regarding the supply and use of PPE and associated FAQs guidance of the same date **[CS/195 - INQ000384374]**. The FAQs do not refer readers to the need for risk assessment nor do they make reference to health and safety requirements under COSHH. This, together with the IPC guidance, served to override Health and Safety legislation without consultation or transparency on decision making.

301. As previously discussed, it is a legal requirement that suitable and sufficient workplace risk assessments are carried out and adequate control measures identified to reduce risk as far as reasonably practicable, in accordance with Regulation 3 of the Management of Health and Safety at Work Regulations 1999 and COSHH. Individuals working in the Care Sector should have been enabled to conduct their own dynamic risk assessment in conjunction with their organisation's

own workplace assessment and permitted to decide the correct PPE on the basis of these assessments. Anecdotal evidence from members indicated that such workplace risk assessments were absent or, where they did exist, were inadequate. Reference to the hierarchy of controls as described in IPC guidance of March 2020 was, in the view of the RCN confusing as this represented unfamiliar language to many employers and staff (except health and safety professionals employed by the organisation), was not implementable given the airborne route of infection and poor ventilation in many areas and did not emphasise the risk assessment aspects of controls under COSHH.

302. The disappointing response from PHE dated 17 February 2021 **[CS/196 - INQ000114314]**, noted how the UK-wide IPC cell had undertaken a review of the evidence and had determined that no changes to the current PPE requirements were needed. The issue was of particular concern at that time due to the emergence of a more transmissible variant of SARS CoV-2 and the implications for infection and the increasing absence of healthcare professionals either due to infection with Covid-19 or shielding. This response prompted the RCN to commission an Independent Review of the UK IPC guidance (the "**Independent Review**") **[CS/018 - INQ000114357]** published on 07 March 2021. This was not a measure the RCN would have expected ever to have to take, but the organisation felt compelled by the inaction of the UK IPC cell, PHE and the UK government. The Independent Review received significant push back from senior health leaders in the four countries on publication. Despite push back by UK health leaders and IPC specialists aligned to the UK IPC cell, the report was widely shared internationally and acknowledged as exemplary work with implications for learning and the management of future pandemics. Given that the UK IPC cell reported that UK IPC guidance was aligned with WHO guidance on Covid-19, the RCN does not understand why existing internationally based methodologies which were available from WHO at that time were not followed.

303. The Independent Review acknowledged that there was a need for the rapid synthesis of the available infection prevention and control evidence at the beginning of the pandemic when the novel coronavirus first emerged. Twelve months into the pandemic, the continuing use of the same rapid review to inform UK wide-guidelines for infection prevention and control was questioned, opinions about the way that Covid-19 was transmitted had changed, and it was becoming apparent that airborne

transmission of SARS-CoV-2 beyond the technical process of aerosol generating procedures was possible. The Independent Review also highlighted that the IPC guidelines omitted detail on the importance of ventilation and advised that higher level PPE must only be provided in certain high-risk settings like intensive care, however as a result of risk assessment it is the responsibility of individual employers whether or not to provide this more widely to other staff.

304. In Wales, NHS Wales Chief Executive, Dr Andrew Goodall afforded the RCN the opportunity to comment on the document 'NHS Wales Covid-19 Operating Framework – Quarter 2 (20/21)'. In its response dated 03 July 2020 **[CS/197 - INQ000417551]**, RCN Wales was pleased to note that the RCN's concerns regarding workforce and well-being remained a priority, especially in regard to availability of PPE for both NHS and the Independent Sector (including adult social care providers), and risk assessments for our colleagues from ethnic minorities and older colleagues. However, the RCN expressed concern that there was no assurance given that anyone being admitted to a care home or returning to one from hospital would be tested before entering the home.

305. Risk assessments were especially important to the nursing workforce in light of the number of Covid-19 deaths in both colleagues from ethnic minorities and older colleagues. However, the RCN was concerned that the risk assessment for ethnic minorities was not tailored to the evident disparities of the risks and outcomes of Covid-19 that were known at that time. In particular, the Bangladeshi community had twice the risk of death compared to those of white British ethnicity and the risk was considerably higher than any other ethnicity.

306. The RCN acknowledged emerging evidence on the transmission of SARS-CoV-2 via the air and called for this to be embedded in the UK government's campaign through broader risk assessments and access to PPE in our 'RCN position on Covid-19', dated 5 January 2022 **[CS/198 - INQ000417529]**, and 'RCN position on personal protective equipment (PPE) for Covid-19', dated 07 January 2022. **[CS/199 - INQ000417530]**

307. In light of the lack of traction with DHSC and PHE on the issue of risk assessment for health and social care workers working in close proximity to patients who have or are suspected to have Covid-19, the RCN worked on developing its

own risk assessment resource for its members to plug the gap between IPC and health and safety requirements. Developed and reviewed with a range of stakeholder organisations, who worked or had members across all health and care settings, including adult social care, the RCN's Covid-19 workplace risk assessment toolkit was launched on 23 December 2021 **[CS/083 – INQ000114284] [CS/005 – INQ000114307]** as set out earlier in the statement.

Reconfiguration of public health services and loss of IPC skills

308. In the RCN's view, the resilience of the health system, and the quality and coherence of pandemic and emergency planning, had been undermined by a series of significant restructures and reorganisations within the NHS in England and the Department of Health, which started with the Lansley reforms in 2012. As a result, by 2018/19, the NHS and UK government had lost much of its corporate memory around the lessons learned from prior pandemics or incidents. Under the Lansley reforms many IPC posts that had routinely supported Adult Social Care settings were lost which put additional pressure on remaining IPC services for this sector during the pandemic.

Changes to the regulatory inspection regime

309. As previously discussed, in England, the Code of Practice, published in 2015 **[CS/200 – INQ000114400]**, placed a requirement on providers of regulated activity to have in place policies and procedures appropriate to regulated activity. Care homes and other providers had, in 2015, a regulatory requirement to have in place policies to manage outbreaks of communicable infections in addition to systems in place to manage the occupational health needs of staff in relation to infection. Both policies should have included the requirement for the use of PPE including fit testing where required. There was no requirement for a policy on pandemic preparedness or management. Whilst we are unable to provide specific dates Rose Gallagher the then RCN Professional Lead for IPC recalls raising concerns verbally at national for a in 2018-2019, including the NHS external coproduction group for non-hospital organisations, , that outside of the NHS, the CQC had not delivered on its regulatory responsibilities with limited assurance on IPC for adult social care, to the extent of ensuring that effective systems were in place to meet criteria 1, 9 and 10 of the Code of Practice (which broadly relate to having systems in place to manage and monitor the prevention and control of infection (1), having and adhering to policies

that will help to prevent and control infections (9) and having a system in place to manage the occupational health needs of staff in relation to infection (10). In this regard, the RCN requested that the CQC conduct a focused inspection in adult social care to strengthen non-hospital-based IPC provision. Despite this, the RCN is not aware of consideration being given to providers, such as care homes, to being assessed in pandemic planning with regard to meeting the fundamental requirements of the Code of Practice or their ability to escalate issues if required.

RCN's view on the monitoring, investigation and enforcement of IPC measures in care settings, including by the HSE

310. The RCN wrote to both the HSE **[CS/096 - INQ000328917]** and HSE NI **[CS/026 - INQ000400948]** on 31 March 2020 raising members' concerns that a number of health and social care organisations were in breach of their obligations under Health and Safety legislation in relation to the provision of suitable and adequate PPE in all settings, including the Care Sector. The letter to HSE NI highlighted the reports received from members regarding fit testing of FFP3 masks not being widely available. In the absence of fit testing, health and care workers were being asked to wear FFP3 masks which they had not been trained to use, resulting in the wearing of potentially ill-fitting equipment and placing them at risk of infection. Although more limited in application than in hospitals settings, AGPs may be carried out in the Care Sector although this varies dependent on the level of care required.

311. Concerns had also been raised that the IPC guidance was being interpreted by employers in response to what PPE they had available rather than what would best protect staff. The RCN also highlighted the emergence of evidence suggesting Covid-19 was being transmitted by asymptomatic carriers. A response from HSE was received on 01 April 2020 **[CS/201 - INQ000328918]** in which they noted they were working closely with the Government and reiterated how an employer must not carry out work which is liable to expose their employees to a substance hazardous to health, such as the Covid-19 virus, unless a risk assessment had shown it was not reasonably practicable for that employer to prevent exposure. In those cases, it was the employer's legal duty to ensure that measures were put in place to adequately control exposure to the virus.

312. Responses were received from HSE on 01 April 2020 **[CS/198 - INQ000328918]** and 02 April 2020 **[CS/097 - INQ000417540]** which noted that HSE had been engaging with PHE and NHSE about fit testing and regulatory requirements. This did little to reassure RCN members that fit testing would be routinely undertaken.

313. The RCN sent an email to the HSE on 04 May 2020 highlighting member concerns regarding fit testing **[CS/125 - INQ000427437].** In particular, members had reported that employers were deviating from published guidance when receiving masks from multiple different manufacturers. The RCN understood from anecdotal evidence that employers had submitted action plans and risk assessments to the HSE to mitigate the issue and move to a process of checking rather than fit testing PPE in the short term. In its response dated 07 May 2020 **[CS/125 - INQ000427437]**, HSE confirmed that there was no derogation from the requirement to fit test and employers must discharge their duty by having arrangements in place to manage the risks that their employees and others are exposed to. The RCN received significant push back from senior nurse leaders on the practical implications of compliance with the need for fit testing indicating a lack of awareness and communication on this issue by HSE aligned to IPC guidance.

314. Further correspondence was sent to HSE on 27 May 2020 regarding the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (**"RIDDOR"**) and the RCN's expectation that all health and care worker deaths related to Covid-19 are reported to the HSE as occupational fatalities **[CS/202 - INQ000417578] [CS/203 - INQ000417579]**. The HSE responded on 03 June 2020 and noted that diagnosed cases of Covid-19 were not reportable under RIDDOR unless there was reasonable evidence that work-related exposure caused the worker's death **[CS/204 - INQ000417580]**.

<u>RCN's concerns in respect of the investigation, monitoring and reporting of Covid-19 infection, self-isolation and deaths of adult social care workers</u>

315. On 30 July 2021, I understand that Jude Diggins (Director of Nursing, RCN) and Rosemary Gallagher MBE (RCN Professional Lead for IPC) met with the CNO for England, and the Deputy CNO **[CS/205 - INQ000114273]**. The RCN had proactively reached out to arrange this meeting in order to offer support for a review of the IPC guidance, to explain the work the RCN was planning on doing to support

members working in adult social care, amongst other settings, with risk assessments, and to raise concerns about health and care worker infection data and the need for greater detail on inequalities. I understand that Jude Diggins and Rosemary Gallagher came away from that meeting feeling like the RCN had not been successful in influencing the CNO and Deputy CNO on the important issues we raised. Whilst the RCN appreciated the opportunity to liaise with the CNO and Deputy CNO and to share our willingness to offer support, we felt that our concerns would not translate into action. No changes were made following this meeting, for example, to the quality and extent of collation of health and care worker infection data despite our concerns. The RCN wanted accurate collection, recording and reporting of health and care worker deaths in all settings to be made publicly available.

316. On 05 August 2021, the RCN wrote to HSE expressing concerns at the reporting of occupational health and care worker deaths from Covid-19 **[CS/206 - INQ000417669]**. The RCN expected all health and care employers to RIDDOR report all cases of health and care workers contracting Covid-19 as disease incidents where they have been exposed to patients with suspected or confirmed Covid-19. The RCN expressed concern that HSE did not have higher numbers of reports considering the emerging evidence suggesting that more than 200 health and care workers had died. In its response dated 17 August 2021, HSE noted that diagnosed cases of Covid-19 were not reportable under RIDDOR unless there was reasonable evidence suggesting that a work-related exposure was the likely cause of the disease **[CS/207 - INQ000417581].** HSE noted how it was for the employer to consider whether or not a confirmed diagnosis of Covid-19 was likely to have been caused by an occupational exposure and to make a decision on whether a report is required.

317. The RCN was also concerned about structural discrimination and institutional bias creating workplace conditions that also increased the level of risk for ethnic minority health and social care workers. The RCN undertakes a survey of its UK membership's views and experience of employment every two years and has done so for the previous two decades. The 2019 employment survey, open to members across all health and care sectors **[CS/208 - INQ000328765]** found that:

i. Nursing staff from ethnic minorities across all sectors were more likely to work additional hours and far less likely to be employed in higher pay grades;

ii. 65% of black respondents and 61% of Asian respondents across all sectors are the main or primary breadwinner in their household in contrast to 55% of white respondents; and

iii. 48% of Asian respondents and 47% of black respondents across all sectors had experienced bullying from colleagues, compared to 38% of white respondents.

318. This contextual information indicates multiple pressures, which may result in greater exposure of staff from ethnic minorities to risk. In addition, it highlights why staff from this group may be reluctant to ask their employers for a risk assessment or redeployment, fearing that they will be viewed negatively by management or colleagues as asking for 'special treatment'. Taken together, these findings suggest that there are problems with both overt and unconscious racism, structural discrimination, and institutional bias.

RCN lobbying on the monitoring and reporting of health and social care workers' deaths

319. On 4 May 2020, Dame Donna Kinnair and other RCN representatives attended a meeting of the Association of Directors of Adult Social Care Services (**"ADASS"**) (England) **[CS/209 – INQ000574710]**. At this meeting, both organisations agreed that the recording and reporting of deaths of health and care workers were inadequate. Issues around staff being asked to work long hours and especially in 'lock-ins', testing and pay, particularly inadequate SSP, was also discussed.

320. It was also agreed that it was important to increase the visibility of the Care Sector and the understanding of the nursing role within it with the aim of achieving parity with the NHS.

Matters relating to end-of-life care

321. The RCN was aware of concerns circulating amongst the general public regarding DNACPRs being applied wholesale to groups of people. To the best of our knowledge the RCN did not receive reports of blanket DNACPR applications being applied to a specific group for example, based on age. Although not specific

to the Care Sector, the RCN was, however, contacted by a member working at an NHS Trust in April 2020, who reported that a new protocol had been issued for suspected and actual Covid-19 patients not to be actively resuscitated. In October 2020, the CQC produced a report, '*Protect, respect, connect – decisions about living and dying well during Covid-19'* regarding the concerns. In response, the RCN affirmed via press release its position that there must never be blanket use of DNACPRs and that end-of-life care must always be delivered with the utmost compassion and as part of a personalised care plan **[CS/210 - INQ000328843].**

322. Members voiced a variety of concerns in relation to end -of-life-care via RCND and posted comments on RCN social media, a selection of which are provided below:

(a) *Member is a Specialist Palliative Care CNS [Clinical Nurse Specialist]. Dealing with end-of-life patients, typically in the last 6 months of life. Provides emotional and symptom control support, with visits and proactive contact. Due to the current pandemic, member and her team were told to discharge their whole case load of 230 patients. If they need support, the patient can ring in. Member is now working with the hospice at home team. Member is extremely concerned about the case load of patients. There are patients that do call in if they need support, but there will be a large number of them who won't, or can't due to being so unwell.*

(b) *Member works in the community - frequently works alone. Employer has told community staff that, if the Covid-19 situation escalates, they will be expected to decide whether to place DNACPR on patients. Nurses will also be expected to certify death. Staff raised concerns about this and were told an hour's online learning would be provided re verification of death. Member concerned about NMC implications, and the level of responsibility nurses being expected to take here.*

323. The RCN provided a number of resources to its members in respect of end-of-life care. This included publication of a Covid End of Life Community Charter in March 2020 **[CS/211 - INQ000328853]**, in collaboration with Marie Curie, Hospice UK and the Royal College of General Practitioners **("RCGP")**, which the RCN endorsed. The aim of the charter was to provide ethical guidelines to ensure the best possible palliative and end of life care to those affected by the Covid-19

pandemic. The charter highlighted eight key principles to guide this type of care, namely: respect, minimising harm, fairness, working together, keeping things in proportion, flexibility and good decision-making.

324. We also issued joint guidance with the RCGP, Hospice UK, National Nurse Consultant Group Palliative Care and the National Association for Hospice at Home on the verification of expected adult death on 09 April 2020 **[CS/212 – INQ000574694]**, applicable in both the NHS and Care Sector settings. The guidance aimed to provide a framework for the timely verification of expected adult deaths by experienced (assessed as competent) registered nurses and was published in direct response to the Covid-19 outbreak to include IPC precautions, the use of PPE, medical certificate of cause of death, referral to a Coroner and notifiable diseases.

325. In April 2020 **[CS/213 – INQ000328867]** the RCN published guidelines for nursing staff having to initiate challenging and courageous conversations remotely as part of end-of-life care during the Covid-19 pandemic. The principles were based on having such conversations in the face-to-face setting but adapted for telephone or video consultations. The guidance included: ensuring a quiet and private space to have the remote consultation, establishing a shared understanding of the individual's condition and potential for sudden deterioration, agreeing the person's priorities and goals of care and how this would be achieved, and discussing and agreeing a recommendation about cardio-pulmonary resuscitation.

326. In May 2020 **[CS/214 - INQ000574709]** the RCN launched an online course for end-of-life care during the Covid-19 pandemic. The course, which was available to all nursing and midwifery staff across all sectors, including non-RCN members, aimed to support the delivery of dignified end of life care and help nursing and midwifery staff recognise the needs of people who are dying and their families. The course content included: tools to prepare a person and their families for end of life, legislation and ethical frameworks underpinning advanced care planning, the principles of sensitive communication styles and effective interpersonal interaction and recognising and supporting the needs of families and carers of the dying person.

327. The RCN also published FAQs on death verification, laying out and last offices published 27 May 2020 **[CS/215 - INQ000328762]**. The guidance included PPE and

IPC requirements in these situations, including the differences between Northern Ireland and the other three nations. In England, Scotland and Wales, there was no requirement for a body bag where the deceased was known or suspected to have been infected with Covid-19, whereas Northern Ireland required measures to help prevent the release of aerosols from the deceased person's mouth as well as the use of an appropriate body bag.

Visiting restrictions and alternative methods of contact

328. 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 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 rights are respected and upheld accordingly, particularly as someone neared the end of their life.

329. RCN members working in adult social care raised a number of concerns about the impact of visiting restrictions as well as the lack of clarity and consistency in their application:

a. A member working in a care home in England contacted RCND on 3 April 2020, reporting that two new residents were being allowed to have visitors while existing residents were not.

b. A member working in a care home in England contacted RCND on 16 July 2020, saying that management had made an exception to allow visitors for one resident, which had now caused other residents to question why they can't have visitors as well as her own concerns that she may become ill from the visitors.

c. In October 2020, a lead nurse in a Scottish care home recalled finding it especially difficult to help families say their last goodbyes while visits were not permitted "*It was very hard. It felt wrong, but there wasn't another option*".

d. On 29 April 2021, a member working in a nursing home in England was warned that they may be disciplined if visitors on her shift did not wear proper PPE as required. They felt this was unfair as it is not possible to constantly observe visitors.

330. As discussed later in the statement, social care workers 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. Some health and care workers reported feeling traumatised by aggressive and forceful relatives.

331. In response to such concerns, the RCN published a position statement **[CS/216 – INQ000574706]** and FAQs **[CS/004 – INQ000574525]** on visiting arrangements in care homes in December 2020. While the RCN recognised the need to reduce the spread of infection in care homes, particularly as many residents are vulnerable, the benefits of visiting and the distress of being alone are also well established and documented.

332. 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.

333. After the first lockdown in March 2020, visiting restrictions in care homes began to ease and outside visits were introduced. 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.

RCN views on access to other healthcare services throughout the pandemic

334. In the early weeks of the pandemic, limited numbers of RCN members reported the suspension of some routine servicing of equipment by employers. By way of example, in April 2020 a care provider in the South-West of England was advised by the company from which they loaned equipment that the routine servicing of equipment would be suspended until 1 July 2020 in order to help maintain social distancing and self-isolation requirements and to limit travel to essential journeys only. This raised a risk of malfunctioning equipment and potential equipment shortages. The RCN's position, captured in a position statement dated 22 April 2020 **[CS/217 – INQ000574744]**, was that all equipment used to support patient care should receive scheduled maintenance to ensure patient and staff safety.

335. Specialist staff were diverted away from vital care services for people with learning disabilities which will have impacted upon health outcomes and may have increased the use of restrictions of liberty, such as restraint and isolation.

336. Diagnostic overshadowing[2] was a concern for people with learning disabilities during the pandemic. To receive equal access to healthcare, people with learning disabilities require reasonable adjustments, which may include specific communication and physical adaptations.

337. An absence of meaningful activity during the pandemic, which can lead to behaviour that causes concern and requires increased restraint, was also concerning. Other issues related to care plans not having been updated, relevant medication reviews not undertaken, and care and support centres being closed. Nursing staff had to prioritize people who were particularly vulnerable and those who were struggling to adapt to changes in routine as a result of the pandemic.

338. The transition to digital appointments and the use of telemedicine accelerated at pace and scale during the pandemic. There were extensive efforts by staff and

[2] Diagnostic overshadowing happens when symptoms of physical ill health are wrongly ascribed to someone's mental health, behaviour or learning disability

employers to maintain access to health and care services in the context of heightened restrictions and social distancing. However, not all health and care services could be delivered online or with the support of technology which led to many treatments and care being postponed during the peak. The pandemic highlighted how important it was for people to be able to access a wide range of health and care services including care in general practice, the community and in care homes.

339. Despite challenges, remote consultations enabled some individuals to access and utilise health and care services. They supported greater flexibility, making it more convenient for many individuals to access healthcare, in particular general practice appointments and follow up consultations. Technology, however, brought limitations for service users as well as benefits. Many people with learning disabilities could struggle to independently use technology. Virtual calls may have presented a challenge and cannot necessarily be adapted to cater for different needs.

340. Digital exclusion may also affect older people, including those receiving care. Prior to the pandemic there were an estimated 4 million older people that did not have access to the internet **[CS/218 – INQ000574743]**. Older people with cognitive impairment or dementia, may not be able to access remote consultation without help. Remote assessment may also not be able to adequately identify if there are issues relating to safeguarding for those accessing care, leaving vulnerable people, including those in the Care Sector, at risk.

341. In order to facilitate remote consultations, the RCN produced guidance for best practice during Covid-19 restrictions **[CS/219 – INQ000328866]**. This included a decision tree to support the triage process and the need to consider reasonable adjustments for those who may have a learning disability or cognitive impairment.

Locked-in staffing arrangements in the adult social care sector

342. 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. The RCN published a position statement on 14 May 2020 addressing the arrangements **[CS/006 – INQ000553909]**.

343. 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.

344. 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.

345. 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.

<u>The harassment of nursing staff in adult social care during the pandemic</u>

346. Nursing staff working in the community, delivering treatments and support in peoples' own homes, reported to the RCN that they were experiencing harassment and abuse from members of the public. This included verbal intimidation as they carried out their duties. At the time of the RCN submission on the proposed Coronavirus Bill in March 2020 **[CS/220 - INQ000114407]**, such behaviour was escalating.

347. The RCN published a separate position statement on bullying and harassment on 25 March 2020 **[CS/221 – INQ000587566]** to make it absolutely clear that any bullying and harassment from any source was completely unacceptable and reinforced the legal duties on employers to provide a safe and healthy working environment. The RCN also maintained a publicly available advice guide on what constitutes bullying and harassment and what to do about it **[CS/222 – INQ000574708]**.

348. The RCN also wrote to the Secretary of State for Health and Social Care on 31 December 2021 **[CS/223 – INQ000328841]** to highlight that violence and aggression against health and care staff was again increasing and called for a strong commitment to a zero-tolerance approach. To the best of our knowledge, the RCN did not receive a response to this correspondence.

RCN Research Society's survey into the impact of Covid-19 on the nursing and midwifery workforce

349. The RCN Research Society's survey into the impact of Covid-19 on the nursing and midwifery workforce **[CS/017 – INQ000525205]** 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.

350. Alarmingly, this survey found that nearly 30% of survey respondents reported experiences indicative of a probable Post Traumatic Stress Disorder (**"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.

351. This study was used to inform national health and social care policy as it demonstrated the impact and importance of measures such as sufficient training on staff wellbeing.

352. 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 **[CS/224 - INQ000114331]**. The toolkit is discussed in greater detail later in the statement.

The RCN's "Building a Better Future for Nursing" survey report

353. The RCN conducted a survey of our members working across all health and social care sectors in May 2020, the results of which were published in August 2020 in a report entitled 'Building a Better Future for Nursing' **[CS/036 - INQ000176038]**.

354. In the independent/private social care sector, the survey found that just under 50% of respondents said that staffing levels had worsened compared to before the pandemic, and 35% reported that their ability to take breaks had worsened. 71% of respondents also reported an increase in paperwork/bureaucracy.

355. The survey found that across all sectors, a third of respondents were working longer hours compared to before the pandemic, but in independent/private sector social care this rose to half of the respondents. Likewise, just under 40% of respondents in the independent/private social care sector reported working at a higher level of responsibility than before the pandemic compared to 28-33% in various NHS settings.

356. There were disparities between different ethnic groups in this respect as well. Of respondents in the social care sector, 35% of white respondents reported working at a higher level of responsibility than before the pandemic, compared to 51% of respondents from all other ethnic groups. However, there were no significant differences in respect of payment for this additional responsibility, with 85-88% across all groups reporting that they were not paid for this additional responsibility.

357. Our survey also revealed that significant numbers of nurses were not being paid for the additional responsibilities and hours that they had taken on during the pandemic, with 90% of respondents across all sectors reporting not being paid more for working at a higher level of responsibility. In independent/private social care, 43% of respondents did not receive any pay for the additional hours they were working.

A summary of RCN helplines and online platforms for nurses in the adult social care sector to report concerns and seek advice during the pandemic

358. As previously discussed, RCND is a call centre and online platform where members from across the four nations can seek advice and access specialist

representation. The RCN received over 28,604 calls relating to Covid-19 between March 2020 and June 2022, of which over 3,700 came from members working in the social care sector. This is a proportionately higher number of calls than from other sectors which reflects the particular challenges faced by the social care sector during the pandemic.

359. The RCN launched a Northern Ireland helpline for members, and it was via this channel that concerns and realities for frontline staff working in Northern Ireland were heard, and the RCN was able to respond and influence on their behalf. During the relevant period, the helpline received around 600 calls from members in all sectors.

Concerns raised by members from ethnic minority groups

360. Concerns raised by members through RCND highlighted the particular pressures and issues facing members from ethnic minority groups, such as health and safety concerns not being listened to and/or acted upon, safe redeployment and underlying health conditions not being taken proper account of. The following are illustrative examples of the types of calls we received from RCN members from ethnic minority groups working in the Care Sector. Those with quotation marks are direct quotes from written correspondence from members, whereas those not in quotation marks are the RCND call operator's contemporaneous summaries of concerns raised by members as recorded in RCND's call logs:

a) *Member has been working nights, employer asked if member could work permanent nights. They now want member to work days - member is worried as more staff work in the day - concerns with exposure to the coronavirus. No covid patients/residents - the home is carrying out weekly tests. Member is worried because of age and BAME background.* – Raised by a member working in a care home in England in July 2020

b) *Employer has done general risk assessment for return-to-work next week but not including ethnicity – member working in a private care home* – Raised by a member working in a private care home in England in June 2020

c) *"I don't think my care home is ready for any risk assessment yet – member working in care home.* – Raised by a member working in a care home in England in June 2020

d) *"I have just been tested for Covid-19 at my workplace on 25/6/2020. I told the service manager that we should be tested for antibodies. The response was that they will try and do that. I am black and I love my job but my health concerns come first".* - Raised by a member working in a care home in England in June 2020

e) *"I will appreciate your interest in me as a member of the RCN to try and contact the care home to do the needful at the right time. Also, I don't appreciate hiding of disposable face mask for staff especially on weekends by the assistant service manager. Thermometer for checking staff temperature at the start of the shift is sometimes not easily reached. The above-mentioned issue sometimes makes me feel unhappy at work. I will be looking forward for a change through your intervention."* - Raised by a member working in a care home in England in June 2020

Mental health support for Social Care workers

361. In early April 2020, NHS England and NHS Improvement launched an emotional, psychological and practical support package for all NHS staff The package was commissioned by the Department of Health and Social Care, in recognition of the "need for additional mental health support for NHS staff". The package included access to wellbeing apps and online resilience support. There was also a dedicated support helpline operated by the Samaritans and 24/7 text service, and a helpline offering bereavement support. The package was not available to those working in the Care Sector. The Government, however, indicated that wherever possible they have ensured the same offer is included in the support package developed for the social care workforce.

362. The Government published guidance on health and wellbeing for the social care workforce in May 2020 **[CS/225 – INQ000574712]**, which included advice to build resilience, manage stress and support mental health. A dedicated app for social care workers was also launched in May, which included mental health toolkits. The initiative Our Frontline, led by mental health charities, offered

mental health and bereavement support to all key workers. This included 24-hour telephone and text support with trained volunteers as well as online tools and resources.

363. In our written submission response to HM Treasury Comprehensive Spending Review in September 2020 **[CS/226 – INQ000114252]**, we recommended that the impact of government funded initiatives to support staff mental health during the first wave of the pandemic should be evaluated, including accounts from staff and employers who used the services and an assessment of the level of take up. A new, fully costed package of care should then be made available for the continued delivery of counselling and psychological support. This costing should include promotion to all health and care staff across all settings, which would include the adult care sector, to raise awareness of the resources available. It was vital that access to this specialist support remained in place beyond the pandemic to sufficiently help staff in coping with delayed responses to trauma.

364. In May 2022 the DHSC published further guidance on "Health and wellbeing of the adult social care workforce" **[CS/227 – INQ000574713]**. The guidance acknowledged that the pandemic was not yet over, but that people were now learning to live with Covid-19. It highlighted ongoing issues for social care staff including: the desire to continue to provide high-quality services which may be impacted by absences among colleagues, personal challenges including those with high-risk dependants, those with school-age or pre-school children, or other care duties who may not be able to take time off due to an increasing workload and are less able to take time off. The guidance indicated that many registered managers were struggling to maintain resilience, but that it was important that, as far as possible, the wellbeing of those who work in adult social care is safeguarded.

365. The guidance stated that government was committed to helping staff recover from their extraordinary role in helping the country through the pandemic. Following the publication of the Adult Social Care reform white paper in December 2022, the government indicated that it would be delivering services such as a listening service, talking therapies and coaching, as well as improving access to occupational health services. A 'Care App' was launched, but unless individual employers provided access to it, the workforce was limited to accessing publicly available services through the NHS as patients. Furthermore, the guidance stressed that it was essential that employers were reinforcing the message that staff wellbeing remained

an utmost priority. Some workers would face increased isolation in their work as well as their personal life and many would face a period of increased pressure and anxiety. Tips and advice available on how employers could take care of the wellbeing of staff at work was also provided.

A summary of the lived experiences of nurses in the adult social care sector captured by RCN Northern Ireland and RCN Scotland's SenseMaker tool

366. As discussed previously, RCN Northern Ireland and RCN Scotland used the SenseMaker tool to capture the lived experience of being a nurse, nursing assistant or student nurse (in Scotland) across all settings including adult social care during the pandemic, with Northern Ireland using the results to publish a report **[CS/016 - INQ000328831]**.

Northern Ireland

367. A further analysis of the Northern Ireland results specific to the independent sector was carried out in January 2025 **[CS/228 – INQ000574705]**. In total 192 members of staff from the independent sector submitted their stories, from 1st March 2020 to 28th June 2022, which equates to 20.46% of all the submitted stories. All of the stories received from the independent sector were provided by individuals working in adult social care. 185 submissions were from private nursing homes and 7 submissions from residential areas. The following paragraphs summarise the key issues reported by respondents working in adult social care during the relevant period and include examples of quotes from these adult social care workers, contained within quotation marks.

368. When asked about what most of their attention had been on during the past week, 68% (118) indicated their work, 3% (6) indicated their wellbeing; and 6% (10) indicated their loved ones. Results suggested that for 23% (39) of respondents, all three areas were important. There were indications in the data that nurses' health and wellbeing were compromised in different ways, mainly a noticeable dominance of a work focus for nurses and neglect of self-care and time with family. This is evidenced by the quotations below:

a. *"Trying to keep both my residents and family safe is so draining!"*

b. *"Having a big knot in my stomach driving to work each day not knowing what I am going to face. Thinking will I get COVID and bring it home to my family. Having to isolate in different rooms from my family. Can't sleep, feel physically sick. Knowing that I did everything in my power to try to keep COVID 19 out of home but unfortunately it arrived. Feeling gutted, deflated, feeling it was all my fault."*

369. The majority of respondents (92%) indicated they needed to adapt to working in new ways. This was further demonstrated in the stories where there were some very positive stories reflecting staff determination to ensure they provide a high-quality, person-centred service. There were also reflections regarding the positive way some staff adapted to new ways of working amid ever changing services and guidance:

> *"'We have adapted to different ways of working and dealing with sick patients."*

370. 87% of respondents (167) indicated that they were taking the initiative rather than waiting for instruction. The stories reflected that staff were doing their best and managing as best they could in the situation:

> *"Everybody's just trying their best to manage whatever we can and what we have under intense pressure."*

371. An analysis of the stories indicated a number of key themes including:

i. rapid pace of change and confusion with guidelines
ii. anxiety and exhaustion
iii. challenges from Covid-19 measures
iv. low staffing levels, increased use of agency staff and low morale
v. communication
vi. challenges with dealing with death and bereavement
vii. positive stories

Rapid pace of change and confusion with guidelines

372. A theme emerged from the stories highlighting the rapid pace of change and confusion with guidance. Many of the stories suggested frequently having to implement new policies/procedures as a result of changes in government guidance, rates of infection, and mounting suggestions relating to transmission and treatment of the virus. In the later phase of the pandemic there were indications of challenges in relation to relatives visiting the homes:

a. *"There is enough PPE in the home but much conflicting advice on its use - regional guidance updated frequently and conflicting advice depending on the organisation you speak to - Trust/ RQIA/DoH."*

b. *"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"*

c. *"We are re-opened to visitors, it has been intense and we are all feeling pressurised, with the pace of change and developments from DoH. I felt staff were looking to me to advise them about visiting and while we comply with guidelines, we faced many aggressive/forceful relatives and staff are feeling traumatised by their attitudes towards them when it is nothing to do with them making the decisions."*

Anxiety and exhaustion

373. Anxiety and exhaustion were common themes throughout these stories. Nurses expressed anxiety about the continuing pressures on their working environments, with very little release.

a. *"I felt very over worked and overwhelmed, as a nurse manager I was lonely and felt that due to exhaustion and being pulled from pillar to post I wasn't able to do the job I am employed to do. You are a councillor to staff and patients and families and at times you don't have time to think about your own needs*

and that of your family. I am a leader of a very new and unexperienced team that has come together during covid and they need me, the residents need me to lead the team; it's tough."

b. *"Staff are feeling exhausted and no end to this."*

a. *"Thankfully the residents have been kept safe, but we are constantly working to stop complacency setting in, it is a daily struggle particularly to maintain standards around PPE and hand hygiene in a busy environment"*

374. Many of the stories and patterns demonstrated a view of an unsustainable working pattern for the nurses who took part. The patterns indicated some over-reliance on self as a source of strength, and less of a culture where people feel able to ask for support. There was an indication from those who responded that nurses had to compromise on their physical and mental wellbeing.

> *"In my opinion the last months we have experienced challenging times, especially at work. Staff absence because of a new cough leading to shortages on the floor, striving to provide safety and give the best care possible to our clients. Uncertainty, leading to lack of confidence and affecting staff mentally not only physically. Me, as a nurse, having to make sure the people in my care were well cared for and the care staff are motivated to work harder to ensure safety and document the work that had been delivered which takes time as we all know well. The morale of staff has not been the best lately and lots of healthcare workers left because did not feel confident in delivering the best care."*

375. There was an undercurrent of fear reflected in the stories, these mainly related to the provision of safe care and the safety of the staff:

> "*During the last week we have lost several members of staff due to burnout and stress. We are all still dealing with symptoms of stress and burn out from the first wave of the covid pandemic and feel physically and mentally overwhelmed with the demands of the job and the expectations from families, the Government and ever-changing guidelines*."

Challenges from Covid-19 measures

376. Some of the stories indicated there were challenges being faced relating to Covid-19 prevention measures, including; weekly testing, PPE, visiting, visitors, observations and communication. This appeared to be particularly challenging within the Care Home setting. There were frustrations indicating conflicting guidance, no clear guidance and the fast pace of change including guidance.

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

b. *"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."*

c. *"…On top of all the problems this has caused us we are trying to interpret all the new regulations and restrictions so that we can safely implement our once a week visiting for our residents when this is allowed as we appreciate how important these visits are for both our residents but also their loved ones.'*

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 corona 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..."

Low staffing levels, increased use of agency staff and low morale

377. There was a recurrent theme that unrealistic expectations were being set particularly by employers. Respondents reported working long hours due to long term sickness of colleagues and staff shortages. There were many stories where the theme was of not having enough staff to cover patient care and how this led to low morale for nurses and their teams:

a. *"I work in a nursing home that cares for 81 residents. It is divided into 4 units. One of the units were short staffed, and on top of that, one of the care assistants working there became acutely ill, and needed to go home, leaving the unit very short."*

b. *"Struggled with staffing levels to provide safe effective care to residents but was overruled by senior management/directors and made to work short staffed."*

378. The use of agency nurses was raised as a concern in some of the stories, mainly as they were unfamiliar with the area they were nursing in. This was particularly highlighted when the majority of staff covering were from a nursing agency:

a. *"We raise concerns about staffing levels there is nothing any one can do as there are no plans or resources in place. One agency nurse sent in but was more of a hindrance than a help."*

b. *"Not enough staff, both carers and nurses. I'm concerned about having all agency carers and nurses on shift at the same time where none of the staff on duty actually know the residents."*

379. There was also a sense from the Care Home sector that they were regarded as less important than their NHS counterparts and of not being supported by the NHS Trusts, which also led to low morale.

a. *"Bombardment of or lack of information following COVID vaccines and now positive residents and staff. Having to support both residents, staff and the families with little to no guidance and maintaining safety within the workplace. A level of uncertainty and lack of education with regards same for the care home sector. Not only this but there is still the day to day running of the care home to maintain with now increasing numbers of staff off isolating and lack of support from Trust due to likely the same issues."*

b. *"Working in a care home environment was and still is very stressful. Severely short staffed especially during the pandemic time. All focus and emphasis is placed on NHS staff. All nurses should be applauded for their hard work. Not only a certain group of nurses."*

Communication

380. Within the stories there was a sense that the respondents were very worried about their patients and relatives and reflected how Covid-19 had affected the ways families were unable to visit and how communications had been interrupted in many ways:

a. *"It was a terrible time for the residents, staff and relatives. There was a lack of communication between the Trust and the Nursing Home."*

b. *"Some staff have felt there is a communication disconnect between management and themselves, so I have endeavoured to act as a bridge between them both as much as possible - informing our management of issues, potential solutions, and what has been going well/badly."*

381. Some felt they were the conduit between communication with the relatives about the patients and also to the patients regarding their relatives. There were stories where staff felt relatives were not supportive of the guidelines. They described ways they supported this communication such as the use of iPads and telephone communications:

a. *"The difficulty of managing the lack of visiting/ restricted visiting. Relatives are expressing their concerns and frustration to the care staff escorting and facilitating the visit. Comments such as 'they think we are going to make you sick daddy that's why we can't come'. We are trying our best to support the residents but the lack of input and support from family who are unable to visit at this time is upsetting for everyone involved in the care of our residents."*

b. *"The experience I had was that of conflict with families over visiting. Families are entitled to one visit per week in a visiting pod and that is very clear in all communication with them but unfortunately it can be very difficult when you have large families for them to understand that what they want is not always possible and does impact on the other clients within the setting."*

382. Within some stories the staff felt they had become like a family to some of the patients:

> *"At times I would rush to work on my days off, in middle of the night as soon as management was informed of any deterioration and together, we spent those final hours and minutes and stayed by their sides to ensure they were not alone or frightened in death. Where possible families video called their goodbyes or made phone calls as we held the phones close to the residents and allowed their families and loved ones the time to say any final words."*

Challenges with dealing with death and bereavement

383. Another emerging theme was staff's fearfulness for the patients and relatives of patients at end-of-life care. Many of the respondents' stories indicated that it became their role to provide critical emotional and social support to patients. This was due to their relatives not being present. This role appears to also encompass support for the dying patients in the absence of relatives and learning how to cope with death. 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. *"Emotional week with some sudden deaths of service users but proud of my team with the amazing person-centred palliative care they gave".*

c. *"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."*

Positive stories

384. There were a few positive stories/themes reflecting; resilience, staff supporting each other and embracing the opportunities for change in the future.

a. "*The whole pandemic period, we kept ourselves and our residents away from this infection by following guidelines and adhering to infection prevention and control methods and I'm really happy that we are all doing a good job by working as a team and following the local guidelines and the code of conduct."*

b. *"Very busy, short staffed, lots of agency staff but despite all of this, standards are still very high and everyone working together as a team to focus and to do the best for our patients."*

385. During September 2021 to March 2022, there were some reflections about trying to get back to normal and taking a day at a time. There was a sense of hopefulness about normality returning and feeling positive for the future.

a. *"We have adapted to different ways of working and dealing with sick patients. It is also a struggle for families who are unable to visit their loved ones. It has been a very difficult time but hoping for more positive times in the future."*

b. *"The difference in visiting now compared to previous months. With the weekly testing for care partners, enabling them to have indoor visits has been of great support to our residents. We have so many more care partners now and it is having a positive impact on our residents. Obviously, there are some tears as families haven't seen each other for some time, however it is lovely to see some normality coming back."*

c. *"Telling residents and families about changes to visiting - great to see and feel the sense of relief that maybe normality is returning."*

386. There were also some very positive stories reflecting staff determination to ensure they provide a high-quality, person-centred service. There were also reflections regarding the positive way some staff adapted to new ways of working amid ever changing services and guidance.

a. "*I am proud to work with the staff that we have in the home as it has not been an easy time for anyone, however, the teamwork remains and the camaraderie with staff continues."*

b. *"I feel as a team we have bonded and are working well together because we are all going through this together."*

387. It was evident from the report that respondents contributed significantly to ensuring safe, effective and patient focused care in the independent sector, but more specifically adult social care in which the respondents were based, in Northern Ireland.

388. There are a number of key messages throughout the stories shared by nurses and health care assistants, and it is important to listen and learn from them. There

is positive experience reflected which can be built upon and the negative experience should be used to improve practices.

389. There is an overall sense with the stories that there are ongoing fears and anxieties contributing to feeling generally challenged, worried, unappreciated, frustrated and angry. Many of the stories show the resilience of nursing staff and the compassion and care they want to provide however often they reflected that there is an increasing burden and pressure on the existing workforce.

390. The stories collected from 1 March 2020 to 28th June 2022, from the Independent Sector in Northern Ireland, of which the respondents were all based in adult social care demonstrated patient-centred care and an ethos of compassionate care, particularly during the pandemic, where there had been intense and sustained emotional and psychological interactions with patients and their families and carers, often under exceptionally challenging conditions.

391. The stories alluded to nurses feeling vulnerable to stress and feelings of anxiety, stress and fatigue which led to reduced levels of resilience and burnout, resulting in an overall poor quality of life, both personally and professionally.

392. There was also some suggestion throughout the stories that many of the respondent's mental health had been affected. A few of the most recent stories shared suggested staff were reflecting on the future both in a fearful way, but with some who had hope of brighter days ahead.

Scotland

393. The RCN Scotland SenseMaker project **[CS/229 – INQ000574742] [CS/230 – INQ000574704]** also heard the experiences of a small number of individuals working in the adult social care sector in Scotland during the pandemic, the majority working in care homes. By way of example, we heard concerns about inadequate PPE, visiting restrictions, staffing shortages and the perceived disparities between the adult social care sector and NHS as evidenced below.

a. *"I work in elderly care in a nursing home and it's a job I used to really love. But all the difficulties we experienced with COVID and PPE and lack of visiting for relatives and now getting vaccinations and trying to get people to*

work is getting ridiculous. I am never off my shift on time and if there is no agency cover I have had to just stay overnight, not often but a couple of times. Who does that in a job? It seems there is never an answer, you just have to try to do your best and struggle through." [Registered nurse], [Care home] February 2021

b. *"I have been the only registered nurse for 52 residents, 2 of which have been at the very end of life. One suffered a fall and one was vomiting blood. I felt I have not had time to spend quality time with any resident or their family. have not had a break on the 13hours I have worked only being able to grab a cup of tea on the go and each time cold when I tried to get a drink. … Feel so sad as I feel privileged to be caring for such a wonderful client group after 36 years of nursing. I have a heavy heart."* [Staff nurse/practitioner], [Care home provider] July 2021.

c. *"Working in a 16-bed dementia unit with a poor skill mix, staff shortages, low morale, high turnover/sickness, high agency usage causing lack of continuity and poor handovers, a stressful shift trying to prioritise workload without compromising person centred care, doing inductions and trying to have a positive attitude." [Staff nurse/ practitioner], [Care home] July 2021.*

d. *"My last week of nursing has been really challenging for me, I feel that as a clinical lead and deputy manager that I have the skills and experience to carry out my job well. However, the last week threw me a curve ball and even though I did everything I could possibly do to rectify the situation, it was unresolved and left me feeling rather hopeless and frustrated. It is very clear to me that there is still a blame culture towards care homes and this needs to change. It made me question myself on why I actually do this job. It's thankless! The reality is I make a difference in people's lives every day, sometimes I have to dig deep to remind myself of that… I am the equivalent of a band 7 in a hospital setting but often treated as a student nurse." [Nurse manager], [Care home] 2022*

394. We also heard of positive experiences from very limited numbers [two] healthcare professionals working in the adult social care sector in Scotland. These related to collaborative working and working with knowledgeable colleagues as evidenced below.

a. *"Took part in collaborative discussion with other nurses and health professionals about addressing palliative support for people experiencing homelessness. We shared experiences of practice and connected. There was a real sense of pulling together to be able to make local change." [Other healthcare worker], [Third Sector] July 2021.*

b. *I felt relaxed, in control and confident because I worked several days with a knowledgeable and dedicated staff nurse on duty. Took weight off my shoulders, as manager of a care home." [Nurse manager], [Care home provider] November 2021*

The RCN Counselling Service

395. The RCN Counselling Service offered trauma-focussed therapy for members, including those working in adult social care, funded by RCN Foundation's Covid-19 Healthcare Support Appeal, such were the challenging emotional issues experienced by our membership **[CS/231 - INQ000328826]**.

396. Our Counselling Service found that 'health' was among the top five workplace issues cited by nurses presenting to the service for the first time. In the period between March and June 2020, our Counselling Service also found that 23% of members who accessed the service reported suicidal ideation (compared with 16% during the same period in 2019). Similarly, 15% of members accessing counselling self-assessed their psychological distress at severe levels of distress, compared to 9% during the same period the previous year.

397. We do not hold separate data on counselling sessions provided specifically to members in adult social care. In total, RCN members accessed in excess of 15,100 sessions of counselling during the relevant period. Almost 790 members were, however, referred for counselling via the RCN member support service RCND. Of these, more than 310 members worked in adult social care. This equates to almost 40% of referrals made, which is high, relative to the comparatively low number of RCN members who work in this sector.

398. Members working in adult social care were referred to the RCN counselling service during the relevant period for a variety of reasons. A number of the referrals

made during the pandemic concerned work-related incidents including stressful work environments, bullying and harassment. Although not specifically referring to the Covid-19 pandemic such incidents may reflect the negative atmosphere and working environments experienced by members during the pandemic. Some of the referrals highlighted the day-to-day struggles members had to cope with in addition to the challenges of working in the adult care sector during the pandemic. Issues specifically related to the pandemic included: the general stressor of the pandemic, the traumatic experiences of care home residents dying from Covid-19, inadequate staffing levels, financial concerns, visa concerns for overseas educated healthcare workers, feelings of isolation including being separated from family members. A selection of the referrals is captured below. Those with quotation marks are direct quotes from written correspondence from members, whereas those not in quotation marks are the RCND call operator's contemporaneous summaries of concerns raised by members as recorded in RCND's call logs:

a. *Member feeling very scared and alone. The home she works at has lost a resident due to covid-19 and other residents are becoming ill as a result of Covid. Member feels like she is failing the residents and feels very scared and distressed by this. Member has found it particularly difficult due to not having a manager in place, so she has shouldered all of the responsibility as Deputy manager and has not had anyone to go to for support* – Raised by a member working in a care home in England, April 2020.

b. *Member is on a sponsorship visa and is feeling trapped. She feels that she is not safe to work there anymore and that she has no support. Member worried about her PIN* [a registered nurse needs to maintain their personal identity number on the Nursing and Midwifery Council register in order to practice clinically] *due to the situation. Work has been affecting her mentally and is not getting support. Member too worried to explain this to her manager…* - Raised by a member working in a care home in England, June 2020.

c. *Member upset on call. Member took time off 2 weeks ago. Member isolated for 7 days. Member took another 7 days off work due to still having symptoms of Covid-19. Member has returned to work and the environment has changed. Member had meeting with manager and she said she wasn't supporting her. Member was told she is the highest paid nurse but doesn't*

deserve it… - Raised by a member working in a care home in England, May 2020.

d. *"Been doing bank work for 3 years. My wife died on the 21/4 and I don't feel strong enough to go back to work. Because it's bank work I'm not entitled to anything – won't have any income coming in* – Raised by a member working in a care home in England, May 2020.

e. *Member is a unit lead of a 38-bed care home. During first Covid-19 wave member lost 20 residents and worked over and above working time regulations. Staffing levels are a constant concern and member has raised her concerns several times in the past…* Raised by a member working in a care home in England, January 2021.

399. Other measures taken by the counselling service to meet increased demand in response to Covid-19 included an increased budget for the Brief Therapy service funded by the RCN, the provision of access licences to a digital mental health platform called Togetherall, and the procurement of an additional 15 affiliate counsellors. We also maximised the availability of our affiliate counsellors to provide 35-40 assessment appointments per week, undertook project planning for a specialist support service to deal with specific mental health issues arising from the pandemic such as anxiety disorders including PTSD and complex bereavement. Our in-house counselling team were trained in trauma focused CBT. We published Covid-19 specific mental health member webpages. We consulted with clinical supervision, peer support and specialist advice to adapt our therapeutic approach to issues presented which have arisen from the impact of the pandemic.

400. As well as supporting members individually via its member support services, the RCN provided support in tackling mental health issues and maintaining wellbeing in other ways. This included: holding evening seminars on the topics of leadership and holistic mental health and wellbeing; attending third-party hosted webinars to talk about PTSD and the support available; and holding targeted training sessions on topics such as self-care and wellbeing.

401. We provided targeted support to staff working in the independent sector including those working in the adult social care sector, promoting availability of trauma focused therapy, as well as highlighting our wide range of member support

services including immigration and welfare advice and peer support. We also hosted one of our webinars for a group of independent care homes.

RCN Foundation Covid-19 support fund

402. In April 2020, the RCN Foundation (an independent charity whose purpose is to support and strengthen nursing and midwifery), launched a Covid-19 support fund to finance awards for nurses, midwives and health care support workers in economic difficulty. Funding was awarded for a number of purposes, including to assist with living costs of those unable to work if they were self-isolating, living costs for those whose financial situation was directly impacted as a result of the virus, and financial support for families of health and care staff who died from Covid-19 to pay for funeral costs. The fund delivered a tangible benefit for health and care staff affected by the pandemic. The fund was set up following a £5 million donation from TikTok and made grants to 30 health and social care organisations and supported over 9,000 individuals.

403. A number of grants were made to organisations operating within the adult social care sector. These included the Care Workers Charity (**"CWC"**), Body and Soul and the Queen's Nursing Institute (**"QNI"**). 39% of the £4,867,447 grants made were to the independent sector, which included the adult social care sector. The fund published an evaluation study in December 2022 **[CS/232 – INQ000417805]**, highlighting some of the success and challenges associated with the fund.

404. The charity "Body and Soul", which provides support for those who have suffered trauma, launched a number of initiatives to try and usefully reach staff in care homes. This included care couriers on bicycles to do welfare checks around London and to take things into care homes. The organisation also began undertaking group work within care homes. This targeted social care workers who would not normally come into contact with the charity. Body and Soul reported that 60% of people they worked with would identify as something other than white, particularly relevant for the social care sector, given the high number of individuals working in the sector from minority ethnic backgrounds. In contrast, the Queen's Nursing Institute Scotland reported initial difficulties in attracting beneficiaries from an ethnic minority background. The Institute reported that they were more successful in reaching this group of health and social care workers when they hosted a session specifically for the social care sector.

405. The CWC reported that the grant that the organisation had received was very helpful. The charity had received emails from people who could not eat and were unable to send their children to school. The CWC commented that the care sector was not thought about in the same way as the NHS but that the grant helped social care workers to "*feel supported and that they were there to help" and that it "helped to have someone in their corner.*"

406. The evaluation report also addresses some of the issues encountered by organisations receiving grants from the fund but also the legacy of the fund. Body and Soul reported some initial difficulties accessing non-NHS providers to provide psychological support. Whereas the NHS might be unsure of approaches by the organisation in relation to psychological support they could appreciate that this was an offer of help, the charity reported challenges to and rejection of engagement by the Care Sector, meaning that the organisation had to adapt its approaches to engage with beneficiaries. It is not clear whether this experience was replicated in other organisations experiences with the Care Sector.

407. The CWC reported that when the funding started, the charity was on a small scale and they had to develop a number of processes to deal with issues such as fraudulent applications and complaints. In turn this helped to make the organisation more "solid". Since the support fund closed in 2021, the CWC has started a campaign for all care providers to donate £500 every year to sustain support for care workers. At the date if the evaluation report 50 organisations had signed up and the charity was hoping for 100 to join the initiative.

<u>The Independent Sector Nurse Managers Network in Northern Ireland</u>

408. Members of the RCN Northern Ireland Independent Sector Nurse Managers Network co-created the content for the RCN Northern Ireland Leading in a Crisis ("**LIAC**") programme alongside RCN staff. The LIAC programme was developed in response to the Department of Health's report *'The Rapid Learning Initiative into the Transmission of Covid-19 into and within Care Homes in Northern Ireland'*, which identified the need for care home staff to enhance their ability to manage effectively during a crisis. A key pillar of the programme design was promoting closer collaboration between independent health and social care staff ("IHSC") staff and public sector Health and Social Care staff in Northern Ireland.

409. The four-day programme **[CS/233 – INQ000612624]** covered a broad range of topics including:

a. key challenges for senior nurses in today's healthcare system
b. roles, responsibilities, and accountability for a Senior Nurse
c. disaster preparedness
d. human factors within care settings
e. emotional wellbeing and resilience of teams
f. communication within teams in a crisis
g. dynamic risk assessment, legal responsibilities and professional accountabilities of leaders in a pandemic
h. collective leadership

410. After a successful pilot programme in December 2020, the content was further refined based on feedback from learners who had taken part. Between December 2020 and February 2022 **[CS/234 – INQ000574707]**, the programme was delivered six times to over 100 delegates, with each cohort taking part in four one-day sessions in a virtual learning environment. Feedback was overwhelmingly positive, with 97 to 100% of participants at each session saying they would recommend the programme to a colleague.

411. Following the success of the programme in Northern Ireland, a four-country pilot subsequently delivered to delegates from across England, Wales and Scotland in September and October 2022.

<u>The issues raised on behalf of the sector with the Department of Health, Health and Social Care Trusts and the Regulation and Quality Improvement Authority.</u>

412. Royal College of Nursing Northern Ireland Networks consist of RCN registered nurses, nursing support workers and students from Northern Ireland with an interest in a specific field or area of nursing. Networks are a member led supportive function with a number of aims including: building member led supportive connections with colleagues who share an interest in a specific field or area of nursing, supporting professional development and enhanced evidence-based practice, influencing regional and national health and social care strategy and policy development, promoting the role and raising awareness of the particular field or area of nursing

and contributing to the national RCN agenda in the context of the particular field or area of nursing and develop and maintain communication links with key people in educational organisations and health bodies such and HSC Trusts.

The Northern Ireland Independent Sector Nurse Managers Network

413. A number of issues were raised by ISNMN with relevant NI Government bodies. In April 2020 a member raised the issue of the refusal by a GP to prescribe anticipatory oxygen for a nursing home patient confirmed to be Covid-19 positive and a refusal by the same GP to have conversations with families around DNACPR decisions. The matter had been raised by the respective home with the relevant Trust and RQIA and was reported by the RCN Network staff link to NI PHA on 29 April 2020 **[CS/235 – INQ000574700].** A response was received on the same day indicating that the PHA would follow the issue on oxygen prescribing with the relevant working group and that the DNACPR concern would fall under the remit of the relevant Trust and RQIA **[CS/236 – INQ000574703]**

414. In April 2020 ISNMN members highlighted a lack of training for testing patients with Covid-19. Members were concerned that unlike colleagues in health social care trusts they had received inadequate training. ISNMN raised the issue with the RQIA on 29 April 2020 **[CS/237 – INQ000574701]** and asked for the provision of training to all nursing homes, encompassing a regional approach. On the same day **[CS/238 – INQ000574702]** RQIA advised that the issue would be escalated through the organisation's silver report. In subsequent correspondence with NI DHSC and Northern Health and Social Care Trust (**"NHSCT"**) **[CS/239 – INQ000574677]** regarding lack of training in a number of nursing homes in the Trust, NHSCT advised that a training video had been reissued to all private nursing homes in the Northern area on 1 May 2020 and that the Trust was in constant contact with care homes which included discussion around training needs.

415. On 6 May 2020 **[CS/240 – INQ000574688]** ISNMN requested guidance from the NI Covid IPC cell on the requirement for follow up testing of Covid-19 positive patients in nursing homes who had been isolated from other patients in the home. ISNMN had noted that staff from ethnic minority backgrounds had experienced

more severe outcomes as a result of Covid-19. As many nursing homes had a high percentage of nursing staff from this community ISNMN queried whether there was any additional guidance for routine testing or additional PPE for staff from this community. The NI Covid IPC cell responded on the same day signposting to the DoH Guidance for Nursing and Residential Care Homes in NI and promising to follow up on the question of testing for staff from ethnic minority backgrounds. On 7 May 2020 **[CS/240 – INQ000574688]** the cell advised that that there was not any specific testing for staff from ethnic minority groups and signposted to the NI national testing programme.

416. On 11 May 2020, **[CS/240 – INQ000574688]** a further query was made to NI Covid IPC cell on whether there was need for a second Covid-19 test following a positive result for nursing homes patients as the PHA guidance did not appear to contain this information. The cell responded on 12 May 2020 **[CS/240 – INQ000574688]** that the issue was complex, that there was not any definitive guidance on a second test but that the subject would be discussed at the expert testing group that week.

417. On 13 May 2020 **[CS/241 – INQ000574689]** the ISNMN requested clarity from the Regulation and Quality Improvement Authority (**"RQIA"**) on a number of issues raised by ISNMN members. These included: stage 1 visiting, staff temperature monitoring and lack of availability of disposable equipment for nursing homes such as pulse oximeters and blood pressure cuffs. A response was received on 14 May 2020 which advised that guidelines for stage 1 visiting would be issued at a later date and a recommendation for recording of staff temperatures twice daily. RQIA advised that they would share the issue of access to disposable equipment with the IPC cell the following day and raise with silver [command].

418. ISNMN wrote to the Directors of Nursing & User Experience at Belfast HSC Trust, **[CS/242 – INQ000574673]**, Northern HSC Trust **[CS/243 – INQ000574674]**, the Director of Primary Care & Older People's Services & Executive Director of Nursing Western HSC Trust **[CS/244 – INQ000574672]**, Executive Director of Nursing Southern HSC Trust **[CS/245 – INQ000574675]**, Director of Primary Care, Elderly & Executive Director of Nursing South Eastern HSC Trust **[CS/246 – INQ000574676]** on 3 June 2020 seeking clarity in relation to infection prevention and control advice for nursing homes. From the outset of the pandemic, members of ISNMN had described receiving conflicting advice and guidance on the

appropriate infection prevention and control measures to be implemented within the homes.

419. To add to the confusion, in the weeks prior to June 2020, Infection Prevention and Control teams across Northern Ireland had introduced an environmental zoning protocol. This protocol designated areas of the home within amber, green and red zones, and was an approach to infection prevention and control not previously used within nursing homes. Given that the nursing home environment is very different from an acute hospital environment, staff working in nursing homes required guidance on the implementation of this protocol within a nursing home environment. ISNMN asked for confirmation that appropriate guidance for nursing homes existed and to be provided a copy of the guidance or if not in existence asked that appropriate guidance was developed.

420. A number of email responses were received in relation to the correspondence including those from Director of Nursing & User Experience Northern HSC Trust on 3 June 2020 **[CS/247 – INQ000612628]**, the Director of Primary Care & Older Peoples Services & Executive Director of Nursing Western HSC Trust on 7 June 2020 **[CS/248 – INQ000612617]**, the Director of Primary Care, Elderly & Executive Director of Nursing South Eastern HSC Trust on 8 June 2020 **[CS/249 – INQ000612625]** and the Executive Director of Nursing on 3 and 9 June 2020 **[CS/250 – INQ000612629].** In summary it was advised that Rodney Morton Director of Nursing at the PHA and chair of the IP&C cell would make contact with the ISNMN on behalf of all recipients of the 3 June 2020 ISNMN email to ensure a consistent approach across the region. To the best of our knowledge a response was not subsequently received from Director of Nursing at the PHA and chair of the IP&C cell.

421. On 27 June 2020 **[CS/251 – INQ000574682]** ISNMN requested clarity from the NI Covid IPC cell on the requirements for gloves and head coverings in nursing homes with the NI Covid IPC cell. A response was not received from the cell, and ISNMN was advised that the Covid IPC cell was no longer operational. On 9 July 2020 ISNMN requested clarity from the HSC Public Health Agency who advised on the same day that this would be followed up with the Senior Health Protection Nurse that sits on the IPC cell. On 16 July 2020 a response was received indicating that the issues would be considered by the IPC cell and a resolved NI position would be

issued to all relevant stakeholders. On 23 July 2020 **[CS/252 – INQ000574699]** we asked for an update on the proposed IPC guidance and on the same day received confirmation that head coverings were recommended but not compulsory and that vinyl gloves were not recommended for direct patient care, although could be used for other activities and that guidance would be issued by the PHA.

422. On 2 July 2020 **[CS/253 – INQ000574670]** ISNMN queried whether guidance to support the safe reinstatement of visiting would be sent to nursing homes, following members receiving calls from relatives around the planned removal of restrictions on visiting in care homes. ISNMN received a response on the same day attaching the current visiting policy and indicating that a training package was being developed to support decision making.

423. On 8 July 2020 **[CS/254 – INQ000574679]** ISNMN raised the issue of the daily requirement for care homes to submit a covid report daily via the RQIA Portal, with the RQIA. The required information was reported seven days a week and ISNMN was concerned that the requirement prevented managers from having downtime from work. Although the task could be delegated to another user, this required the user to set up their own account with a work email address which some care home staff did not have. As the RQIA had stepped down their support at the weekend the RCN asked, on behalf of ISNMN, that this be reciprocated for care home managers and the details updated on a Monday morning.

424. On the same day the RQIA responded that they had raised this issue with the Department of Health who mandated the returns and the Public Health Agency who had a statutory function to collect this data, and they were clear that it must be collected on each day over the weekend. The RQIA acknowledged the concerns and advised that they had spoken with a number of managers regarding the issue who had given an undertaking to personally complete the requirement. The RQIA indicated that they would forward their correspondence with the RCN to the Department of Health and Public Health Agency and advise the RCN of any response. **[CS/254 – INQ000574679]**

425. ISNMN questioned the availability of free non-Covid training for the independent sector with The Department of Health NI (**"DoH NI"**) on 8 July 2020 **[CS/255 – INQ000574680]**. Members of ISNMN had reported that all non-Covid training had a cost from 1 July 2020. ISNMN advised that nursing homes had a

difficult time during the pandemic and were not always able to book the training due to courses being fully booked and staff shortages. ISNMN highlighted that this was an excellent time for employers to avail themselves of the vital training to help them 'upskill' their staff in preparation for the second surge. The Independent sector had appreciated free access to this training and would want to ensure they were well trained, prepared and able to support their patients and recipients of care during the second surge.

426. Concerns around implementation of the Regional Action Plan for the Care Home sector were raised with NI DHSC on 15 October 2020 **[CS/256 – INQ000547690]**. The Regional Action Plan **[CS/257 – INQ000574691]**, published by the Department of Health Adult Social Care Governance Covid-19 Surge Planning Working Group on 18 September 2020, aimed to deliver a comprehensive response to prevent, mitigate and build resilience in relation to the COVID 19 pandemic response across the care home sector and broadly encompassed action items on the following:

a. epidemiology and public health management
b. partnership working
c. strengthening of IPC
d. testing
e. shielding and lockdown
f. staff
g. mitigation
h. resilience (service continuity)

427. Care home providers were assigned a number of the action items from the Regional Action Plan, as detailed below:

a. co-produce a communication strategy with residents and relatives to ensure all official information and guidance is cascaded directly to the residents & relatives.
b. review the built environment to inform best practice regarding IPC
c. provide training for the domestic staff response in a pandemic
d. ensure footfall is kept to a minimum, whilst supporting essential access from health and social care staff

e. have a plan in place to rapidly isolate residents who have suspected or confirmed Covid-19. These must take account of Deprivation of Liberty considerations
f. provide alternative occupation and activities for residents who have limited opportunity for communal activities
g. provide opportunities for residents to exercise appropriately to maintain their mobility, appetite and digestion, and reduce risk of deconditioning
h. implement staff rotas and robust IPC practices to reduce movement of staff between settings to an absolute minimum, including agency staff and students
i. establish mechanisms to engage with staff, including communication of key messages and receipt of feedback.
j. put in place systems to promote the physical health, wellbeing, mobility and independence of all residents, particularly those post COVID infection

428. The Care Home Implementation Arrangements required monthly progress reporting **[CS/258 – INQ000612621]** on the implementation of the action items assigned to care home providers. ISNMN members were concerned with a number of requirements of these arrangements at a time when nursing homes were experiencing an increased workload and were struggling to meet all the demands that were already currently being asked of them. Some homes were already experiencing the second wave of Covid-19 and had huge staff shortages due to Covid-19 related absences. Added to this, homes also now had to manage staff and patient testing, complex visiting requirements as well as the impending introduction of care partnership arrangements. All of this was required without the provision of additional resources. A number of requirements from the plan were not feasible in the current circumstances and with existing resources. These included: the requirement of care homes to disseminate all official information and guidance to the patients and their families, provide training for domestic staff response, the provision of alternative occupation and activities for residents who have limited opportunity for communal activities and the reduction of movement of staff between settings to an absolute minimum, including agency staff and students.

429. Following concerns by members, ISNMN raised the issue of recent care home inspections with the RQIA on 22 October 2020 **[CS/259 – INQ000574695]**. Some managers reported being told that they would be issued with a requirement for improvement as they were falling behind on their monthly audits/training, although reportedly being advised at the start of the pandemic to "do the best they could".

Members advised that the amount of work that testing and visiting had created, whilst prioritising safe and effective care had placed them under tremendous pressure and that they were really struggling. Some managers reporting working 15 days in a row in order to manage Covid-19 infection outbreaks in the homes. A response was received on 23 October 2020 **[CS/260 – INQ000612630]**, which indicated sympathy to the pressures, but that a care home had required temporary closure, and another was moving towards the same in order to address deficits and that there needed to be balance to ensure the safety of service users. Furthermore, although the pressure that care home managers were under was recognised, good governance arrangements and ensuring staff were appropriately trained was still required.

430. On 22 October 2020 **[CS/261 – INQ000574696]**, ISNMN also queried with the DoH NI whether the deadline for the introduction of family members care partners would remain in place for 5 November 2020. The deadline was originally announced in a letter to care homes from the CNO NI on 24 September 2020. Members of ISNMN had raised concerns about their ability to meet the deadline. The DoH NI responded on the same day **[CS/262 – INQ000574697]** that a draft paper had been circulated on the 22nd addressing these concerns. It was confirmed that there would be no penalty to care homes should they not have the process operational by 5 November 2020.

431. On 6 November 2020 **[CS/263 – INQ000574683]**, ISNMN wrote to the NI Government in relation to weekly Covid-19 testing of Care Home staff. ISNMN was concerned that the announcement to increase the testing of care home staff from fortnightly to weekly intervals had been made on 3 November 2020 without any prior engagement with nursing home representatives. ISNMN was concerned that nursing homes were facing unprecedented staffing challenges and were all too frequently operating below normative staffing levels and the testing regime, which is highly labour-intensive, presented an additional challenge and administrative burden on a sector that was already struggling to match demand with available resources. Covid-19 testing, as discussed earlier in the statement, was frequently described by RCN members as a distraction from the provision of safe and effective care to patients.

432. The RCN Independent Sector network was keen to understand the scientific evidence for increasing testing from fortnightly to weekly and to explore if the

infrastructure was there to support the timely return of test results, given the experience when fortnightly testing initially commenced.

433. After an initial lack of response, follow up emails were sent on 9 December 2020 **[CS/263 – INQ000574683]** and again on 7 January 2021 **[CS/264 – INQ000574678]** in which an urgent meeting to discuss the concerns and possible solutions was requested. In the 7 January 2021 email, ISNMN also reported a lack of response to queries raised by ISNMN regarding Care Home Implementation Arrangements on the 15 October 2020, 22 October 2020, 30 October 2020 and 01 December 2020, as well as an unsuccessful attempt to arrange a telephone call to discuss on 15 December 2020. To the best of our knowledge a response to the email of 7 January 2021 was not received.

434. As previously discussed, a response letter was received from the Department of Health on 27 January 2021 **[CS/062 – INQ000574487]** acknowledging the challenges of regular testing and that additional funding, recently announced by the Minister, included an allocated sum to assist with testing requirements.

435. On 10 December 2020 **[CS/265 – INQ000574685]**, ISNMN raised member queries around mental capacity and decision making for Covid-19 vaccination of care home residents with the DoH NI. On the same day **[CS/266 – INQ000574687]** a response was received indicating that residents should give consent where possible and that GPs were being asked to advise of any reasons, such as when the resident was receiving end of life care, why a resident should not receive the vaccine as well as any resident allergies.

436. The lack of availability of local testing facilities for healthcare workers during Covid-19 outbreaks was raised with the DoH NI on 10 December 2020 **[CS/267 – INQ000574686]**. ISNMN had received reports of care home staff unable to be tested on site during the outbreak due to lack of capacity. Also on the 10th, the DoH advised planned changes to the testing regime which would be communicated out via a letter from DoH. The DoH advised that Trusts were responsible for outbreak testing and advised of the NI lead for testing. The issue of local testing was raised with the NI lead on the 10th **[CS/268 – INQ000574693]** and again on 16 December 2020 **[CS/268 – INQ000574693]** when a response was not initially forthcoming. To the best of our knowledge a subsequent response was not received.

437. On 23 February 2021 **[CS/269 – INQ000612623]**, in view of the proposed strengthening of IPC support for care homes by the PHA, ISNMN queried with DoH NI whether each trust would have an IPC link responsible for care homes which could be shared with members. On the same day, **[CS/269 – INQ000612623]** a response was received indicating that all the IPC guidance and support was linked to individual homes through the care home support teams and the single point of contact set up under during the pandemic and that the aim was to increase this support going forward.

438. A further query regarding visiting guidance for care homes was raised by ISNMN with NI PHA on 01 June 2021 **[CS/270 – INQ000574668]**. The question was whether, given the relaxation of the requirement for temperature checks for visitors to care homes, a similar review was planned for staff and residents. PHA responded that the query had been forwarded to DoH who was in the process of updating care home guidance to include temperature recording.

439. On 01 June 2021 **[CS/271 – INQ000574669]** ISNMN contacted RQIA about members concerns regarding decision-making processes around deprivation of liberty and documentation and capacity issues within trusts. Some managers had been waiting 10 months for updates on capacity assessments etc. but still did not have the documentation requested from Trusts. ISNMN queried whether RQIA could do anything further to ensure compliance with the guidance and whether emails to the respective Trusts requesting documentation would constitute guidance if requested during an inspection. To the best of our knowledge a response was not received as it is understood that the intended recipient was absent from the office on 01 June 2021. We are unable to confirm whether a subsequent call was arranged.

The RCN's Healthy Workplace Toolkit

440. As previously discussed, the RCN developed a Healthy Workplace Toolkit, containing pandemic-specific guidance in relation to workplace health, safety and wellbeing which was published online and made available to members, including those working in adult social care in June 2021 **[CS/224 - INQ000114331]**.

441. The RCN takes a holistic view when defining a healthy workplace. It is far more than offering wellbeing support to individuals but about taking a proactive approach

to tackling the work-related factors that can lead to stress and poor mental health and building on established evidence on what constitutes good work. The RCN defines a healthy workplace as one which offers fair pay and rewards and has high quality employment practices and procedures which are inclusive, promote a good work-life balance, protect and promote employees' physical and psychological health, design jobs which provide employees with autonomy and control and provide equitable access to training and learning and development.

442. The toolkit provided organisations with a systematic framework to use to improve working environments. The RCN recognised that there were a number of frameworks in place to improve working environments and the health and wellbeing of the workforce, however this framework had been developed with nursing staff with the aim of improving their working environment and conditions and the subsequent impact this will have on their health and wellbeing. The toolkit was designed to be used by any size of organisation that employed nursing staff, from a care home to a large NHS trust.

443. Nursing staff played an indispensable role in delivering health and care services and they went above and beyond during the crisis to support and care for patients. Many nursing staff were involved in extremely stressful and traumatic situations as highlighted by some of concerns of members who were referred for counselling as discussed earlier. In the short term, health and care staff were focused on caring for patients, but the psychological impact of caring for increased volumes of very sick patients and distressed relatives, many of whom were at very high risk or highly emotional, cannot be understated. Striving to deliver high-quality, safe care in such adverse circumstances put nursing staff at a heightened risk of developing compassion fatigue and becoming burned out.

444. Based on our regional intelligence gathered during the first wave of the pandemic, increased levels of staff absence were having an impact of the ability of nurses to provide safe and effective care and had a significant impact on their own health and wellbeing. Registered nurses had been under strain from increased workloads, while nursing support workers reported lower levels of supervision and feeling forced to work above their competency. This was further exacerbated during the second wave, with nursing staff displaying symptoms of PTSD.

"Facing COVID-19: RCN reps share stories of the pandemic"

445. The impact of the pandemic on adult social care was seen from the RCN publication 'Facing Covid-19: RCN reps shared stories of the pandemic' **[CS/272 - INQ000328832]**. Fiona Devlin, RCN steward, Board Chair and Council Member, Northern Ireland, indicated that a lot of the focus of the pandemic response had been on the acute sector. We heard some of the issues from our RCN learning reps working with members in the care sector as illustrated by the quotes below:

a. *The pandemic hit our staff in the same way as the rest of the population, with lives imploding overnight, as happened for so many. There were anxieties about families, clients and their own safety, alongside worries about practicalities such as childcare and how their jobs might change. Some adapted quickly while others struggled. It was crucial that we continued to deliver services to our clients to prevent hospital admission, as beds were in short supply and needed for COVID-19 patients, while avoiding transmission of the virus was paramount.* From a large independent network of residential and nursing homes in England and Scotland

b. *Going into the pandemic was a very difficult transition for staff. The workload on top of business as usual was significant, with those on the ground having to put everything in place. And for those who could work remotely, some loved being based at home while others found it much more of a struggle.* From a large independent network of residential and nursing homes in England and Scotland

c. *Before we did the webinar, people didn't really know what PTSD was, let alone think they might be experiencing it themselves. They might have felt tired, short tempered or had problems sleeping, without realising these could be symptoms. People were making excuses and saying they were just under the weather, without linking it to what they'd been through. But PTSD runs you down and physically drains you. They understand much more about its effects now.* From an independent national care agency providing services in people's homes.

d. *Although lockdown has lifted, we're very clear that COVID-19 hasn't gone away. Transition is a process and it will take time. It's about adjusting*

gradually and just as there was turmoil when the pandemic began, there is a similar amount as we emerge, especially given the toll there has been on people's mental health. At the workshop, many people's concerns were personal, but of course they have an impact on their professional lives. If someone has childcare issues because there is an outbreak at the school, there will be an impact on their work, what they're able to do and how. From an independent national care agency providing services in people's homes.

e. "*We work for a large independent network of residential and nursing homes in England and Scotland. During the pandemic, we've experienced a very mixed picture. Some homes had no positive cases of COVID-19 for either the residents or staff, while sadly others have witnessed deaths. Staff are always badly affected if they lose a resident, with stress levels and morale plummeting in those homes where it happens.*

Successes in the adult social care sector response to the pandemic

446. As discussed during the statement, alongside the accounts of trauma and difficulties experienced by adult social care staff, we heard stories of the resilience of many when working under extreme pressure.

447. Social care workers became "family" for residents and during end-of-life care worked hard to ensure a dignified death for that individual.

448. Nurses and nursing support workers in the Care Sector adapted to new ways of working and innovations and contributed significantly to ensuring safe, effective and patient focused care.

449. Although not specific to the Care Sector, the RCN considers that the establishment of the temporary register was quick and effective, which allowed nurses who had previously left nursing to return to assist with the pandemic responses. This included nurses who were able to return to working in the Care Sector.

Recommendations

450. We recommend the following for future planning for a pandemic response in relation to the Care sector. As an overall recommendation, the Care Sector must be treated equally as a critical sector supporting the NHS and some of our most vulnerable members of society and not as an afterthought. This includes the equal provision of PPE and access to testing if required. More detailed recommendations are included below.

451. Equal level of risk assessment and professional clinical support such as occupational health, expert infection prevention control and advice as well as the same hierarchy of control measures as available in the NHS.

452. A focused structured review of adult social care providers in each UK country to assess the competency level of available infection prevention and control and occupational health and health and safety knowledge and capability to aid improvements in care standards and future pandemic/incident preparedness. The review should be published and recommendations incorporated into national health and care funding/commissioning contracts to ensure standards across health and care systems.

453. A strengthened focus from all stakeholders including: employers, Governments of the UK and Devolved Nations, professional bodies and trade unions, on significantly improving wider control measures including:

i. working conditions, employment policies and systems that provide for greater safety, first-line protection and resilience, for example:
    a. accessible and private staff changing rooms with showers,
    b. in-house laundry facilities,
    c. provision of fit-for-purpose uniforms,
    d. proper rest breaks and facilities,
    e. safe working hours,
    f. full pay for any health-related absence, including time off to seek medical assistance,
    g. regular health assessments for shift workers,
ii. protection of the rights of adult social care workers if they refuse redeployment,

iii. a commitment to no detriment - e.g. furloughing, on full pay if necessary for vulnerable workers.

454. Consideration of the health and safety risks for social care workers and the associated impacts of living-in and lock-in arrangements.

455. Greater regulatory support and scrutiny of adult social care from an IPC perspective.

456. Parity of testing in the Care Sector with that of the NHS. Early access to testing of social care workers, residents and visitors. Training on testing and protection of full pay for social care workers required to self-isolate following testing results.

457. Adult social care to be considered in pandemic stockpiles or a 'system' by which the Care Sector can rapidly access sufficient provision for PPE as part of a future national incident or pandemic response.

458. Meaningful engagement with stakeholders from professional bodies who may have a role in intelligence gathering, communication or the wider pandemic response. Stakeholders should be included in pandemic planning as well during any future pandemic.

459. In respect of stakeholder engagement – the UK Government and Devolved Administrations should ensure professional nursing input into the production of national guidance that impacts on nursing obligations. Employers must have policies in place to support dynamic risk assessment for individual residents.

460. Engagement with trusted individuals in ethnic minority communities to address vaccine hesitancy, rather than mandating vaccination as a condition of employment.

461. Appropriate planning for the discharge of residents from hospitals to care homes, including testing prior to discharge.

462. Early access to interventions to support the psychological and physical needs of social care workers.

463. Better provision and communication of information to social care workers including the legal positions of restrictions and advice on professional practice.

464. National decisions on care home visiting should include consideration of the human rights of the care home resident and family members as well as the benefits of a partnership of care with friends and relatives and the distress experienced by residents, who are frequently at the end of their lives, when face to face visiting is absent.

465. The rights of vulnerable groups, including older people and people with learning disabilities, must be explicitly considered within future policy developments to ensure equity of access.

466. All guidance should be available in accessible formats, with input from relevant stakeholders, experts and people with lived experience. It should be informed by published human rights impact assessments.

467. Monitoring of challenges to Deprivation of Liberty Safeguards should be conducted to ensure that they remain appropriate.

468. The crisis in staffing levels in care homes must be addressed. As part of this, the Care Sector needs increased long-term investment. Long term funding for the Care Sector must be based on a robust assessment of population needs and sufficient to provide fair pay, terms and conditions for all social care workers in all parts of the UK. Investment levels must fund staffing for safe and effective care in all social care settings. The next iteration of the NHS People Plan, and a people plan for the social care sector, must prioritise the need for the UK Government to hold accountability for assessing the health and social care workforce and delivering a strategy for workforce planning and supply.

469. In respect of workforce capacity, current barriers to the employment of international care workers should be removed so that they have a clear route to employment in the UK. Furthermore, barriers within the UK Government's immigration rules should be addressed to ensure that the UK remains an attractive destination for international nurses, and also to make it easier for international nurses to be able to work in the UK. RCN members have reported difficulties in bringing family members to the UK through the Sole Responsibility and Adult

Dependency routes because of the high burden of evidence that is required by the Home Office. This can potentially leave nurses separated from direct family members who may require their ongoing care. Ultimately, these kinds of barriers within the immigration system can present real challenges to internationally educated nurses and can also contribute to ongoing recruitment and retention challenges for the workforce within the UK.

470. All providers should be required to allow their workforce data to be reported on publicly, not only NHS Trusts. This needs to include services which are commissioned by local authorities including social care providers. Reporting must include full-time equivalent numbers of staff by role and care setting, along with vacancy data. All providers should be required to collect and report on vacant posts, including a breakdown of how many posts are being filled by bank or agency staff.

471. The Government should make an effective route available for social care workers from overseas to be able to join the UK workforce. This could be undertaken through the development of an additional immigration route or amending existing Tier 2 visa route.

472. There should be clearer pathways to promote all nursing roles in the sector including promotion of movement between social care and the NHS, on a secondment or training arrangement.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

SIGNED **Personal Data**

DATED .....21/05/2025.....