Witness Name: Patricia Cullen
Statement No.:1
Dated: 25 April **2024**

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PATRICIA YVONNE CULLEN

I, Patricia Cullen, General Secretary and Chief Executive 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 Impact of Covid-19 pandemic on healthcare systems in the four nations of the UK, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 26 May 2023, in relation to Module 3 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 and profession.

Introduction

4. Since July 2021 I have held office as General Secretary and Chief Executive of the RCN. I was previously employed as a Community Nurse in West Belfast before working for the Public Health Agency and the Health and Social Care Board. I commenced employment with the RCN in 2016 as Operational Manager. In May 2019, I became Director of Northern Ireland, RCN. In April 2021, I became Acting General Secretary and Chief Executive before I was confirmed in my current role in July 2021.

5. My predecessor, Dame Donna Kinnair, was RCN General Secretary and Chief Executive from 2018 to 2021 and therefore led the RCN at the outset of the pandemic and into 2021. Whilst I was involved in discussions with Donna Kinnair as part of the Executive Team throughout this time, there will unavoidably be some gaps in the evidence as I was not party to all of the meetings, correspondence and communications she was having at the relevant time.

6. In order to ensure a holistic response to the Inquiry, this statement has been prepared following the collation and review by the RCN of documents relevant to Module 3 and discussions with colleagues. I have sought to indicate where evidence is not within my personal knowledge.

7. In this statement I cover the following matters:

    a. A brief overview of the role, function, aims and membership of the RCN across the UK and in England, Scotland, Wales and Northern Ireland respectively together with its role across the UK in response to the Covid-19 pandemic during the relevant period at paragraph 9;

    b. A description of the RCN's role across the UK in response to the Covid-19 pandemic at paragraph 12;

    c. A summary of the key concerns of the RCN and its members at paragraph 13;

    d. An overview of the RCN's liaison and communication with UK Government and Devolved Administrations throughout the pandemic at paragraph 14;

    e. An overview of the pre-pandemic state of healthcare systems across the UK at paragraph 31;

f. The RCN's view of the Impact of the Covid-19 pandemic on healthcare systems in the four nations of the UK at paragraph 45, including:

i. Staffing;
ii. The impact on healthcare professionals including physical health, mental well-being and the disproportionate impact Covid-19 had on colleagues from ethnic minority groups;
iii. Healthcare provision and treatment including use of DNACPR, backlogs and waiting lists, treatment of patients with Covid-19 and patients with learning disabilities;
iv. Long Covid and the support that has been put in place for nurses;
v. Discharge and movement of patients;
vi. Shielding; and
vii. Remote working.

g. Recommendations to improve the provision and quality of nursing care and conditions for nurses and nursing students in the event of a future pandemic at paragraph 220;

h. A list of all reviews or reports authored by the RCN in relation to 'lessons learned' where those are relevant to the scope of Module 3 at paragraph 234.

8. A separate witness statement provided by Rosemary Gallagher MBE, addresses the matters in the Inquiry's Rule 9 request concerning infection prevention and control ("**IPC**") and personal protective equipment ("**PPE**").

Brief overview of the role, function, aims and membership of the RCN

9. 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.

10. The RCN is the world's largest professional body in and 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 – over 300,000 members are employed in the NHS. 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.

11. As a member-led organisation, the RCN works collaboratively with its members to ensure that the voices of nursing and their patients 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.

A description of the RCN's role across the UK in response to the Covid-19 pandemic during the relevant period

12. Throughout the pandemic and its aftermath, the RCN supported members and professional stakeholders and campaigned in the interests of the profession, patients and the general public. Examples of its work include:

a. **Support services**: The RCN Foundation (an independent charity but forms part of the RCN Group) 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. The RCN also utilised its existing interactive support services via a call centre and online platform, known as RCN Direct ("**RCND**"), where members seek advice and access specialist representation. The RCN received 28,604 calls from members on Covid-19 related issues during the period from March 2020 to the end of June 2022. Examples provided in this statement are by no means exhaustive and a summary of the data held by the RCN is exhibited here **[PC/001 - INQ000328870]**. Of the calls received by the RCN, 9.0% were from members who identified as Asian or Asian British, 10.1% identified as Black, Caribbean or Black British, 1.1 % identified as Mixed or Multiple ethnic groups,

0.9% identified as other ethnic groups and 58.8% identified as White. 20.2 % of callers did not provide information on ethnicity. The RCN categorised these Covid-19 related calls into key themes and the breakdown of calls is as follows:

i. Workplace/Employer – other issues (not related to equipment, PPE and health & safety) more relevant to the employer, e.g., pay, annual leave.(26.2%).
ii. Member at risk – issues regarding a member's pregnancy or underlying health conditions (15.3%).
iii. Equipment/PPE/health & safety – relating to equipment, PPE, working time, health and safety matters (9.3%).
iv. Vaccination queries (9.1%).
v. Self-Isolation – queries where the member or a dependant has had to self-isolate (9.0%).
vi. Raising concerns – for example issues regarding patient care and staffing levels (4.4%).
vii. Long Covid (1.3%)
viii. Personal – other issues which aren't covered in the above categories, and which are relevant specifically to the member, e.g., travel problems, time off for dependants and school closures (17.9%).
ix. Other – queries not captured in the above categories (7.4%)

We also received 800 contacts on RCN Social Media (Facebook and Twitter) on a wide range of subjects between March 2020 and the end of September 2020 as exhibited here **[PC/002 - INQ000328871]**.

b. **Advice and guidelines**: The RCN compiled extensive guidance and advice on a rolling basis, in anticipation of and in response to emerging issues, to support members in their clinical roles, their employment and their mental health and wellbeing. This included a Covid-19 workplace risk assessment toolkit **[PC/003 - INQ000114307]** developed with other professional bodies including: the British Association for Parenteral and Enteral Nutrition ("**BAPEN**"), the Association of UK Dieticians ("**BDA**"), the British & Irish Association of Stroke Physicians ("**BIASP**"), the British Society of Gastroenterology ("**BSG**"), College of Paramedics, Fresh Air NHS, GMB Union, the Hospital Doctor's Union ("**HCSA**"), National Nurses Nutrition Group ("**NNNG**"), the Queen's Nursing Institute ("**QNI**"), the Royal College of Speech and Language Therapy ("**RCSLT**"), Unite the Union, the British Occupational Hygiene

Society ("**BOHS**") and the Chartered Society for Worker Health Protection. The tool, which was published in December 2021, was developed to support healthcare professionals to consider and manage risks associated with the transmission of respiratory infections and aid decision making as to the level of personal respiratory protective equipment (**"RPE"**) required. The Toolkit provides advice on the risk assessment process together with an online risk assessment tool for respirable biological exposures to Covid-19 and a safety tool to assist healthcare workers in considering and controlling the transmission of the virus. The toolkit also provides guidance on RPE and provides signposts to additional resources. RCN personnel have been closely involved in relevant clinical and government advisory groups, feeding into the development of guidance where afforded the opportunity to do so.

The RCN recognised very early on that a dedicated webpage needed to be established and continuously updated to give RCN members working in all health and care settings, information about the virus including its symptoms and how nursing staff could protect themselves and their patients. It also hosted the latest guidance and updates from the Department of Health and Social Care, the Foreign and Commonwealth Office and public health bodies across the UK **[PC/004 - INQ000328934]**. FAQs were routinely published including: How can I protect myself at work? **[PC/005 - INQ000328757]** Washing and reusing single use PPE **[PC/006a - INQ000328759]**, Reuse of single use clinical equipment **[PC/006b - INQ000328760]**, death verification, laying out and last offices **[PC/007 - INQ000328762]** and negative tests before returning to work **[PC/008a - INQ000328764]**.

c. **Influencing and campaigning**: The RCN contributed to consultations and published open letters and position statements to escalate urgent issues affecting nursing practice up the government's agenda. For example, the RCN responded to the Public Accounts Committee consultation on the supply of PPE and made submissions to the Women and Equalities Select Committee and Baroness Lawrence's review into the impact of Covid-19 on ethnic minority groups. The RCN led a coalition of health experts to demand that the Prime Minister tackle inadequate protection of nursing staff.

d. **Engagement**: The RCN undertakes regular surveys of its membership. It conducted two online surveys on PPE (April and May 2020), sent to all members across all UK health and care settings. The results revealed a detailed picture of the effects of the pandemic. The RCN has collected qualitative data about nurses' experiences of the

pandemic in Northern Ireland and Scotland. Northern Ireland recently published its SenseMaker report which sets out its findings.

e. **Research and data**: The RCN played a key role in furthering scientific understanding to inform UK Infection Prevention and Control Guidance. The RCN commissioned an independent review of guidelines for the prevention and control of Covid-19 in UK health care settings, and an evaluation and messages for future infection-related emergency planning.

Summary of the concerns of RCN and its members

13. This statement explores the following issues:

Staffing and workforce planning

a. Ambiguity about responsibility for policy and funding interventions for supply, recruitment, retention and pay of nurses and other health care workers has led to workforce shortages and Parliament missed the opportunity to address this lacuna when it rejected workforce amendments to the Health and Care Bill.

b. The absence of effective workforce planning across the UK and resulting workforce shortages added to the challenges of responding to the pandemic.

c. The UK nursing vacancy rate in March 2020 was 9.9% and this figure increased during the pandemic as more nurses left the register than had in the preceding years. Low staffing levels during the pandemic impacted patient care and staff morale and contributed to increased numbers of nursing staff considering leaving the profession.

d. Internationally educated nursing staff play a vital role in providing safe and effective care and contributing to our health and care workforce but, during the pandemic, the number of European Economic Area ("**EEA**") nurses joining the Nursing and Midwifery Council's ("**NMC**") register reduced by 91% and the number leaving it significantly increased.

e. Whilst the number of people on nursing courses rose during the pandemic, the small increase in applications fell far short of how many nurses the UK Government needed to close the vacancy gap and achieve its 50,000-more-nurses target in England.

f. Elevated staff sickness levels (and 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. Nurse-to-patient ratios were diluted, impacting the level of care that could be provided.

Redeployment of nursing staff

g. Those joining the temporary register and those being deployed to new areas needed support and supervision. This placed additional pressures on already over-stretched staff.

h. Members had to adapt to new ways of working at a rapid pace and often without adequate support. Some were redeployed while others had to do their job in a different way, such as online working practices and remote consultations. Nursing staff took on additional responsibilities. This put additional pressure on nursing staff, contributing to increased levels of anxiety and burn out.

Impact on nursing staff health and well-being

i. Members told us that they were attending work despite not feeling well enough to perform their duties.

j. Extended periods of time spent wearing PPE caused damage to our members' skin and contributed to fatigue and heat stress.

k. Surveys and data showed that nursing and midwifery staff were feeling depressed, anxious and stressed, and reporting experiences indicative of a probable post-traumatic stress disorder diagnosis. Staff burnout and exhaustion in turn impacts on patient safety.

l. RCN members were presented with professional dilemmas, such as whether to treat patients without PPE, how to delegate tasks appropriately, whether to undertake work at a higher level than they were familiar with or do unpaid overtime to ensure care was completed.

m. Members working in the community reported receiving harassment and abuse from members of the public, and NHS staff reported incidents of being robbed for their ID badges.

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

o. The pandemic worsened the financial difficulties experienced by many RCN members, who reported concerns surrounding entitlement to sick pay. There were also issues surrounding the level of pay that shielding members were entitled to from their employers.

p. Internationally educated nurses were particularly impacted by the pandemic and contacted the RCN for advice about recourse to public funds and visas.

Nursing students

q. Nursing students were another cohort which suffered as a result of Covid-19. Feedback from this group included concerns about academic deadlines, clinical placements and deployment, testing and risk assessments, fees, loans and bursaries, registration, pay and sick pay, indemnity and life assurance, and stress levels.

Pregnant nursing staff

r. Pregnant members and those on maternity leave raised queries about their rights and obligations in relation to attending work in high-risk areas, and those already with children experienced childcare difficulties.

s. There was limited evidence on the risk of Covid-19 to pregnant women and the uncertainty about whether they should shield caused anxiety within the RCN membership.

Long Covid

t. Members contacted the RCND in large numbers with queries about Long Covid. Across the UK, the prevalence of Long Covid amongst staff working in health care and social care is significantly higher than the wider population. Many RCN members who contracted Long Covid via exposure to Covid-19 at work are now at risk of losing their employment due to ongoing health issues and the lack of workplace support to enable them to remain in employment.

Disruption to non-covid treatment

u. Non-urgent care and treatment was, at times, postponed, causing anxiety to patients, and leading to backlogs and longer waiting lists.

v. Bed occupancy rates were above recommended levels due to the extreme pressure hospitals were under from a high number of emergency admissions and the escalating care needs of patients who had been experiencing delays in elective treatment due to the pandemic. This impacted the ability of trusts to provide safe and timely services for all patients, increased the risk of infection and reduced the ability of hospitals to respond to outbreaks.

Impact on patients

w. The Covid-19 pandemic brought into sharp focus the disadvantages and inequity experienced by patients with learning disabilities.

x. The pandemic also caused disruption to the delivery of mental health services, which were in higher demand due to the impact of the pandemic.

y. The RCN received reports of breaches of the Mental Capacity Act and safeguarding processes for those with mental health conditions. Members reported concerns about patients being restricted in their movements whilst being acutely unwell.

z. There were concerns that Do Not Attempt Cardio-Pulmonary Resuscitation Notices ("**DNACPR**s") were being applied wholesale to groups of people. The RCN's position has always been 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.

aa. There were concerns about the arbitrary discharge, or prevention of discharge, from hospital into care homes and particularly for people returning to their own homes.

bb. The Covid-19 pandemic led to unprecedented demand on health care services, resulting in increased use of remote consultations. Some patients were unable to access remote services effectively or at all.

Liaison and communication with the UK Government and Devolved Administrations

England

14. The RCN engaged 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.

15. The RCN had direct lines of communication with senior healthcare leaders including the Secretary of State for Health and Social Care, the Minister for Care and Chief Nursing Officers. Donna Kinnair 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, Chief Nursing Officer ("**CNO**") for England and IPC decision making bodies was also a mechanism for raising formal issues and occurred on a regular basis.

16. By way of example, 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. Donna Kinnair raised substantial concerns about: 'lock ins' for staff at care homes; the need for IPC training and the reporting of nursing deaths.

Wales

17. 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 (e.g., care homes) were of concern. Our members required accurate and up-to date information of the legal position on restrictions, the best advice on professional practice and access to the right equipment.

18. In this period, the Director of RCN Wales held a seat on the Welsh Partnership Council group with the First Minster, which met every week for discussion and briefing 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.

19. 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.

20. Telephone contact was maintained at least weekly with the Special Adviser of the Minister and the office of the CNO.

21. Formal correspondence by letter 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 address specific matters of concern and contributed to public discussion.

22. 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 the parliament to provide information on matters of concern.

Scotland

23. 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 ("**WSLG**") - a multiagency group with Scottish Government officials
- Clinical Professional Advisory Group - Care Home specific group with a range of stakeholders

- Louisa Gordon Programme Board – a multiagency group to establish the equivalent to the Nightingale Hospitals in England.
- HSC Winter Planning and Response Group - to plan for the 2021 winter surge.
- Pandemic response in Adult social Care Group ("**PACS**")

24. Regular meetings between the RCN Scotland Director and the Cabinet Secretary provided an opportunity for the RCN to raise members 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.

25. In addition to direct dialogue with the Scottish government, RCN Scotland worked to highlight members concerns around safe staffing, access to PPE, 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 RCN Scotland penned a joint letter with the Royal College of General Practitioners Scotland and Scottish Care (representing care home providers) 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.

Northern Ireland

26. 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 some of which are detailed below:

- Availability and standard of PPE
- Lack of Covid-19 testing
- Unavailability of fit testing and FFP3 masks
- Sickness/absence and safe staffing

- Staff redeployment and student nurse allocation
- Psychological, emotional, wellbeing support
- Clarity on infection control guidance
- Covid-19 vaccination programme

27. Early in the pandemic correspondence was forwarded to the OFMDFM raising concerns about the lack of PPE, lack of Covid-19 testing, and the confusion and ambiguity with infection control guidance. In addition, joint correspondence was forwarded from the RCN and the Irish Nurses and Midwives Organisation raising similar issues alongside seeking agreement that travel restrictions would not endanger cross border working for members. In this correspondence it was pointed out that inadequate workforce planning had limited the ability to respond to the Covid-19 crisis and asked that nursing and midwifery not be included in any further employment restrictions.

28. 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.

29. 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.

30. During this time RCN Northern Ireland had a high profile and level of engagement across all mainstream media outlets and social media platforms.

The pre-pandemic state of healthcare systems across England, Scotland, Wales and Northern Ireland

31. Across the UK we do not have enough beds to meet the needs of the population. In Northern Ireland, the number of beds fell by 22% between 2010 – 2021 (Statista, August 2021). Alongside Portugal, Northern Ireland, Scotland and Wales have the fewest intensive care/critical care beds per person in the developed world. With 100 beds (as of March 2020), Northern Ireland had 5.3 ICU beds per 100,000 people. Wales had 5.4 and Scotland had 5.1. All four UK countries (and Ireland) lag behind countries such as the USA (34 per 100,000), Germany (29.2) and Romania (21.4) (Queen's University Belfast, 2020).

32. Taking all this together, the UK has one of the lowest hospital bed capacities in Europe.

33. The publication, NHS Vacancy Statistics England February 2015 – March 2020, Experimental Statistics show how immediately prior to the onset of the pandemic there were close to 50,000 nursing vacancies in the NHS in England, and approximately 122,000 vacancies in social care according to Skills for Care data. These workforce shortages resulted in unsafe staffing levels, which impacted on patient safety as well as on the nursing staff themselves, leading to stress, moral distress and burnout.

34. The Nurse Staffing Levels (Wales) Act 2016 was the first law of its kind in the UK. It requires health boards to provide sufficient nursing staff so that all patients can receive sensitive care. Section 25B defines the appropriate number of nurses for children's wards and adult medical and surgical wards. RCN Wales continues to campaign for the extension of Section 25B to new settings, particularly mental health inpatient wards, community nursing, and care homes.

35. In June 2019 the Health and Care (Staffing) (Scotland) Act became law, the first legislation in the UK to set out requirements for safe staffing across both health and social care services. Implementation has been delayed due to the COVID-19 pandemic. Following sustained pressure from RCN Scotland, the Scottish government has now published a timetable for implementation. The timetable sets out a 21-month programme of work which will see the Act come into force from April 2024.

36. Following industrial action during 2019/2020 to achieve pay equality and safe staffing, the priority for RCN Northern Ireland is to hold the Department of Health and Northern Ireland Executive to account for the delivery of the Health Minister's safe staffing framework, particularly in relation to the implementation of safe staffing legislation.

37. In England, however, there is no legal provision for safe staffing. The RCN continues to campaign for legislation to guarantee nurse staffing levels in England across all sectors and settings.

38. The National Institute for Health and Care Research ("**NIHR**") paper "Staffing on Wards - Making decisions about healthcare staffing, improving effectiveness and supporting staff to care well" suggests that determining optimal staffing levels is a

complex process. Nonetheless, NIHR indicates a strong link between patient safety and the number of registered nurses working on a hospital ward. Given a constant in the number of patients, it would stand to reason that nurse shortages within a team are likely to result in a higher workload for existing staff members. The European Union funded RN4CAST study found that for common general surgery, an increase in the workload of a registered nurse by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7%. Conversely, a 10% increase in the number of degree educated nurses was associated with a 7% decrease in the likelihood of death. Moreover, research suggests that the patient experience of care can be affected by pressurised work environments, which in turn can negatively impact patient safety across a wide range of healthcare settings (Doyle et al, 2013).

39. The RCN's Nursing Workforce Standards **[PC/009 - INQ000416485]** are the first national blueprint for tackling the nursing staff shortage levels across the UK. They set the standard for excellent patient care and nursing support in all settings, and all UK countries. Developed by the RCN's Professional Nursing Committee, the Nursing Workforce Standards suggest a roadmap for designing a workforce in both the NHS and the wider health and social care sector that can offer patients the quality of care they deserve. By way of example, the Nursing Workforce Standard requires escalation of incidents when the substantive nursing workforce falls below 80% for a department or team.

40. The 2014 NICE guidance, "Safe staffing for nursing in adult inpatient wards in acute hospitals" references a number of indicators for safe nursing, including: missed breaks by nursing staff, nursing overtime, planned, required and available nursing staff and a heavy reliance on temporary nursing staff. As discussed below, we have regularly heard such concerns from our members both before and during the pandemic.

41. Prior to the pandemic, our members were telling us that they were significantly overworked. In 2019, our UK-wide Employment survey showed that 77% of nursing staff worked in excess of contracted hours at least once a week; 39% did so several times a week and 18% worked additional hours on every shift **[PC/010 - INQ000328765].** Data from the 2018 NHS Staff Survey showed that 43.5% of the 127,564 registered nurses and midwives in England who responded reported feeling unwell due to work-related stress.

42. In October 2019, the NMC surveyed nurses and midwives who left the register between November 2018 and June 2019. Results published in the 'Nursing and Midwifery

Council (2020) Leavers' Survey 2019' revealed that 26% of those leaving the register cited "too much pressure" (including stress, poor mental health) as one of their top three reasons for leaving, and "too much pressure" was the second most common reason for leaving the register, after retirement.

43. The RCN published its report "UK Staffing for Safe and Effective Care: State of the nation's nursing labour market" in February 2022. The report highlighted that 73% of nursing staff surveyed by the RCN going into the pandemic in January 2020 said that the staffing levels on their shift were not sufficient to meet all the needs of the patients safely and effectively and that one in five (19%) said they felt unable to raise their concerns about staffing levels and patient care **[PC/011 - INQ000328766].**

44. As these figures show, working conditions and the workplace have been a significant cause of stress and burnout for nursing staff for some time. The pandemic would further exacerbate many of the issues created by the workforce shortages that nursing staff had been facing in recent years.

Details of the concerns of the RCN and its members

Staffing

45. The Covid-19 pandemic shone a spotlight on the critical role undertaken by nursing staff across the UK. It also highlighted that successive governments across the UK have underfunded the nursing profession and the wider health and care system over the past decade. Too few nurses have studied at university and joined the profession, too many have left their nursing careers and, of our colleagues that remain, too many feel overstretched and undervalued.

46. There has been a continual boom and bust approach to nursing supply as well as NHS and care funding. Emergency funding packages have become commonplace because the system's finances are left to reach a critical stage before action is taken. As a result, health and care providers focus on the immediate financial and safety concerns at the expense of taking a longer term, strategic approach. Patient care and outcomes inevitably decline when the health and care system is continually fighting to maintain the status quo, unable to develop the necessary capability to improve and innovate.

47. Despite the shortages being well recognised, the pandemic further highlighted the fragility of our health and care system; thousands of retired nurses came back into work, and nursing students across the country disrupted their studies to support the emergency to cover the workforce gaps.

48. Members raised a number of concerns relating to staffing, including staffing levels; the redeployment of staff; staff to patient ratios; insufficient training; and unsafe working conditions. 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. *Employed on a Surgical ward which is running as an Acute covid ward. No induction, no preceptorship, no contract. Was put in charge of a shift after 6 weeks…There was insufficient staffing, a poor skill mix and a lack of support. Member is not trained on certain duties - doing bloods for instance. She felt it was fundamentally unsafe - she completed a Datix. She's considering handing in her notice now.*

    b. *Member is a B5 gynaecology staff nurse…She has been in post 3 weeks supernumerary. Today she has been told she is being redeployed to an acute respiratory area which is a red area...She has never had any acute training…*

    c. *"Among our trust's major challenges was staffing. At one point, around three-quarters of our ward's nursing team was off work, either isolating or with Covid-19 symptoms."*

    d. *Since the start of the pandemic, the team has been moved without consultation, over 4 times from different locations, finally to a community hospital 16 miles from their home base. During this series of moves they have lost their administrative support and faced changes to working patterns, again without consultation. The service has moved to 7-day provision, with many staff members regularly working 10 days straight shifts while covering for a number of staff required to shield or self-isolate.*

    e. *…Member was under impression that safe staffing levels in A+E should be 1 nurse to 4 patients. Due to short staffing Member is looking after 7 rooms in majors…Member feels her (nursing) pin and patient safety at risk. Member also triaging and concerned someone could deteriorate or even die in one of the rooms without her knowing…*

f. *…Had only 1 hour training for Non-Invasive ventilation (NIV). Does not feel it is enough, is taught over several months in university…Now expected to look after NIV patients, should be 4 nurses to 8 patients. Now 1 to 6…*

g. *Staffing issues; currently 5 nurses short. Biopsies etc usually managed by registered nurses. It is highly likely that some of these duties will be assigned to Nursing Assistants, who are not trained or competent in doing it.*

h. *"…there is going to be potential for myself (a 5 month newly qualified children's nurse) to be moved to an adult setting to support them. I have not been offered any additional training to work with adults and I have not been offered to complete some shadow shifts prior to moving. I feel this is unsafe for both myself and any future adult patients I may have and was wondering what I can do as I am extremely anxious."*

49. During the relevant period, the RCN raised its concerns in relation to staffing levels and critical care capacity in several submissions to government. The RCN also corresponded directly with a number of Government officials and departments on the matter. What follows in this section of the statement is a summary of the points made in the following documents:

a. In March 2020, the RCN submitted written evidence to MPs and members of the House of Lords ahead of the Westminster Government debate on the proposed Coronavirus Bill **[PC/012 - INQ000114407]**.

b. At the same time RCN Scotland submitted written evidence to MSPs on the proposed Bill.

c. In April 2020, the RCN, along with Unison and Unite, responded to a consultation request from NHS England and NHS Improvement regarding guidance on deployment and redeployment of nursing and midwifery staff during the Covid-19 pandemic. **[PC/013 - INQ000418367]**

d. On 22 May 2020, Dame Donna Kinnair and Dee Sissions, RCN Chair of Council, wrote to The Rt. Hon Boris Johnson MP, and copied to The Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, highlighting the substantial shortage of nursing staff. **[PC/014a - INQ000418034] [PC/014b - INQ000418050]**

e. In May 2020, RCN Wales submitted written evidence to the Health, Social Care and Sports Select Committee on the inquiry into the Covid-19 outbreak.

f. On 31 July 2020, Donna Kinnair wrote to Baroness Armstrong, Chair, Public Services Committee, following the Public Services Committee's session on 'Lessons from Coronavirus' to discuss the nursing workforce in June 2020. **[PC/015 - INQ000328768]**

g. In September 2020, the RCN submitted written evidence to the government's HM Treasury Comprehensive Spending Review, highlighting how well-recognised nursing workforce shortages significantly affect patient outcomes and inviting governments across the UK to invest in measures to tackle the shortage **[PC/016 - INQ000114252]**.

h. On 10 September 2020, Theresa Fyffe, Director of RCN Scotland, gave oral evidence to the Scottish Affairs Committee inquiry into coronavirus in Scotland.

i. In September 2020, the RCN provided written evidence to the All-Party Parliamentary Group (APPG) for Coronavirus detailing the most pressing and significant challenges nursing staff faced during the pandemic, of which staffing was one **[PC/017 - INQ000176039]**.

j. In January 2021, RCN Northern Ireland submitted supplementary evidence to the NHS Pay Review Body 2021-2022, summarising the key nursing workforce issues in Northern Ireland **[PC/018 - INQ000114328]**.

k. In January 2021, the RCN submitted written evidence to HM Treasury Budget 2021, inviting commitments to fund safe staffing levels **[PC/019 - INQ000114341]**.

l. In January 2021, the RCN submitted evidence to the NHS pay review body: 2021/22 pay round that the pandemic had reinforced staff shortages **[PC/020 - INQ000114340]**.

m. In June 2021, the RCN submitted evidence to the Health and Social Care Select Committee on 'Workforce burnout and resilience in the NHS and social care'. **[PC/021 - INQ000418108]**

n. In October 2021, the RCN made a written representation to HM Treasury Spending Review and Budget 2021, calling on the UK Government to use learning from the pandemic to rectify the absence of funded health and workforce strategies in every country of the UK. **[PC/022 - INQ000417820]**

o. On 23 December 2021, the RCN wrote an open letter to the Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care sharing concerns about

nursing vacancy rates and urging a delay in the mandatory vaccine rollout and the removal of the temporary suspension of pensions abatement for NHS staff in order to support nursing workforce retention. **[PC/023 - INQ000417535]**

p. On 31 December 2021, the RCN again wrote to the Secretary of State for Health and Social Care, highlighting, amongst other issues, the subject of staffing for the planned Nightingale hospitals and associated safe patient care and suggested measures to help recruit, retain, and motivate the nursing workforce. **[PC/024 - INQ000328841]**

a. In March 2022, the RCN made a written submission to the Pay Review Body 2022-23, calling for a substantial, restorative pay rise to address the nursing workforce crisis. **[PC/025 - INQ000417713]**

b. In March 2022, the RCN made a written submission to the UK Parliament's Health and Social Care Committee Inquiry into 'Workforce: recruitment, training and retention in health and social care'. **[PC/026 - INQ000418109]**

c. In June 2022, the RCN published the report, 'Nursing under unsustainable pressures: staffing for safe and effective care in the UK', which highlighted the negative impact of the departure from the European Union and the ongoing consequences of the Covid-19 global pandemic, on the existing, long-standing issues with health and care workforce supply in the UK.**[PC/027 - INQ000417714]**

50. The following guidance documents were developed by the RCN and shared with members to assist in their re-deployment:

a. In March 2020, the RCN published a briefing for the health and social care workforce on how best to support re-deployed individuals. The guidance included advice for managers on a variety of topics including: the induction process, accountability, meeting the needs of the nurse and midwife, training needs, promoting wellbeing as well as links to RCN and other resources **[PC/028 - INQ000417515]**.

b. Nursing Support Workers were also required to make adjustments to their normal duties, and the RCN developed an FAQ to support them on 29 April 2020.**[PC/029 - INQ000418964]**

c. The RCN, as part of the Critical Care National Network Nurse Leads Forum ("**CC3N**"), helped draft a national role profile and competences for Nursing Associates currently working in Critical Care in June 2020.

d. In November 2020, the RCN produced a poster and postcard on safe staffing levels, highlighting potential concerns for staff and signposting to the RCN's safe staffing campaign.**[PC/030 - INQ000417511].**

e. Launched in January 2021, the RCN had input into a learning tool, 'Introducing Critical Care', with bite-sized resources covering the many different aspects of critical care, to support nursing staff who may never have worked in critical care but were deployed there during the pandemic.

Nursing numbers during the pandemic

51. The NMC is responsible for collating data on registered nurses and provides regular reports, which are available on its website. Data from the NMC indicates that the total number of nurses, midwives and nursing associates on the permanent NMC register as of 31 March 2020 was 716,607, of which 37,913 were midwives and 7,142 were nursing associates. There were also 7,658 nurses and midwives on the NMC temporary register as of 31 March 2020. The membership of the RCN as of March 2020 included more than 470,000 nurses, nursing support workers and students, from a wide range of ethnic backgrounds and ages. By March 2021, the RCN membership had risen to almost 490,000 and reached almost 500,000 members by March 2022 **[PC/031 - INQ000417518].** The RCN does not hold disaggregated figures of how many nurses there were in each healthcare setting nor does the RCN hold details of members identifying as having a disability. The RCN does not have a separate membership category for midwives.

52. The publication, "NHS Sickness Absence Rates - January 2020, Provisional Statistics" which includes data for England only, indicates that the overall sickness absence rate for England was 4.8% in January 2020. The overall figures included rate of 1.54 % for NHS Hospital and Community Health Services ("**HCHS**") doctors, 5.06% for nurses & health visitors, 5.76% for ambulance staff, 3.49% for scientific, therapeutic & technical staff and 6.64% for clinical support staff for doctors, nurses & midwives.

53. By April 2020, the overall NHS sickness absence rate for England had increased by almost a third from January 2020 to 6.2%. Increased sickness absences rates were seen

in almost all staff groups but most noticeably: HCHS doctors 3.01%, nurses & health visitors 7.41%, ambulance staff 7.06%, scientific, therapeutic & technical staff 4.19% and clinical support staff for doctors, nurses & midwives 8.53%. 30.6% of all absences recorded in April 2020 related to Covid-19.

54. In January 2021, the overall NHS sickness absence rate for England was 5.7%, significantly higher than January 2020, with the majority of staff groups seeing relatively high rates of sickness/absence including: doctors (2.03%), nurses & health visitors (6.73%), ambulance staff (8.93%) and clinical support staff to doctors, nurses & midwives (7.96%). The NHS Sickness Absence report for the month indicated that 637,734 full time equivalent days were lost due to Covid-19 related sickness absence in January 2021, equating to 28.6% of all absences recorded, compared to 18.4% in December 2020. This is close to the peak of 30.6% in April 2020.

55. During January 2022, the overall sickness absence rate for England was 6.7%. This is higher than both January 2021 (5.7%) and January 2020 (4.8%).

56. Although the RCN has not conducted research specifically into the impact of absences of healthcare workers other than nurses during the pandemic, it would be reasonable to anticipate that the shortages of a number of staff had a significant impact on the ability of nursing staff to provide safe and effective care.

Nursing vacancies

UK

57. Prior to the onset of the pandemic, domestic nursing supply was fragmented and had not kept pace with the rising population need, causing an unethical overreliance on international staff to fill the gaps in some parts of the UK. Whilst the RCN stresses the contribution made by professionals from around the world to our health and care services and defends the rights of individuals to work in the UK, the College was concerned about the number of new joiners to the NMC register that have been recruited from the "red list" of 47 countries that the UK government insisted should not be actively recruited from. The UK list mirrored the World Health Organization ("**WHO**"), which says these 47 countries face the most pressing health workforce shortages and must not be targeted for systematic recruitment by NHS or independent employers. The UK government had been warned by relevant cross-party parliamentary groups, health think tanks, trade unions and other influential health sector organisations, about the growing scale of the nursing

workforce shortage, within the context of growing population needs. The RCN routinely urged ministers to pay close attention to fixing the existing workforce gaps as well as addressing the issues related to an aging workforce: many of our professionals are in the later stages of their career - a third on the register are over 50 years of age. The shortage of nursing staff and the absence of a fully funded workforce strategy in England and Northern Ireland remain fundamental concerns of the RCN.

58. The RCN 'Building a Better Future' survey of around 42,000 RCN members in August 2020 showed a worrying rise in those reporting that they were considering leaving the profession, with 61% of members citing pay, and almost half citing low staffing levels as a key factor **[PC/032 - INQ000176038]**. Whilst some additional support from professionals from the NMC's Covid-19 temporary register had been made available, over a third (38%) of nursing professionals who responded to this survey during the pandemic said staffing levels had worsened compared to before the pandemic. Indeed, a third of respondents reported that they were working more hours than before the pandemic.

59. By June 2021, NHS Vacancy Statistics from NHS Digital indicated that there were 38,952 FTE registered nurse vacancies in England, equating to a vacancy rate of 10.3%. Vacancies were more severe in areas of care which were clearly identified as service delivery priorities in the NHS Long Term Plan. There had been consistent decreases in the number of NHS district nurses (-44.0%), school nurses (-30.6%), learning disability nurses (-44.0%), mental health nurses (-6.1%), and health visitors (-22.4%) between September 2009 (when workforce reporting began) and July 2021. In NHS Scotland, as of June 2021, there were 4,845 nursing and midwifery vacancies, up from 4,494 in March 2021 and a previous high of 4,013 before the pandemic, in June 2019. This represented a vacancy rate of 7.1% (Turas Data Intelligence). The percentages of nurses leaving the register were most concerning for Northern Ireland, with NMC data as published in their report 'The NMC register Northern Ireland 1 April 2021–31 March 2022' indicating a 20.8% increase in leavers between 2021-22 from 2020-21.

60. In November 2021, the NMC mid-year register report suggested that although the register was growing, the number of nurses leaving it had reached its highest point in almost five years. During the period from April to September 2021 24,036 nurses, midwives and nursing associates joined the UK permanent register for the first time. During the same period, however, 13,945 nurses, midwives and associates left the register, which was the highest level since 2017.

England

61. In July 2021, the RCN published the report, 'Nursing Workforce Shortages in England: 21 Missed Warnings' which highlighted the UK Government's failure to heed the multiple warnings about inadequate workforce planning by numerous organisations in the years before the pandemic and that, due to the scale of workforce insufficiency for the delivery of safe and effective care, it was necessary to execute emergency powers to enable the regulator to register retired nurses, and to deploy nursing students. **[PC/033 - INQ000469933]**.

62. On 12 January 2022, the RCN wrote an open letter to NHS Chief executives in England, highlighting concerns regarding members working in extraordinary circumstances, under extreme pressures and with challenging nurse-to-patient ratios and highlighting employer's duties to staff under The Health and Safety at Work etc Act 1974 (GB) or equivalent legislation **[PC/034 - INQ000328775].**

63. In March 2022, the RCN reported to the NHS Pay Review body that the situation for the nursing workforce was even more critical than the previous year. The NHS was under intense pressure with a growing number of organisations having declared 'critical incidents' meaning they were unable to provide a range of critical services, as they struggled to cope with the impact of soaring staff absences caused by Covid-19 both within the NHS and the wider health and social care system.

64. In recognition of the unprecedented pressures Covid-19 had added to the NHS, the Government had announced several packages of additional funding for the NHS in England, including a £36billion investment to tackle the NHS backlog of elective care, funded by the new Health and Social Care Levy. However, without a specific commitment of funding to address staffing shortages across the health and care workforce, recovery from Covid-19 will be impossible and the crisis facing our health and care system will remain. We need dedicated funding for workforce supply, recruitment, and retention through a fully funded workforce strategy.

Scotland

65. In March 2022, RCN Scotland published a report 'The Nursing Workforce in Scotland', which highlighted members' concerns about the negative impact of poor staffing levels both before and during the pandemic, and which showed that the vacancy

rate across all Agenda for Change bands had increased between December 2019 and December 2021 **[PC/035 - INQ000328776]**. The highest vacancy rates in December 2021 were in district nursing (13.0%), public health nursing (12.6%), paediatrics (12.5%), mental health nursing (12.4%) and school nursing (12.0%) health. Whilst the RCN does not have particular insight into why vacancy rates were more pronounced in these areas, the increase in the overall vacancy rate was due to increased demand for Registered Nurses during this time due to additional services, such as the need for a vaccine workforce.

66. Similarly, in March 2022, the RCN invited nursing and midwifery staff from across the UK to share their experiences of the last time they were at work. The response from staff working in Scotland was significant, more than 2,300 responded, accounting for 13% of total responses, well above Scotland's per capita share. Key findings were pulled out into a separate report **[PC/036 - INQ000328777]** and included:

a. Fewer than 1 in 4 respondents from Scotland said the right number of Registered Nurses were on their last shift (the lowest figure out of any part of the UK).

b. Nearly 90% of respondents from Scotland said the number of nursing staff on their last shift was insufficient to meet all the needs of patients or service users.

c. Nearly 70% of staff working in Scotland felt that patient care was compromised on their last shift, due to staffing levels (well above the UK average of 62%) and only 16% agreed that they had enough time to provide the level of care they would like.

d. Staff were risking burnout by covering for gaps in the workforce - nearly 40% were unable to take their breaks and 62% worked additional time during their last shift.

Wales

67. The Welsh Government and/or NHS Wales failed to publish national figures for nursing vacancies in the NHS, even though the vacancy rate is a critical indicator of the pressures faced by Health Boards and is one that is published in the other countries of the UK. In the absence of any official data, RCN Wales estimated, in its report 'The Nursing Workforce in Wales 2020, that there was a minimum of 1,612 nurse vacancies in the NHS and that overtime worked by the existing workforce equated to 926 full-time

nursing posts **[PC/037 - INQ000328778]**. These estimates were based on vacancy data found in Health Board, Audit Wales and Committee papers and the real figure is likely to be higher.

68. Following numerous anecdotal reports from members, citing a sharp increase in highly dependent patients and a serious decrease in the available nursing staff, Helen Whyley, Director RCN Wales, wrote to Health Boards on 14 December 2021 **[PC/038 - INQ000417751]**. She highlighted these issues and asked the Health Boards for an urgent response to the question of whether they had paused elective services and how they were using the Local Options Framework to manage the current situation. The majority of Health Boards responded to say, in summary, that all reasonable steps were being taken. **[PC/039 - INQ000417753] [PC/040 - INQ000417754] [PC/041 - INQ000417755]] [PC/042 - INQ000417756]**

69. In light of ongoing concerns from members regarding extremes of demand and shortages of capacity, and the resulting impact on healthcare staff, RCN Wales wrote to Health Boards on 10 Januarly 2022 **[PC/043 - INQ000417761]**, highlighting the requirement for employers to adhere to their legal duty to ensure a safe working environment under The Health and Safety at Work etc Act 1974 or equivalent legislation.

Northern Ireland

70. Department of Health figures published on 30 September 2020 illustrated that there were 1,671 funded nursing vacancies across the health care sector, comprising 1,379 registered nurses and 292 nursing support staff. The registered nursing and midwifery vacancy rate stood at 7.4% and the nursing and midwifery support staff vacancy rate was 5.2%. It is important to understand that these vacancies only related to posts that, in the Department of Health's own terminology were "actively being recruited to" and that they also excluded the independent or nursing home sector, in which it had been estimated that the nursing vacancy rate was between 15% and 18%.

71. Whilst the overwhelming reasons given for leaving the register in Northern Ireland were retirement (53.1%) and personal circumstances (32.2%), it is interesting to note from the August 2020 survey (above at paragraph 58) that the two groups most commonly reporting Covid-19 having a 'strong' influence on their decision to leave were respondents who had practised in Northern Ireland (12.6 percent) and in the EU/EEA (12 percent).

72. The factors creating the nurse staffing crisis in Northern Ireland had been many years in the making and will take many years to resolve.

73. The need to promote the recruitment and retention of nursing staff in Northern Ireland was one of the two matters that led to RCN members in Northern Ireland taking industrial action in 2019. Indeed, for most RCN members, the need to secure safe nurse staffing was a more pressing consideration than the desire for pay parity with England. Moreover, the pursuit of pay parity was viewed primarily by RCN members as a mechanism to promote safe staffing, given the negative impact of pay inequality upon nursing workforce recruitment and retention.

74. The additional impact of Northern Ireland's workforce shortages had been manifested in, for example, the need for redeployment, the curtailment of mainstream services, the escalating use of agency staff, and the ever-increasing evidence of psychological trauma and burnout amongst nursing staff. Emergency measures to protect Health and Social Care ("**HSC**") during the pandemic might not have been required to the same degree or for the same length of time if an adequate nursing workforce had existed at the onset of the pandemic. The Northern Ireland Executive had, over many years, failed to build and sustain a nursing workforce that was capable of meeting the health care needs of the population.

75. This failure also impacted healthcare workers. By way of example, this was illustrated in a letter the RCN sent to a number of Trusts, such as Western Health & Social Care Trust on 21 January 2021 **[PC/044 - INQ000328779]**, in which we indicated that RCN members were contacting us in unprecedented numbers, sharing their accounts of working in extraordinary circumstances, under extreme pressure, with nurse-to-patient ratios that would not be considered as acceptable even in normal circumstances. We also explained that members were concerned that they would not be able to deliver safe and effective care for their patients and feared disciplinary action if something went wrong. We advised that staffing levels and nurse to patient ratios were an issue for employers and the wider healthcare system rather than one for an individual nurse's practice. We advised that we would continue to encourage members to raise their concerns and called for organisations to recognise their duty under The Health and Safety at Work (Northern Ireland) Order 1978 and asked that the Trust take immediate steps to reassure the registered nurse workforce that they would not be held individually or professionally accountable for any omission of patient care which can be attributed to inadequate staffing levels, skill mix, or low levels of experience in the relevant area of practice.

Safe staffing, workforce planning and resourcing

76. The pandemic highlighted long term failures in workforce planning and the need for workforce planning across health and social care to be a focus of recovery, particularly in light of the changed landscape for services and workforce.

77. Ambiguity about responsibility for policy and funding interventions for the supply, recruitment, retention and pay of healthcare workers led to endemic and systemic workforce shortages. There is currently no specific legal accountability for the provision of staffing for taxpayer-funded services. As a result, costed workforce planning is not done consistently or strategically; nor is it based on credible modelling of population health to meet patient demand. This could lead to missed care and patient safety being compromised. Chronic staff shortages, especially in emergency and critical care nursing have impacted on the system's ability to cope both with the pandemic as well as ongoing service demands.

78. Prior to the pandemic, the RCN had repeatedly called for governments in England and Northern Ireland to introduce legislation to create clear roles and responsibilities for workforce planning throughout the health and care system **[PC/016 - INQ000114252] [PC/018 - INQ000114328] [PC/019 - INQ000114341] [PC/020 - INQ000114340]**. The Welsh government has set out legislation on how decisions about staffing should be made and scrutinised (the Nurse Staffing Levels (Wales) Act 2016) **[PC/045 - INQ000114398]**. In Scotland, the Health and Care (Staffing) (Scotland) Act 2019 had been passed setting out requirements for safe staffing across both health and care services, but the implementation was delayed due to Covid-19 **[PC/046 - INQ000114399]**.

Wales

79. The Nurse Staffing Levels (Wales) Act 2016, the first of its kind in Europe, was introduced to empower nurses, protect patients and ensure there is a safe level of nursing staff to care for patients. It means Health Boards and NHS Trusts in Wales must "*have regard to the importance of providing*" appropriate numbers of nurses in all settings. The requirements go further in adult acute medical and surgical settings and in children's wards, where nurse staffing levels must be calculated according to a specified methodology and maintained at that level.

80. RCN Wales wrote to Vaughan Gething, Minister for Health and Social Services, on 6 May 2020 **[PC/047 - INQ000328786]**, requesting confirmation that nurses would not be pressured into working in a scenario where safe staffing ratios were not being complied with, acknowledging that poor nursing staff levels results in patient harm. On 28 May 2020 RCN Wales received a response from Vaughan Gething **[PC/048 - INQ000328787]** confirming that the Nurse Staffing Levels (Wales) Act 2016 remained effective during the Covid-19 pandemic, and that the Chief Nursing Officer for Wales ("**CNO for Wales**") had made that clear to NHS Wales' Executive Nurse Directors.

Scotland

81. In 2019, the Health and Care (Staffing) (Scotland) Act received Royal Assent. The legislation places a duty on NHS and social care providers to make sure that, at all times, there are suitably qualified and competent staff working in the right numbers. The Act also requires NHS boards to seek clinical advice when making staffing decisions and to establish a clear process for concerns about unsafe staffing levels to be reported and escalated. However, due to the pandemic, work on implementing the legislation had been paused.

82. On 16 December 2020, Theresa Fyffe, wrote to Jeanne Freeman, Cabinet Secretary for Health and Sport, regarding a lack of progress on the implementation of the Health and Care (Staffing) (Scotland) Act. This was followed up with a letter to Diane Murray, Deputy Chief Nursing Officer, dated 23 December, reiterating RCN's concerns regarding the lack of progress and requested an indication as to when the Act may be brought into force. The letters were discussed at a subsequent meeting on 14 January 2021, after which the RCN Scotland Director received a follow up letter from the Cabinet Secretary on 25 January 2021 **[PC/049 - INQ000328788]**. The Cabinet Secretary agreed on the importance of the Act and indicated that although implementation of the legislation had paused due to the pandemic, a Healthcare Staffing Programme had been established within Healthcare Improvement Scotland ("**HIS**") and that this programme would assist boards in meeting their obligations under the Act, providing support and guidance and monitoring compliance. The letter also indicated that the programme would be responsible for the development of staffing tools and methodology, as well as their review.

Northern Ireland

83. Despite RCN members in Northern Ireland taking industrial action in 2019 over the issue of safe staffing, the need to secure safe staffing legislation remains. The RCN has consistently highlighted over a number of years the absence of effective workforce planning for nursing, with 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 the HSC service because of shortages within the community nursing workforce upon which the refocusing of services is largely dependent. These issues have previously been noted by the NHS Pay Review Body, yet none of them have adequately been addressed by the Department of Health. One of the elements in the Minister's safe staffing framework, was the need to develop effective workforce planning. The framework was endorsed by the NI Executive in January 2020. Details of the proposed framework were shared with Trade Union representatives following discussions with Departmental officials in relation to the Agenda for Change industrial dispute also in January 2020 **[PC/050 - INQ000417513]**. However, as of January 2021, there had been little discernible progress in delivering this.

84. Current and pre-existing deficits within nursing workforce planning in Northern Ireland were identified and analysed in two major reports published during 2020; the report of the Department of Health Nursing and Midwifery Task Group, and a report published by the Northern Ireland Audit Office on workforce planning for nurses and midwives. The RCN commended both reports to the NHS Pay Review Body in January 2021 and suggested that it may wish to seek information from the Department of Health, the universities, and the NMC on programme attrition rates and the gap between the numbers of those who successfully complete programmes and those entering employment within the HSC. If the Minister's safe staffing framework was to have the desired impact, it was essential that progress was measured and evaluated.

85. On 18 June 2020, RCN Northern Ireland gave evidence to the Northern Ireland Assembly's Committee for Health. The issues raised were varied, but high on the agenda was safe staffing legislation.

UK and England

86. In responding to the government's commitment to increase nurse numbers in the NHS in England by 50,000, which formed part of the budget statement on 11 March 2020, the RCN was clear that detailed plans were needed for how new nurses would be educated or recruited, and how nurses leaving the NHS would be persuaded to stay.

87. The findings of the Public Accounts Committee's 'NHS nursing workforce report' of 23 September 2020 reflected this. The RCN shared the committee's view that there must be a proper long-term plan for the nursing workforce in England and national plans to increase recruitment and retention. Government should have been aiming for 'oversupply' after years of under-investment.

88. On 11 February 2021, the UK government published a White Paper on Health and Care setting out the latest steps to reform parts of the NHS in England, which suggested that Ministers were inching closer to taking responsibility for ensuring safe and effective care with enough nursing staff. The proposals, however, needed to be made a priority and matched with investment.

89. In May 2021, the RCN published professional standards on staffing for the nursing workforce in the UK with a view to them being used by those responsible for funding, planning, contracting, commissioning, designing, and providing services which require a nursing workforce in any setting **[PC/009 - INQ000416485]**.

90. In January 2022, the proposed Health and Care Bill was a landmark opportunity to address structural issues and embed more collaborative working across health and social care. The RCN was clear that, as it stood at the time, the Bill did not go anywhere near far enough to address the concerns of nursing staff and ensure patient safety. We continued to call for the expansion of accountability for workforce planning and funding in law, and investment in nursing higher education in England.

91. Responsibility for safe staffing in the health and care system must sit with the Secretary of State. The scale of the workforce crisis and the lack of sustained political response to credibly tackle these issues in a sustainable way, demonstrate that the existing powers and duties in legislation are inadequate to hold government to account.

92. Baroness Watkin's proposed amendment to the Bill was supported by the RCN and 90 other organisations. Had the amendment been accepted, the Bill would have required the Secretary of State to lay before Parliament a fully funded health and care workforce strategy to ensure the numbers and skill mix of health and care staff were sufficient for safe and effective delivery of health and care services. The amendments were designed to ensure health and care services had the workforce needed to deliver safe high-quality

services now and in the future. Unfortunately, the amendment was rejected by MPs and a vital opportunity to put England's workforce planning on a strong legislative footing was lost.

Overseas qualified nurses

93. Internationally educated nursing staff play a vital role in providing safe and effective care and contributing to our health and care workforce. While the RCN has been clear that international recruitment cannot be used as a substitute for a properly resourced domestic workforce, overseas recruitment has been vital and must continue so that people can receive safe and effective care.

94. The RCN Labour Market Review for the 2021-22 pay round provided an update on numbers of nurses, midwives and nursing associates on the NMC register **[PC/051 - INQ000328790]**. This showed that 16% of the NMC register was made up of internationally trained nurses.

95. However, many EEA nurses were choosing to leave the UK, and many others were choosing not to come in the first place. This was both likely due to uncertainty and hostility around immigration and the impact of Covid-19. Overall, since the EU referendum, over 14,000 EEA nurses and midwives have left the UK workforce. A similar trend is reflected in the number of EEA registrants joining the register for the first time - with a 91% reduction between March 2016 and September 2020 (from 10,179 to 938).

96. During the same time period, the number of non-EEA nurses and midwives joining the NMC register for the first time grew by 300% (from 2,389 to 9,545), and the number of non-EEA nurses leaving the UK also reduced by 37% (from 2,090 to 1,318), however this growth in non-EEA nurses and midwives has not made up the overall shortfall in nurses from abroad since the referendum.

97. The NMC publication, "Mid-year update 1 April–30 September 2020" indicates that there were 30,895 professionals (nurses, midwives and nursing associates) from the European Economic Area ("**EEA**") on the register in September 2020, compared with 31,385 in April 2020. The number of overseas qualified professionals from outside the EEA, however, increased from 84,316 to 85,873 during the same period. Of these professionals, 33,595 (39.1%) trained in the Philippines and 24,866 (29.0%) trained in

India – a combined total of 68.1%. Additionally, as of September 2020 there were 182 EEA nurses and 234 Non-EEA overseas qualified nurses on the temporary register.

98. By the end of the relevant period, at 30 September 2022, the NMC "Mid-year update 1 April-30 September 2022 ", indicates that the number of professionals from the EEA on the register had fallen further to 28,434, a fall of almost 8% since 1 April 2020. In the same period, however, the number of professionals from outside the EU/EEA grew to 123,863, an increase in of almost 47%. Additionally, as of September 2022 there were 215 EEA nurses and 249 Non-EEA overseas qualified nurses on the temporary register. The NMC reports do not include details of the specific roles that overseas qualified nurses were working in. The RCN also does not hold this data.

99. On 23 April 2020, the RCN wrote to the Chair of the Home Affairs Select Committee, asking that the scope of the Committee's inquiry into Covid-19 be expanded to review the treatment of internationally recruited nursing staff throughout the pandemic and to consider how the UK Government valued their skills **[PC/052 - INQ000328792]**. The letter set out concerns that migrant health and care workers might be at heightened risk of contracting Covid-19 but were living in fear of having their sponsorship revoked if they needed to self-isolate or shield.

100. Anecdotally, our members had reported the impact that no recourse to public funds was having on their lives. Whilst British nationals unable to work whilst shielding or self-isolating due to Covid-19 benefitted from the security of public financial support, we were concerned that migrant workers were being forced to choose between continuing to work despite being at risk, or otherwise staying at home and falling into destitution. This was wrong and would put staff and patient lives at unnecessary risk.

101. In September 2020, the RCN welcomed the Migration Advisory Committee's recommendation that nursing support workers and assistants across health and care be added to the shortage occupation list to assist with the workforce crisis facing the nursing profession. The RCN recognised the importance of removing arbitrary barriers that prevent talented and much needed overseas healthcare professionals from working in the UK.

Nursing students

UK and England

102. RCN members raised their concerns about deployment of nursing students as early as 5 March 2020, which covered the following issues:

a. The extent to which clinical placements were a learning experience and the need to place students in clinical areas which they were familiar with;
b. Infection prevention and control and whether students should be placed in high-risk coronavirus areas;
c. Issues around registration, pay, indemnity; and
d. Whether deployment of students should be voluntary.

103. These concerns were escalated on 9 March 2020 via a conference call with representatives from the RCN, CNO and Health Education England ("**HEE**") in attendance. Some of these points, particularly in respect of clinical placements were met with some initial resistance from HEE **[PC/053a - INQ000328793] [PC/053b – INQ000328794] [PC/053c – INQ000328795]**. The RCN suggested that nursing students should only be deployed to areas in which they were already assigned to for their respective placements, as this would lessen the impact on their education. HEE were of the view that nursing students should be deployed to wherever was needed.

104. The RCN's early position on deployment of nursing students was set out in a press release dated 19 March 2020 and on 24 March 2020, the RCN submitted joint comments with UNISON and Unite on HEE's document 'Student Support guidance during Covid-19 Outbreak' **[PC/054 - INQ000328797]**. These comments highlighted issues including:

a. Whether students could remain in their own field settings;
b. Access to student loans;
c. Entitlement to sick pay; and
d. Timelines for students to make decisions about "opting in" to additional clinical placements.

105. By 24 April 2020, 2,000 nursing and midwifery students had opted to work on the front lines in the fight against Covid-19, and the RCN maintained its commitment to put their safety and interests to the fore, especially in relation to the availability of PPE but also in relation to remuneration, bursaries and student loans **[PC/055 - INQ000328798]**. An FAQ on student pay and employment was first published on 9 April 2020 **[PC/056 - INQ000328799]**.

106. Once the first wave of the pandemic subsided, the aim was for students to transition back to supernumerary placements so that they could complete their studies. The RCN was consulted on a set of FAQs, produced by HEE alongside the NMC, the Council of Deans of Health, NHS Employers and other unions in June 2020 to help address the transition. This included clarity on paid placements, which we welcomed for our student members.

107. In January 2021, students in England, although not in Wales, Scotland or Northern Ireland were again called upon to support the pandemic response via paid placements. The RCN's position was that the local decision to ask final year students to volunteer should only be done where all other options for increasing the workforce had been exhausted, and that no student should feel pressured to do so; and that any students being asked to provide support must be given the same rights and protection as all other frontline workers, including vaccinations and PPE **[PC/057 - INQ000328800]**. Final year students were offered the option to assist, on a local basis, with individual higher education institutions and placement provider organisations implementing paid placements. Students were aware that the offer was optional, not mandatory. The RCN continued to be contacted, however, by limited numbers of student nurses regarding issues around PPE, including problems with fit testing, fears over a lack of protection from the level of PPE provided, psychological difficulties around wearing masks and limited opportunities for refreshments while wearing PPE.

Wales

108. RCN Wales worked with the CNO for Wales and Health Education and Improvement Wales ("**HEIW**") to produce guidance and information for nursing and midwifery students who were undertaking their course in Wales **[PC/058 - INQ000328801]**. However, RCN Wales was disappointed not to have been engaged in the arrangements to ensure consistency for nursing students as set out in the 4 May 2020 letter to the Chief Executives of Health Boards and Trusts from the CNO for Wales and NHS Wales. This disappointment was expressed in a letter of 5 May 2020 from Helen Whyley, RCN Wales Director which raised concerns about confusion surrounding deployment of student nurses and the lack of parity around training and support **[PC/059 - INQ000328802]**. RCN Wales was keen to ensure that CNO Nursing Officers worked in partnership with RCN Wales to best utilise the RCN's professional expertise to inform the development and implementation of guidance affecting nursing students. The CNO for Wales replied on 20

May 2020 on behalf of both recipients, acknowledging the valuable working relationship with the RCN and explaining how the joint correspondence dated 04 May 2020 had been issued to address the lack of coordination in implementing the agreed deployment guidance for nursing and midwifery students **[PC/060 - INQ000328803]**.

109. On 12 May 2020, RCN Wales wrote to the Welsh Government Minister for Education, asking that the value and commitment of nursing students in Wales be recognised by way of a reimbursement of tuition fees and forgiving of current debt **[PC/061 - INQ000328804]**.

110. On 19 June 2020, RCN Wales provided written evidence to the Children, Young People and Education Committee inquiry into Covid-19 **[PC/062 - INQ000328805]**. It recommended:

a. Universities and Health Boards should work together to ensure every nursing student that assisted the Covid-19 response in Wales is offered a debrief and access to mental health support and resources;
b. The Welsh Government should ensure that no student has suffered educational or financial detriment as a result of their assistance in response to Covid-19 and ensure any maintenance loan debt is waived; and
c. The Welsh Government should aim to mitigate the impact of Covid-19 on prospective nursing students and ensure recruitment to nursing is not negatively impacted by Covid-19.

111. For the duration of the Covid-19 crisis, second and third year nursing students in Wales could opt to extend their clinical placement to a maximum of 80% of their degree programme (retaining 20% academic time) by providing frontline care. If they did so, they were paid at a Band 3 or 4 level, depending on their completed time on their degree programme. Their degree was not suspended; instead, the university, NHS Wales and the NMC recognised the time spent working clinically as counting towards the required clinical placements hours for the degree. In addition, students with six months or less to qualification were offered the option of spending the last part of their programme 100% in placement and to join a temporary section of the NMC's emergency register working in a Band 4/5 role.

112. The beneficial intention of this policy was clear: it was an attempt to ensure that nursing students would not need to work more to "catch up" to their degree and that

Wales would not suffer from a cohort of "missing nurses" once Covid-19 subsided. However, in practice, this policy was implemented poorly, creating more confusion, anxiety and distress than necessary. RCN Wales received a high volume of calls from anxious and worried students:

> *"I'm extremely disappointed by the lack of communication and support during this time. It has made myself and many other students feel unvalued and unsupported. I'm very confused as to how and why we had to opt in or out without knowing any terms and conditions of the agreement, no contract, no information on our new role or payment. All we know is we will be expected to work full time as band 4 which I'm more than happy about but we also have to complete all our academic work of 3 essays, third year competencies, management competencies and our portfolios. It appears no consideration has been made to how people will achieve this with no access to library or other places to do academic work and research. When not in work those of us with children are home schooling our children"* - E-mail from RCN Wales student member

113. Nursing students overwhelmingly aided the Welsh Covid-19 response, despite confusion over the polices and guidance. Nursing students assisted in the treatment of patients with suspected or confirmed Covid-19. It is important to consider the mental impact, especially on individuals' anxiety, that this may have had on these students. The RCN called for nursing students to be offered a debrief to discuss their own unique experience during the Covid-19 response.

Scotland

114. RCN Scotland offered comments on a student support document from Scotland's Chief Nursing Officer (**"CNO for Scotland"**) **[PC/063 - INQ000328807]**, flagging additional member concerns about:

a. Academic deadlines;
b. Stress levels;
c. Bursary payments;
d. The lack of clarity on options available to them;
e. PPE; and
f. Issues surrounding registration.

115. Nursing students in Scotland felt so lost and concerned about the future of their degrees that they wrote to Nicola Sturgeon, the First Minister of Scotland at the time **[PC/064 - INQ000328808]**. In support, RCN Scotland wrote to student members to outline everything being done on their behalf **[PC/065 - INQ000328809]**. It also updated FAQs for nursing students in Scotland **[PC/066 - INQ000328810]**

116. On 28 January 2021, RCN Scotland wrote to the CNO for Scotland **[PC/067 - INQ000328811]**, attaching a selection of feedback from student members and requesting the following:

a. Nursing students with clinical placement hours to make up to be enabled to graduate within appropriate timescales;
b. Protection of supernumerary status of students on placement;
c. Ensuring the suitability of placements for students with travel requirements or childcare commitments;
d. Clarification of nursing student key worker status;
e. Alternatives to placements for students with individual risk factors; and
f. Financial support to extend to the current cohort of third year students.

117. In her response, dated 2 February 2021, the Chief Nursing Officer committed to continuing discussions, while addressing some of the issues directly **[PC/068 - INQ000328812]**.

118. RCN Scotland created a comprehensive set of guidance and FAQs for student members in Scotland which were made available on the RCN website.

Steps taken to increase the number of registered nurses

NMC Temporary Register

UK and England

119. Registered nurses, midwives and nursing associates across the UK are required to be registered on the NMC register in order to practise.

120. The Coronavirus Act 2020 introduced powers for the NMC to establish a Covid-19 temporary emergency register ("**the Covid-19 temporary register**"). 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.

121. 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.

122. 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 Covid-19 temporary register ("**the Joint Statement**"), which was released on 19 March 2020 **[PC/069a - INQ000328814] [PC/069b - INQ000328815].** 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.

123. On 2 April 2020, a further update on the Joint Statement on expanding the nursing and midwifery workforce in the Covid-19 pandemic was issued by the NMC **[PC/070 - INQ000300100].** The statement identified two additional groups of people who the NMC would invite to join the Covid-19 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 Return to Practice programmes.

124. 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%).

125. The RCN was clear that, if there was an issue relating to a member of nursing staff whilst temporarily registered that led to consideration of their removal from the Covid-19 temporary register, it expected the NMC to take into account the context in any cases that arose and ensure fair processes. The RCN urged that a full 'human factors' approach must also be considered when reviewing any incidents which occurred, including the staffing levels and skills mix at the time of the incident as well as working conditions. The

RCN is not in a position to identify the number of occasions where a temporarily registered nurse was in fact subject to consideration of removal from the temporary register. This would be a matter for their regulator, the NMC.

Scotland

126. 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 **[PC/071 - INQ000328817]**. Anecdotal evidence, discussed in the WSLG suggested that mobilising the student workforce in Scotland 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 never have worked and where there was no existing central system that could identify need because of the nature of providers; protecting vulnerable group ("**PVG**") 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 **[PC/072 - INQ000452514]** to help support the deployment of students and returners recruited through the Covid-19 Accelerated Recruitment portal.

127. Although mobilising the student workforce in Scotland may not have initially been as quick as it could have been, data for the NHS Scotland workforce showed that by June 2020, 2,423 nursing students were in employment within the nursing support workforce (making up 3.8% of a workforce of 63,178). This data is an underestimate, however as some NHS employers added student details only to the NHS payroll system and not also to the NHS HR system, in order to progress induction at pace, and NHS Education for Scotland excluded individuals not recorded on both systems from the NHS Scotland national workforce statistics.

128. 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

129. Following the release of the Joint Statement on expanding the nursing workforce on 20 March 2020, Helen Whyley wrote to, amongst others, the CNO for Wales, and Director of Nursing HEIW, requesting an urgent meeting to discuss the implementation of the Covid-19 temporary register in Wales **[PC/073 - INQ000328818]**.

130. On 3 November 2020, a letter from Vaughan Gething documented a meeting with Helen Whyley that had taken place on 8 October 2020 **[PC/074 - 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.

131. 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 Health Education and Improvement Wales ("**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 was unclear.

132. 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 **[PC/075 - INQ000328820]**.

The impact of the pandemic on doctors, nurses and other healthcare staff

133. 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. 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.

134. 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 Post Traumatic Stress Disorder ("**PTSD**"). Chief nurses had reported their concerns about the ongoing impact of the pandemic on staff health and wellbeing and had real fears about the long-term impact of PTSD.

135. As early as 1 May 2020, the results of the RCN Research Society's survey into the impact of Covid-19 on the nursing and midwifery workforce showed that staff were feeling depressed, anxious and stressed during the Covid-19 pandemic. There had been issues in gaining access to suitable and sufficient PPE and insufficient access to Covid-19 testing for health and care workers, meaning that many nurses and nursing support workers had been unnecessarily self-isolating, placing additional pressure on other staff. Furthermore, alarmingly almost 30% of survey respondents reported experiences indicative of a probable PTSD diagnosis three-months after the first pandemic peak.

136. In an effort to combat the impact of the pandemic on the mental health of healthcare workers, the RCN worked with '87 Percent Limited' to provide members working in emergency and critical care settings access to the Royal College of Emergency Medicine's Wellbeing App.

137. The RCN also 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 in June 2021 **[PC/076 - INQ000114331]**.

138. The RCN undertook a number of extensive surveys of its members working across all health and social care sectors. In August 2020, the RCN published the findings of a survey of 42,000 members' experiences of the pandemic in a report entitled 'Building a Better Future for Nursing' **[PC/032 - INQ000176038]**. Results clearly showed that working during the pandemic was a stressful experience for nursing staff. Some of the survey's key findings:

a. over half (56%) of respondents said that staff morale was worse than before the pandemic;
b. a third of respondents reported working additional hours;
c. three quarters of nursing staff reported higher stress levels than before the pandemic both among their colleagues (87.1%) and themselves (77.2%), with stress cited as a major reason for considering leaving the profession;

d. although 88% of participants said they were passionate about the nursing profession, 91% were concerned about the wellbeing of colleagues.
e. 58% of respondents reported that they were concerned about their own physical health;
f. 52% worried about their own mental health; and (84.1%) stated they were worried about health and safety.

Physical well-being

"Will you be helping nurses whose hands are red raw, blistered, swollen, painful from the hand sanitisers, their faces are bruised and swollen due to the masks, goggles, visors for 13 hours a day!"

"All Critical care nurses are suffering from having to spent 12 hours at a time in this PPE. Pressure cuts on nose – sore hands – it's horrific."

139. During the pandemic, the use of PPE was essential to protect against the virus. As the pandemic progressed, however, it became apparent that wearing PPE for extended periods of time caused considerable discomfort and damage to skin. As any damage to the skin could become a portal for potential infection, this was particularly concerning. In April 2020, therefore, the RCN published guidance entitled 'Maintaining Skin Safety when using PPE' **[PC/077 - INQ000328822]**.

140. Working long days, with few or no breaks, or limited recovery time between shifts, can lead to fatigue and wearing PPE for long periods can cause heat stress and discomfort to the user. Fatigue is a recognised factor in safety incidents and can lead to staff exhaustion and burn out. Lessons learnt from the Ebola outbreak identified fatigue associated with the use of full PPE as a risk to staff being able to perform clinical tasks safely and for extended periods of time (Li et al. Infectious Diseases of Poverty (2018) 7:92). Donning and doffing of PPE and clothing also carries a high risk to healthcare workers of contamination of micro-organisms and therefore will place staff at risk of exposure to Covid-19. Guidance on the physical impact of wearing PPE, along with a wide range of other employment and clinical advice was published on the RCN's website throughout the pandemic. An example of this is a captured by a copy of the front page of the RCN's Covid-19 website pages from January 2021, which lists the range of advice, guidance, and information available on the RCN's website about Covid-19 **[PC/078 - INQ000472315].**

141. A further possible consequence of staff fatigue during the pandemic was an increase in the incidence of needlestick injuries and similar incidents. In May 2021, the RCN's report 'Blood and Body Fluid Exposures in 2020' identified a significant increase in such events (15% of respondents reported such incidents in 2020 compared to 10% in 2008), and hypothesised that this could be attributed to Covid-19 workloads, fatigue, lack of training, lack of safer sharps and sharps bins, cumbersome PPE and stress **[PC/079 - INQ000328823]**.

142. The RCN considered that a potential by-product of these pressures could lead to an increase in fitness to practise referrals being made to the NMC. The RCN wrote to the NMC on 15 January 2021 **[PC/080 - INQ000418038]** referencing the perilous circumstances that our members were working in. This was in part due to insufficient number of registrants needed to meet current demand as well as insufficient guidance from the NMC on adequate staffing ratios in both High Dependency and Intensive Care Units. The RCN was clear that with so many interrelated issues impacting on safety, there must not be a compromise on the delivery of safe patient care. The RCN was clear that employers must take responsibility for decisions over which individual nurses had little or no control and asked that the NMC worked with employer organisations to put in place clear guidance and processes for registrants working in highly challenging environments. The NMC responded on 22 January 2021, acknowledging the extraordinary challenges nurses were facing, as well as the exceptional efforts they were making to care for patients during the Covid-19 pandemic, and setting out the measures it had in place to support them **[PC/081 - INQ000328824]**.

143. The effects of the pandemic on the health of healthcare workers were broader than fatigue and skin health. In October 2021, the RCN launched its Winter Wellbeing campaign, to encourage members to prioritise their own health following RCN analysis that showed NHS staff in England were more at risk of chest and respiratory problems and migraines than before the pandemic **[PC/082 - INQ000328825]**.

Mental wellbeing

144. The RCN provides members with free confidential advice, including financial advice and counselling. The RCN saw a dramatic increase in calls to our member helpline

relating to stress, burnout and mental health during the pandemic. The RCN has analysed tagging for these calls using the terms "stress(ed)", "anxiety", "anxious", "tired", "Post Traumatic Stress Disorder", "tearful", "exhausted", "overwhelmed" and "drained". For the period from March to mid-August 2020 there was a 27% rise in these types of calls compared with the same period in 2019.

145. A summary of some of the calls follows:

a. *"In my area during the pandemic, we lost about 50% of our workforce because they were shielding or self-isolating. We had to change our shift patterns. I didn't get to see my kids for months apart from some distance, I couldn't live with the idea that I could bring something home...I went to work with a daily fear of dying. I actually had some colleagues in hospital with COVID-19…the emotional impact was just terrible and talking about this is actually making me feel quite emotional…This will come back later to affect nurses".*

b. *"Keeping my children safe at home between shifts is keeping me awake at night"*

c. *"I have been a qualified nurse for almost thirty years. I was redeployed to ICU in March 2020 and really struggled on return to my own job. Now I've been diagnosed with PTSD. I feel like a failure. Or have I been failed?"*

d. *"…looking after the mental health and wellbeing of staff has been a constant concern for me. At health and safety meetings, I ask for a breakdown of figures for those staff who are off work with mental health issues, rather than simply focusing on the COVID-19 statistics that are usually provided. We've seen a rise in the numbers of people who are off with stress and it's so important we know how many people are struggling."*

146. The RCN Counselling Service offered trauma-focussed therapy for members, funded by RCN Foundation's Covid-19 Healthcare Support Appeal, such were the challenging emotional issues experienced by our membership **[PC/083 - INQ000328826]**. The need for such support was reinforced by the results of the NHS Staff Survey 2020, which revealed that over 45% of nurses worked on Covid-19 wards during the pandemic and that nearly half (44%) of all NHS staff reported feeling unwell as a result of work-related stress.

147. Our Counselling Service also 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.

148. 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.

149. RCN Northern Ireland and RCN Scotland sought to capture the lived experience of being a nurse during the pandemic using the SenseMaker tool **[PC/084 - INQ000328827] [PC/085 - INQ000328828] [PC/086 - INQ000328829] [PC/087 - INQ000328830]**. Nurses were asked to share a story from their recent experience and to answer some follow-up questions related to their specific experience. This distributed approach allowed for the capture of a high volume of qualitative narratives which could then be analysed using quantitative patterning. Overall, in excess of 900 stories were collected. This afforded nurses the opportunity to document their experience in their own words.

150. 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' **[PC/088 - INQ000328831]**. The results were clear – that stress and exhaustion were taking their toll. The key themes arising from the report are detailed below:

A) Rapid change and the impact of redeployment:

There were many positive examples of how nurses rapidly adapted to new ways of working and used their professional judgement to deal with unknown and new situations. The importance of teamwork and a sense of camaraderie were highlighted as

key enablers of resilience. Being innovative and using one's own initiative were attributes that were demonstrated frequently by nurses when faced by the new situations and challenges. Later in the pandemic, redeployment was more commonly cited in relation to increased stress and exhaustion. An over-reliance on bank and agency staff who were unfamiliar with the wards they found themselves in was also said to be contribute to a lowering of morale.

B) Reflective practice and adaptable support:

Time to reflect, support from peers and line managers, and flexibility in the face of changing circumstances were highlighted as effective ways to support nurses to get on with their jobs and adapt to new ways of working. Post the immediate 'crisis' in March to April 2020, stories reflected the need for proactive rather than reactive support. Reflective practice opportunities during the May to September 2020 period were said to be vital in supporting the workforce to make sense of the crisis phase and build resilience and learning from the experience.

C) Personal health and wellbeing:

A consistent pattern over the project duration was that nurses prioritise their work and patients over their personal health and well-being. Physical and psychological safety are key components of wellbeing and the evidence from the stories shows that these were not adequately in place during 2020-2021. There were many 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.

D) Leadership and communication:

The importance of calm effective leadership was frequently highlighted, particularly during the early stages of the crisis. Many nurses spoke of being inadequately prepared for the ensuing workforce changes. A common experience shared in the stories was about nurses hearing news about redeployment or other issues through the media, rather than through internal management lines and leadership role holders. Nurses reported they were confused and unsettled by the rapid changes in guidelines and the issuing of frequently contradictory information.

E) Teamwork:

The overriding theme common in almost all narratives captured in October to December 2020 was that of stress and exhaustion. Emotional support and camaraderie in close teams was reported to be a source of resilience.

F) Bereavement:

Throughout 2020–2021, nurses' stories described the emotional and professional challenges they experienced when confronted with a much higher than usual frequency of death in patients. The emotional toll was experienced in a personal way as while patient deaths are not unusual in some settings e.g., critical care, the numbers and range of patients who died as a result of Covid-19 caused a different form of distress. Nursing staff found themselves challenged to manage expectations of families and patients, while offering empathy and support, especially when they felt that their personal ethics of care had been compromised by Covid-19 restrictions.

151. November 2020 to January 2021 brought another wave and lockdown. Stress and exhaustion became a recurring theme of the calls that were received into RCND, as illustrated in the quote below. Nurses often felt like they had to compromise their own personal safety in order to make ethical decisions and care for their patients, although they continued drawing strength from one another.

"Since this whole thing has started, nothing has been the same. My homelife has completely changed, I haven't seen my family members for at least eight weeks, my work routine has been turned upside down and I'm not sleeping. The situation is ever changing from the perspective of my work – the plan that is agreed one day will have changed within the space of 24 hours. I find this very disconcerting and very stressful... as a senior nurse I am trying to support my team but I feel powerless as I can't answer many of the questions they have nor can give them the assurances that they are looking for. I feel I am constantly asking them to change, adapt, be flexible in how they work to meet the needs of the current situation. I feel completely overwhelmed by how much they have all achieved in such a short space of time."

152. Many nursing students felt that they had been accelerated into situations beyond their level of readiness and talked of the detrimental effect this was having on their health and well-being:

a. *"I feel utterly deflated".*

b. *"I'm exhausted and feel disillusioned".*

c. *"I feel like walking".*

d. *"Exhausting, emotional, tired and worked to the absolute max".*

e. *"Working like this for the past 2.5 years as a student nurse has made me constantly doubt a career in nursing. Registered nurses are undervalued and miserable… The ward has been understaffed and…" I've hit my breaking point."*

f. *"I feel completely broke, I couldn't keep up with workload, it got more heavy and busy. It took me more time to recover after each shift. Every inch of my body hurts after a 12.5 hour shift and its made me wonder if nursing is where I want to be".*

g. *"Working and studying as a student nurse has never been harder. Juggling family life and financial burden alongside a pandemic, is taking the enjoyment out of my end goal of becoming a nurse. Every day we go into placement and hear the staffing numbers my heart drops knowing that today I will not learn from my mentor.*

153. The RCN also captured the experience of its RCN elected trade union representatives who represent union members in the organisation where they are employed and provide feedback and intelligence from their respective workplaces. Their experiences were summarised in the publication 'Facing COVID-19: RCN reps share stories of the pandemic' **[PC/089 - INQ000328832]**. The publication illustrates members' experiences on a wide variety of topics including supporting members with Covid-19 risk assessments, advising on staff vaccination and highlighting PPE availability. RCN representatives adapted quickly to new ways of working and worked tirelessly to ensure RCN members still received support and representation.

Financial concerns

154. The 2020 RCN Member survey findings highlighted the impact of the pandemic on personal lives with just under half (48.2%) reporting having worries about their own financial circumstances **[PC/038 - INQ000176038]**.

"Pay is not good enough. When a qualified nurse leans on family financially before and after covid for basics like food is not acceptable. after I've paid my outgoings have £200 for food, fuel, clothes, for a family of 4 for a month."

Band 6 senior nurse

155. Financial concerns were particularly acute among younger nursing staff (57% of respondents aged 44 or younger stated they were worried about their financial situation) and among staff from black or ethnic minority background (76% of black respondents and 74% of Asian respondents) as well as those employed on lower pay bands (59% of respondents employed on Agenda for Change bands 1-4 and 54% on band 5), highlighting the pressures felt by different groups within the nursing workforce.

156. Between November 2020 and the first week in January 2021, enquiries about payment of Statutory Sick Pay ("**SSP**") for Covid-related absences generated in excess of 90 calls to RCND **[PC/090 - INQ000328833]**.

157. Members were also concerned about whether they would be paid when self-isolating. The RCN's position was that health and care staff should not suffer any financial detriment for being away from work to protect public safety.

158. We were also told about some employers asking members to remain at work when they should be self-isolating and to sign documents purporting to provide exemption from the Government's advice on self-isolation. The RCN did not support such documents and expected that all governments in the UK and employers should ensure full pay for staff who were self-isolating **[PC/091 - INQ000328835]**.

159. 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

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.

160. The possibility of receiving only 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 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 **[PC/092 - INQ000328836]**.

161. 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 undertaking 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 indicated to RCN members that they 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 and others' health at risk by continuing to work. These concerns were raised by the RCN in a letter to the Chancellor of the Exchequer of 15 May 2020, which called for clarification and, if necessary, amendment to the Treasury Direction **[PC/093 - INQ000328837]** To the best of our knowledge, the RCN did not receive a response from the Chancellor in response to the letter.

162. In July 2020, the RCN and other health unions won 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. 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.

163. The RCN supported the removal of the pension-related financial barriers to allow retired or partially retired nursing professionals and health care staff to return to work or increase their working commitments without having their pension benefits suspended or reduced. However, RCN Scotland had to seek clarity on Scotland's position by writing to the Cabinet Secretary for Health and Sport in December 2021, when it became apparent that the temporary suspension of the pension abatement for NHS staff in England was to end in March 2022 **[PC/094 - INQ000328839]**. The RCN were concerned that if the suspension was lifted, it would disincentivise members from remaining working in NHS Scotland and therefore detrimentally impact staffing levels.

Unequal impact of Covid-19 on ethnic minority groups

164. The NHS Workforce Race Equality Standard report for 2022 suggests that there is an overrepresentation of staff from ethnic minorities at Bands 4 to 6, which represent those professionals providing care on the frontline. Nursing associates, represented at band 4 on the NHS Agenda for Change pay scale bridge the gap between healthcare assistants and registered nurses, enabling the registered nurse to focus on more complex care. A newly qualified nurse would normally be employed as a Band 5 practitioner. The next step for the Band 5 nurse, following a period of progression through the Band 5 pay scale, would usually be a Band 6 position. The key differences between a Band 5 and Band 6 nurse would be in terms of responsibilities, skills and experiences. While the Band 5 would normally work under the guidance of senior staff, the Band 6 nurse would take on increased responsibility, often working as a Team Leader or Specialist Practitioner, supervising more junior staff, providing more advanced nursing care and being involved in service development of quality improvement projects. Throughout the pandemic, the RCN warned that staff from ethnic minorities may therefore be at increased risk of exposure to Covid-19. We also highlighted the fact that, as the pay bands increase, data shows larger increases in the number of white staff at each pay grade compared to staff from ethnic minorities.

165. Concerns raised by members through RCND highlighted the particular pressures and issues facing members from ethnic minorities, 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 call we received from our members from ethnic minorities:

a. *Member and colleague, both BAME, are the only members of their team being allocated covid patients. Member works in the community. Highlighted to team leader and Matron who both brushed off concerns…Asked for risk assessment. Risk assessment was done. Didn't take into consideration that member has underlying conditions, and BAME more at risk…*

b. *Member had a covid risk assessment and the results were that she was high risk. This is due to member being under a cardio clinic as she suffers with palpitations and blood pressure problems - member also suffers with asthma and is part of the BAME community. Member is also concerned as her husband is undergoing investigations for suspected lung cancer. Infection control and occupational health advised that member does not work with covid positive patients. It was advised that member be redeployed to outpatients to administer the vaccine. Matron has refused to redeploy member. Due to low staffing member is now being put back on the ward and is working with covid positive patients…*

166. The RCN's submission to the Women and Equalities Inquiry into the unequal impact of Covid-19 on Black, Asian and minority ethnic (BAME) people in July 2020 highlighted how our members from ethnic minorities reported feeling unsafe and unsupported in the workplace, with a disparate experience of Covid-19 to their White British counterparts **[PC/095 - INQ000328840]**. By way of example, we received increasing reports of staff from ethnic minority groups being asked ahead of others to care for people with COVID-19. Anecdotally, our members reported feeling invisible, dispensable, and not valued. Some nurses reported experiencing racism and stigma because of how their race and ethnicity had been affected by Covid-19, so individuals believed that they were therefore also carrying the infection. The RCN Second Personal Protective Equipment Survey of UK Nursing Staff published in May 2020 **[PC/096 - INQ000328873]** showed that for nursing staff working in high-risk environments (including intensive and critical care units), only 43% of respondents from minority ethnic groups said they had enough eye and face protection equipment. This was in stark contrast to 66% of white British nursing staff. Furthermore, 70% of respondents from ethnic minority groups said that they

had felt pressured to care for a patient without adequate protection as outlined in the PPE guidance, almost double the 45% of white British respondents who had felt this pressure. In July 2020, 19.7% of all staff working in the NHS and 21.8% of registered nurses, health visitors and midwives were from an ethnic minority background and Skills for Care estimated that 38% of the registered nursing workforce in social care were from an ethnic minority background.

167. The RCN was also concerned about structural discrimination and institutional bias creating workplace conditions that also increased the level of risk for this group. 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 **[PC/010 - INQ000328765]** found that:

a. Nursing staff from ethnic minorities were more likely to work additional hours and far less likely to be employed in higher pay grades;
b. 65% of black respondents and 61% of Asian respondents are the main or primary breadwinner in their household in contrast to 55% of white respondents; and
c. 48% of Asian respondents and 47% of black respondents had experienced bullying from colleagues, compared to 38% of white respondents.

168. 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.

Harassment of nursing staff

169. 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, such behaviour was escalating.

170. The RCN position on bullying and harassment, published on 25 March 2020, was clear that staff must be able to do their jobs without fear of bullying or harassment from colleagues, patients or third parties, that everyone should be treated with dignity and respect at work, and that any form of bullying and harassment of health and care staff in the workplace is completely unacceptable and potentially unlawful under the Health and Safety at Work Act 1974 and/or the Equality Act 2010.

171. Members also reported incidents of health and care staff being accosted leaving work and having their NHS ID badges stolen. The RCN developed a position statement, dated 30 March 2020, calling for all UK governments to issue clear communications to the public about treating health and care staff with respect and dignity at all times.

172. On 31 December 2021, the RCN wrote to the Secretary of State for Health and Social Care to highlight the increasing violence and aggression being displayed towards healthcare staff [**[PC/024 - INQ000328841]**] We called for a strong demonstration of political leadership and cross-governmental commitment to a zero-tolerance approach.

Experience of Long Covid

173. Cases of Long Covid amongst health care workers started to emerge during the late spring of 2020, with the growing number of incidences becoming a major concern. The exact number of healthcare workers who are affected by or have been affected is unknown, as no national data collection took place nor is it taking place today. This lack of data was further exacerbated by the pausing of self-reported Long Covid information in March 2023, by the office for National Statistics. In addition, there is strong evidence which shows there is a risk of developing Long Covid when re-infected with the Covid-19 virus (ONS report Feb 2023 and research paper by Bowie et al 2022).

174. Although exact figures are not known, the prevalence of Long Covid amongst staff working in health care and social care in the UK is thought to be significantly higher than in the wider population. ONS statistics estimate that 3.2% of staff working in health care and 3.5% of staff working in social care reported having symptoms of Covid more than 12 weeks after contracting it, compared to 2% in the wider population. Support for these staff members needs to continue and the impact of Long Covid in terms of increased long-term absence needs to be factored into workforce planning.

175. RCN members contacted RCND in large numbers (over 50 calls from November 2021 to December 2021 and almost 500 calls during 2022) with queries about Post-Covid syndrome or Long Covid. A small selection is reproduced below.

a. *"We kept this country going during the pandemic. Now I feel like we're being punished for not getting better or not dying."*

b. "*Have been [off sick]… since 13/1/21. I fractured L1, then contracted Covid-19 in hospital. Was then ventilated for 7 weeks. Now have back issues as they were unable to operate and Long Covid. On ambulatory oxygen and have chronic fatigue… My employers are looking to terminate my contract on medical grounds."*

c. *Has been off sick from work since diagnosed with Long Covid. Member is struggling with shortness of breath, chest pains, foggy, forgetfulness - under on-going doctor investigations. She was referred to OH December and is still unfit for work…*

d. *Member has elevated heart rate and palpitations and fatigue post covid. Suffering from post-covid so could be Long Covid. Has paid for her own private cardiology assessment to try and speed up any treatment options. Is anxious about taking more time off as one more absence will trigger stage 2 of the sickness policy. Her doctor expected her to take a day off work but she is too scared to.*

176. RCN members with the condition have reported disbelief and reluctance among the medical profession to give Long Covid the recognition it deserves. Although keen to get back to work, many RCN members have found workplace support lacking and reasonable adjustments difficult to secure. Many have therefore faced reduced pay and some have lost their jobs. These issues cause further pain for those who are already debilitated by the condition.

177. As a consequence, the RCN developed a guide on Long Covid for members, including advice on returning to work and resolving difficulties with employers, which can be found on the RCN website. The RCN also hosts a peer support network for members

with Long Covid. There are currently around 300 members with Long Covid in the network, sharing experiences and informing the RCN's work on the condition.

178. On 15 March 2023, members of the RCN's Long Covid peer support network delivered a petition with nearly 130,000 signatures to Downing Street, calling for a compensation and pension scheme for key workers with Long Covid, in line with the 2022 All-Party Parliamentary Group on Coronavirus report, which found:

a. The UK is out of step with other countries in not classifying Covid-19 as an occupational disease. Over 50 countries provide formal legal recognition for keyworkers who contract Covid-19 because of workplace exposure and offer corresponding compensation and support schemes.
b. Many living with Long Covid face barriers in accessing support, there is a lack of awareness amongst employers and employees of what protections and adjustment are available in the workplace.
c. Long Covid is not automatically recognised as a disability under the Equality Act 2010, although many people meet the criteria due to suffering with Long Covid for longer than 12 months.
d. Many key workers living with Long Covid feel the support is insufficient now, and that some need long-term additional support.

179. The report recommended:

a. The UK Government should recognise Covid-19 as an occupational disease for all key workers, which will allow the required support and compensation schemes to be put in place.
b. The UK Government should launch a compensation scheme available to all frontline key workers currently living with Long Covid.
c. The UK Government must produce guidelines for employers in both private and public sectors on managing the impact of Long Covid amongst their workforce.
d. The UK Government must urgently collect accurate and comprehensive data on Long Covid prevalence in each employment sector.

180. The RCN endorses the report's recommendations and has subsequently campaigned for Long Covid to be recognised as an occupational disease requiring appropriate policy, occupational health and support. To date, despite most European

countries classifying Covid-19 as an occupational disease, the UK government is yet to follow suit. The increased risks of Covid-19 infections faced by nursing staff from ethnic minorities, and thereby increased risks of Long Covid, require particular consideration.

181. Furthermore, it has been recognised by the Independent Industrial Injuries Advisory Council that there is a large body of consistent supporting evidence which shows that for health and social care workers, whose work brings them into frequent close proximity to patients or clients, there is a significantly increased risk of infection, subsequent illness, and death. Evidence for the establishment of Long Covid as an industrial disease is still under review by the IIAC.

182. Long Covid was of such concern to RCN members that a motion was tabled at RCN Congress in June 2022 for "*equitable and effective support for RCN members who suffer from Long Covid*". Delegates heard that diagnosis and treatment varied hugely across the UK, with Long Covid treated as a physical condition in some clinics but predominantly as a psychological condition in others, and the existing services were woefully inadequate to meet the level of demand.

183. It is clear that the UK government must significantly increase its investment in Long Covid research and care to ensure equitable treatment and prevent exacerbation of health inequalities.

Healthcare provision and treatment

Concerns raised by RCN members about shortages of medical supplies and equipment used to provide care for Covid-19 patients during the relevant period

184. We received overwhelming reports about the shortages of PPE during the relevant period, as addressed in the separate witness statement of Rosemary Gallagher MBE. RCND also received calls directly from members regarding shortages of equipment and supplies, for example:

> *Member is community nurse and visiting patients in homes following surgery. Member is changing dressings etc for patients. Member has been provided with no hand sanitiser for 3 weeks and is using her own hibi-scrub. No masks are provided, only gloves and aprons. Member is concerned as they are now running low on regular dressings as well as PPE because orders are taking so long.*

185. In the early weeks of the pandemic, limited numbers of RCN members also 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, was that all equipment used to support patient care should receive scheduled maintenance to ensure patient and staff safety.

Concerns raised by RCN members about the use of Do Not Attempt Cardio-Pulmonary Resuscitation ("DNACPR") notices

186. We received a number of reports from members, extremely worried about the use of DNACPR notices during the relevant period. A selection of calls and social media comments are provided below:

a. *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.*

b. *Can you clarify why folks have been asked to sign DNR / also why some folks are finding that while fully capable and cognisant a doctor has signed it against their will and without their consent? Surely this is both unethical and illegal?*

c. *Her manager is a GP and asked her to contact patients over 65 to check for DNR and their wishes about dying at home or in hospital Manager very direct, advised her to say that due to Covid-19 they may not survive as not enough ventilators. She is not comfortable with being so direct, feels it is for the hospital to decide and communicate this.*

d. *…Some NHS Trusts (this is national) have advised staff that if a patient has suspected or confirmed Covid-19, they are not to receive CPR. Staff have been advised that they should apply Defib pads and shock once, if there is no spontaneous sign of life, they should stop. Said that this process deviates from the guidance provided by Public Health England, as they state that mouth to mouth should not be carried out, but normal CPR should be. Is concerned that the key staff providing care to patients are more at risk of catching the virus, and they will not be resuscitated if they become very unwell as a consequence.*

187. Throughout the Covid-19 pandemic the discussion around the use of do not attempt cardiopulmonary resuscitation (DNACPR) documentation increased at both a local and national level. In some cases, media coverage fuelled the anxiety of the public and the ethics of the decision-making process was challenged. This led to the development of new resources to inform and support both the public and clinicians. In March 2020, the RCN and NMC made a joint statement regarding decisions relating to cardiopulmonary resuscitation ("**CPR**"), to reiterate and augment the position published in 2017 **[PC/098 - INQ000328842]**. In short, in the absence of an explicit decision about CPR, there should be an initial presumption in favour of CPR, but where a healthcare professional makes a carefully considered decision that CPR is of no benefit and not in a person's best interest, they should be supported not to commence CPR.

188. There were concerns, however, that notwithstanding such guidance, DNACPRs were 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. The RCN, however, was 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 Care Quality Commission 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 **[PC/099 - INQ000328843].**

Concerns raised by RCN members about care and treatment for patients with non-Covid conditions

189. Members reported concerns about their ability to provide adequate care for patients with non-Covid conditions due to the impact of Covid restrictions. For example:

> *Member has been shielding due to underlying health conditions and working from home. She has been asked to do a report ready for mental health Tribunals service to review a patients case and she has been told that she cannot have access to patients notes as this cannot be done safely (she can't go into the workplace and the notes can't be sent to her) also she won't be able to have face to face contact with the patient…Member's line manager has told her she can use the notes from the previous report. Member did see the patient last in Jan this year so has that information, but she is very concerned about just using this entirely as it is not up to date and she considers the patient a significant risk if she is discharged. She has no accommodation to go to…Member feels really compromised.*

Maternity services

190. Members reported some difficulties around caring for patients in maternity services, including Covid-19 positive birthing partners, the wearing of masks and vaccination status as illustrated below:

a. *"…as a maternity unit we have no legal redress against partners or patients who refuse to wear a mask. We do offer a visor. We have people laughing at us as they know we can do nothing. We are at risk from these uncooperative people, who deliberately don't care. We have had birth partners who have stated that they are positive for Covid and expect to come in. We are in an area where the majority of pregnant women are unvaccinated. What can we do?"*

b. *"In my epu we are being asked to admit partners but not able to keep 2m distance."*

Cancer services

191. Members also reported concerns around cancer services, including that redeployment of cancer care specialists led to a reduction in the provision of cancer services:

a. *Member, colorectal nurse, redeployed due to Covid-19 onto Covid ward. No patients now but need to keep an area open just in case …Consultant concerned at lack of*

experienced colorectal nurses now. Others have gone back to usual wards except member's ward and urology…

b. *Member is Band 7 in bowel cancer screening. She has been told she is being moved to critical care…*

c. *"I am concerned that we are not treating enough cancer patients. There are many empty beds in my hospital. Whilst I know there is a risk of cancer patients contracting Covid-19 I also feel that we can reduce this risk with the appropriate PPE. And also feel that we are going to potentially see deaths from untreated cancer if we do not act."*

Orthopaedic care

192. We received some reports of disruption to orthopaedic care:

a. *Member's substantive job is in Orthopaedics outpatients. - this has been closed due to Covid-19...*

b. *"My original post is in the Orthopaedic Theatres and I have been redeployed in the middle of November 2020…it has been 3 months now."*

Mental health services

193. We also received communication from members about issues with mental health services:

a. *Member is Clinical lead for Community mental health team…Since March team have been working from home - few staff have work equipment and are using their own. Many staff are offering therapy virtually e.g. using their own phones for over 20 hours a week to deliver therapy*

b. *Member works in a Mental Health setting. Staff have been advised that the current ward will be cleared in preparation for caring for MH [mental health] patients with or suspected of having Covid 19 in isolation…*

c. *"With the recent news, information on nursing patients in acute mental health settings with mild/moderate confirmed Covid-19 would be useful. Paying particular attention to barrier nursing those that are non compliant or acutely disturbed. We need further guidance, please."*

194. It is widely accepted that the pandemic caused disruption to the delivery of mental health services, which were in higher demand due to the impact of the pandemic, particularly in groups with existing conditions and inequalities, the bereaved and socially isolated, and those with financial worries. Care and services diverted towards the pandemic impacted people with pre-existing mental health conditions, especially higher risk individuals with severe mental health conditions such as schizophrenia and bipolar disorder. The Covid-19 pandemic exacerbated an existing workforce crisis and overstretched mental health services did not currently have the capacity to support this increased demand.

195. The impact of the pandemic on mental health services was clearly seen from the RCN publication 'Facing Covid-19: RCN reps share stories of the pandemic' **[PC/089 - INQ000328832]** as illustrated by the quote below:

"As I work with mental health inpatients, a key aspect of their recovery is to try to integrate them back into their communities again, with regular breaks away from the ward environment. All of that stopped almost instantly, which made some service users feel very anxious and isolated.

Unfortunately, one of our patients became very distressed and tried to end their life twice. There were a number of factors that led to what happened, including visits from family no longer being allowed because of Covid-19. Seeing their children regularly had been a positive factor in their recovery and when those visits stopped, they found it very difficult. Dates would also be given when limited visiting might be allowed, only to have the goal posts moved. Although it was for safety reasons, it had a big impact on many of our service users."

196. The RCN heard concerns from its members about patients being restricted in their movements whilst being acutely unwell, held either formally under the Mental Health Act (1983) or informally, who may not have the capacity to understand the requirements around self-isolation, be unable or unwilling to agree to testing, and/or are unable to

practise social distancing. We received reports of breaches of the Mental Capacity Act (2005) and safeguarding processes, which posed serious concerns for the rights of patients, including increased prescribing of antipsychotic medications and gaps in local practice determinations.

197. In its briefing 'Tackling Inequalities – Mental health', RCN Scotland called for a commitment to undertake modelling to project the mental health workforce growth required in light of the impact of the pandemic **[PC/100 - INQ000328844].**

People with learning disabilities

198. The Covid-19 pandemic brought into sharp focus the disadvantage and inequity experienced by people with learning disabilities. Members were concerned that an absence of meaningful activity during the pandemic for people with learning disabilities could lead to concerning behaviour requiring increased restraint. Other concerns included outdated care plans, lack of medication reviews, and closed care and support centres. Nursing staff were having to prioritise particularly vulnerable people and those struggling to adapt to changes in routine. Reports by Mencap of people with learning disabilities being asked to consent to DNACPR notices by their GP surgery were also very concerning (see paragraphs 186-188.

Backlogs and waiting lists

199. In November 2021, the RCN published '10 Unsustainable Pressures on the Health and Care System in England' **[PC/101 - INQ000328845]**, two of the identified pressures related to waiting lists. Early in the pandemic, the number of attendances to A&E departments dropped, leading to a decrease in the number of admissions and improved performance against the four-hour target. However, by October 2021, these numbers were back to pre-pandemic levels. The number of patients waiting for over 12 hours on 'corridor trolley beds' reached a record high. The number of four-hour waits in A&E also substantially increased. Temporary measures introduced to help deal with the pressures, such as 'escalation beds', led to difficulties in maintaining safe and effective care, including optimum infection control measures.

200. Figures from NHS England 'Combined Performance Summary' showed record numbers of people waiting to start consultant-led elective treatment at the end of

September 2021. The number of people having to wait more than 52 weeks to start treatment in September 2021 increased by over 180 times the number in February 2020 (1,613), on the eve of the pandemic. Urgent cancer referrals made by GPs increased 19% in the two years to September 2021. Levels of patients not being seen by a specialist consultant within two weeks of an urgent GP referral also increased.

201. The RCN raised the issue of backlogs in a March 2022 document setting out its expectations of HM Treasury Spring Statement **[PC/102 - INQ000328846]**. At that point in time, the House of Commons Health and Social Care Committee report 'Clearing the backlog caused by the pandemic' suggested over six million patients in England were waiting for elective treatment, with this number expected to grow. We regularly responded to emerging performance statistics and data on waiting times, calling for action from the Government to address the pressures.

Treatment for patients with Covid-19

202. As early as February 2020, the RCN, alongside NHS Employers and other trade unions, produced guidance for NHS Employers across the UK to support the management of coronavirus. It encouraged NHS trusts to immediately put in place measures such as advising all staff on how to lower infection risk, assessing employees who would be most at risk should there be confirmed cases and training on donning and doffing of PPE **[PC/103 - INQ000328847]**. As issues and questions developed about specific treatments for Covid-19, the RCN sought to get clarity for its members, for example:

a. In March 2020, the RCN queried the PHE comms line on the use of non-steroidal anti-inflammatory drugs **[PC/104 - INQ000328848]** and relayed the update from NHS England **[PC/105 - INQ000328849]**, developing this into an FAQ document for members on 19 March 2020 **[PC/106 - INQ000328850]**.

b. In April 2020, the RCN adopted the position of the Royal College of Physicians ("**RCP**") in relation to the use of the National Early Warning Score 2 system to alert health care staff to the potential deterioration of patients who are unwell with Covid-19 **[PC/107 - INQ000328851]**.

c. In May 2020, the RCN worked with internal and external nurses to develop a learning resource for nursing and midwifery staff delivering end of life care

during the pandemic **[PC/108 - INQ000328852]** later bolstered by the 'Covid End of Life Care Community Charter' **[PC/109 - INQ000328853]**.

d. In November 2020, the RCN and RCP developed guidance on "Multidisciplinary patient review in Covid-19 cohort wards" **[PC/110 - INQ000328854]**.

e. RCN Northern Ireland developed a series of training videos, including:

i. The recognition of 'at risk' or deteriorating adult patients **[PC/111 - INQ000328855]**;
ii. Introduction to respiratory treatments **[PC/112 - INQ000328856]**;
iii. Management of the patient with non-invasive ventilation **[PC/113 - INQ000328857]**; and
iv. Management of the patient on oxygen **[PC/114 - INQ000328858]**.

Discharge and movement of patients

203. Members voiced a variety of concerns in relation to the discharge of patients via RCND and posting 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 currently working as a mental health nurse and has been advised verbally by the manager that everyone needs to reduce their caseload to 0 and discharge all patients regardless of their circumstance as the service will be closing and staff will be redeployed due to coronavirus.*

c. *Member is a Care package Coordinator. Member is assessor for and oversees packages of care that are delivered by external care agencies. Covid has seen an increase in discharges from hospital. Packages can no longer be delivered in a timely manner. Patients waiting longer and longer. Patients experiencing increasing number of untoward incidents; e.g. falls. Gov.uk restrictions, sickness, shortages all having an impact. Management aware but member has concerns about own accountability.*

204. In November 2020, the RCN wrote to the CMO, CNO and Chief Social Work Officer ("**CSWO**") in Northern Ireland **[PC/115 - INQ000417517]**, in response to a joint letter from the CMO **[PC/116 - INQ000268083]** and accompanying research report commissioned by the Department of Health, from Dr Niall Herity, a consultant cardiologist in the Belfast Health and Social Care Trust. The RCN was not aware of the research prior to publication and were concerned that the content and tone of the letter and the associated report bore the hallmarks of research that had been commissioned primarily in order to prove a specific point i.e. a lack of evidence that patients were discharged, including those into care homes, as a result of "Ministerial or Departmental communications" and that "Consultants indicated robustly that they make such decisions independent of any external influence." As the research related to "two specific weeks in 2020", the RCN also raised concerns about the credibility of the evidence base.

205. The conclusion of the report was not necessarily the experience of our members. By way of example the following are member quotes:

a. *Our ward was a 14 bed elderly rehab ward. All our patients were discharged so we could become Coronavirus ward.*

b. *Community sister: Discharged all patients to be ready for acute patients.*

206. In the letter to the CMO, CNO and CSWO NI we raised a number of issues around the discharge of patients from and admission to hospital. These included:

a. The Department of Health's Rapid Learning Initiative report, which provided examples of patients being declined admission to hospital.

b. The Committee for Health meeting in May 2020, where Professor Martin McKee of the London School of Hygiene and Tropical Medicine commented upon the low level of hospital capacity in Northern Ireland and the UK generally compared with many other countries and made reference to "a push to get people out of hospital", stating that this is "feeding the infection in care homes".

c. The CNO for NI, in the week following the Committee for Health meeting, acknowledged that things could have been "done differently" in relation to care homes, but that in the early stages of the pandemic, the focus (rightly or wrongly) had been on acute hospital capacity and the associated fear of the HSC being overwhelmed.

d. In early June 2020, the Commissioner for Older People reported that the discharge of patients into care homes had been a major issue during the early stages of the pandemic. He acknowledged that the purpose was to free up acute hospital capacity but said that discharging patients to care homes without testing had been a significant concern.

207. In its submission to the Joint Committee on Human Rights' inquiry into 'The Government's response to Covid-19: human rights implications' in August 2020, the RCN expressed concerns about the arbitrary discharge, or prevention of discharge, from hospital into care homes, particularly for people returning to their own homes **[PC/117 -INQ000328859]**.

Shielding and the impact on the ability of nursing staff to work

208. We received high volumes of calls from members who were vulnerable, including due to pregnancy, and concerned about the impact of that vulnerability on their ability to work. The following are typical examples of their enquiries:

a. *Member is a band 5 staff nurse usually working on an acute admissions ward. She has developed a cough, is self-isolating and is waiting for a test result. Member is also Insulin dependent/immunosuppressed and 28 weeks pregnant. Has been told that she should return to her ward by management and Occupational Health if her test is clear, even though there is no PPE available, and, if a confirmed case is found on the ward, she will be redeployed.*

b. *The member has been off sick for 6 months with a respiratory condition. Her GP has now started her on asthma treatment, and she is being referred to a respiratory specialist. Member has used up some annual leave and due back in next week. Her employer has refused her working from home even though she can, and her GP has advised this.*

c. *Has asthma. Yesterday requested to open ward for covid patients. No sanitiser, very limited PPE. Explained her health concerns. Failed fit test – going to be refitted on Friday. Phone issues when contacting OH. Hasn't been risk assessed. Manager said it's not serious as member has not been hospitalised for asthma.*

d. *"I am writing as I am 25 weeks pregnant this week and until yesterday was told I would be shielding at 28 weeks; the…trust has since yesterday said they won't shield us. I work in a front line acute medicine NHS job as a sister, have you any idea where I may stand on this? as you can imagine I am very upset and angered by this, as suddenly myself and my unborn child's added risk suddenly takes a backseat to staff shortages. I don't know what to do. The advice they are looking at hasn't been updated since we've re-entered lockdown…"*

e. *"I was looking for advice due to being 33 weeks pregnant. The government are "strongly advising" against even having my own friends or family round to my home. Yet I'm a staff nurse at the local hospital and I'm expected to continue my work on the wards next week. This is obviously so contradictory and hard to know what is the right thing to do.*

209. Members also contacted us with concerns about their rights and obligations at work in light of the vulnerability of their family members:

a. *Member at risk due to health issues. Member has asthma and children have asthma and on steroids so member feels cannot send them to school as key worker. Husband recovering from cancer/brain tumour and on steroids with compromised immune system - husband very high risk. Matron happy to give leave but asking member what kind of leave and how long? No discussion about pay as yet but member also very anxious about this. Member very anxious*

doesn't want to put herself and family at risk. Member has never taken time off before.

b. *Husband type 1 diabetic and has other health conditions. Member still seeing children in clinics and very worried about passing covid on to husband. Spoke to manager to say husband doing social distancing and children being sent home - manager initially agreed to let member work from home as husband can't care for children but after a meeting said cannot as member a worker and if school offers a place will have to come to work. Has emailed school about childcare as essential worker but school saying will only stay open if both parents are essential workers - member has let them know about husband's health and waiting from reply. Member mainly concerned about passing illness on to her husband.*

c. *Member concerned that she will be on placement for last 6 months. Lives with grandparents who are both over 75 and one has COPD. Should she make arrangements to live elsewhere?*

d. *"I suffer from Diabetes and hypertension. At home, I have 4 children, my wife suffers from asthma and has ongoing health issues. I am the main contact and support to my elderly parents (who live next door) who have chronic health issues. I have safety concerns at my work re: Covid19 that I have reported. I have asked for unpaid leave for next 2weeks to protect myself and my family, but told I can't, is this correct?"*

210. Members raised concerns about the available advice and guidance about shielding:

a. *"I am a community nurse... I am a type 1 diabetic. There is no clarity on what NHS Scotland is doing regarding high-risk groups with regard to covid19. In Dundee, high risk staff including pregnant staff have been sent home. In Grampian, high risk groups have been sent home. In Angus we have been told nothing…"*

b. *Pregnant asthmatic nurse - working in nursing home, no sick pay if off. Still working clinically and no changes, no new risk assessment provided today following RCOG new guidance. Was told by HR it's only advice or guidance last week so no need to be off - no changes to role or duties.*

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

a. On 24 April 2020 the RCN attended a meeting of the Rapid Expert Advisory Group to consider NHS support for those shielding.
b. In July 2020, the RCN developed a set of FAQs on shielding to steer its members through the government guidance in each of the four countries **[PC/118 - INQ000328860]**.
c. 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 **[PC/119 - INQ000328861]**.
d. On 16 March 2020, the RCN attended a briefing with the Deputy Chief Medical Officer ("**CMO**"), Jenny Harries, regarding policy changes around pregnancy and Covid-19 **[PC/120 - 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 healthcare 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.
e. 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 **[PC/121 - INQ000328863]**.

Remote working and the impact of Covid-19 on people's experience of healthcare

212. Remote working in the healthcare sector impacted both staff and patients. The lived experience of RCN members was captured in the November 2020 submission to the House of Lords Inquiry 'Is life online damaging our wellbeing?' about the transition to digital appointments and the use of telemedicine **[PC/122 - INQ000328864]**, which covered:

a. The positive and negative impacts that using technology has on the relationships nursing staff build and maintain with people in their care;
b. The impact of technology on how patients, clients and residents access health and care services; and

c. How nursing staff felt about the increased use of technology and what training and support was required to effectively maximise its use.

213. To assist health and social care staff with the change to online working practices, the RCN provided guidance on remote consultations for school nurses in March 2020 **[PC/123 - INQ000328865]** and further general guidance, in May 2020 **[PC/124 - INQ000328866]** in addition to guidelines comprising "10 Top Tips" for working through difficult conversations by telephone or video in an effective way **[PC/125 - INQ000328867]**.

214. Nurses working in general practice saw a great increase in the use of remote consultations and an improvement of technology within their setting. The roll out of technology and innovation has been extremely beneficial to GP surgeries and consideration should be given to extending this to other healthcare settings as acknowledged in a letter from RCN Wales to the Chair of the Children, Young People and Education Committee of Senedd Parliament on 2 June 2020 **[PC/126 - INQ000328868]** and at an RCN event on digital exclusion in Health and Social Care in October 2020 **[PC/127 - INQ000328869]**.

215. Remote working by healthcare staff brought both benefits and disadvantages for patients; the extent to which remote working brought benefits or disadvantages was primarily governed by the clinical needs of the person and how able they were to communicate virtually. For example, it is easier for someone with a single healthcare need and no sensory or cognitive loss to access an effective healthcare consultation virtually than it is for an individual requiring any form of diagnostics or someone who has complex interrelated health care needs. Remote consultations worsened existing inequalities because those with poor health literacy, typically from groups who already suffer health inequalities, are less able to identify or "label" what is wrong with them and therefore less able to identify and self-refer to alternative pathways. Furthermore, the move to accessing services either over the phone or online risks further increasing health inequalities amongst those who find it difficult to or have no means by which to access services in that way.

216. Remote consultations, however, can support greater flexibility for those using healthcare services, particularly in relation to general practice appointments and follow up consultations.

217. Online and video consultations can enable people with long term conditions to contact their specialist or practice nurse, which is useful for reporting symptoms, asking questions, uploading images and seeking initial advice. However, the use of apps may be more challenging particularly where a physical assessment is required, For example, it is important to smell wounds if infection is suspected and, in some instances, being able to use touch to see what pressure elicits pain helps staff to adequately ascertain the problem.

218. A potential difficulty with the use of remote consultations was for Nursing staff who had to initiate challenging and courageous conversations around end-of-life care. Hearing deficits, cognitive impairments, having English as a second language also presented challenges.

219. The RCN heard a mixed response to remote working from nurses during the pandemic. Those with vulnerabilities such as pre-existing health conditions were often anxious to avoid the clinical setting and grateful to be allowed to work remotely. Some struggled with a sense of isolation and longed to return to the ward environment. Others found that their whole way of operating had changed overnight which badly affected their mental health.

Recommendations

Workforce

220. **Legislative underpinning of government accountability for workforce planning and supply across health and social care.** The long-term failure to invest in the nursing workforce meant health and care services were chronically under-resourced to deal with the pressures of the pandemic. Whilst nursing staff stepped up to be redeployed including to areas of critical care to protect those most in need, they were continually let down by failures at the highest levels. The substantial nursing shortage meant student nurses being called to the frontline, disrupting their studies and readiness to qualify, to join the Covid-19 temporary register in their thousands.

221. Development of a sustainable nursing workforce supply through a fully-funded workforce strategy for recruitment and retention and ongoing assessment of workforce requirements in health and social care. The failure of the UK government to tackle the issues facing the nursing workforce, including in recruitment, retention and

burnout, remains a serious risk to the country's ability to robustly tackle future pandemics. Currently, in England, there is not yet a shared credible system for understanding workforce shortages and responding to increasing demand in both population and service. Persistent, systemic workforce issues put nursing staff and patients at risk – this was even more in evidence during the Covid-19 pandemic when many frontline staff had to self-isolate and nurse-to-patient ratios were challenging, unsustainable and frequently compromising to patient safety.

222. **Safe staffing legislation in Northern Ireland.** Legislation, as exists in Scotland and Wales, needs to be brought forward without delay in Northern Ireland to ensure that the need to provide enough nursing staff to deliver safe and effective care to the people of Northern Ireland is never again subject to the vagaries of ad hoc workforce planning and budget constraints.

223. Proper representation of the community and care home sectors in plans for scaling up the nursing workforce in future pandemics. A whole system approach will benefit emergency planning.

Stakeholder engagement

224. **Greater opportunities for professional bodies to feed intelligence and expertise to key decision- makers as a national level.** During the Covid-19 pandemic, a vital opportunity was missed by UK government and its agencies to recognise the value of the contribution the RCN could have made due to its access to clinical expertise and strategic oversight/intelligence on nursing issues impacting on delivery of health and care services especially to the most vulnerable in all settings.

Nursing leadership roles

225. **Dedicated nurse leadership roles in new structures in health and care systems.** This includes within Integrated Care Boards and national bodies, as well as within the UK government. Nursing leaders were essential within organisations and their role must continue to be valued. Nursing leadership was evident at all levels and with many nurses being in the constant 24/7 presence for patients, they were essential for safety and care. The pandemic also gave the opportunity for outstanding multi-professional team working with many professions working alongside their nursing colleagues. During the pandemic nurses required the highest clinical skills and in order to maintain this clinical excellence

there must be ongoing investment in nurse education. This is essential in preparation in the event of a further pandemic.

Sustainable funding for public health services

226. **Long term increased, sustainable funding settlement for public health services commissioned and delivered by local authorities in England [PC/128 - INQ000114416 pp.8].** The pandemic exacerbated the health inequalities in the UK's population (including health care workers) and exposed the fact that the historic underfunding of public health had undermined the capacity of local public health teams to effectively improve health and reduce inequalities and respond to the Covid-19 pandemic. Increased funding will enable local authorities to plan and deliver safe and effective services that improve and protect the health of their population and reduce inequalities. At minimum, the public health grant should be immediately restored to its 2015 level. The most deprived areas of England, where health needs are greatest and which have been disproportionately affected by the Covid-19 pandemic, should receive additional public health investment to level up health across the country and support an equitable recovery from the pandemic.

RIDDOR reporting and data collection

227. **Comprehensive data collection and systematic reporting on deaths, infection rates and self-isolation rates for nursing staff.** Data should capture ethnicity and gender information in order to accurately scrutinise the impact of infection, prevention and control measures.

Health and well-being of healthcare workers

228. **Further research into the disproportionate effects of the pandemic on staff from ethnic minorities.** This should seek to understand the underlying causes, which have contributed to worse outcomes for staff from ethnic minorities and must be tackled.

229. **Proper management and support for the health and wellbeing of nursing staff.** This includes enabling staff to take breaks and annual leave and reviewing and controlling working patterns to prevent long shifts or excess hours being worked. We invite a particular recommendation that all employers make available and fund timely access to

confidential counselling and psychological support for all staff, to which they can self-refer.

230. **Effective self-management and support in the community for those with Long-Covid.** It is vital that the findings of research into Long Covid amongst health and social care staff inform workforce planning needs. Support for these staff members needs to continue and the impact of Long Covid, in terms of increased long-term absence, needs to be factored into workforce planning.

231. **The UK government must classify Covid-19 as an occupational disease and afford healthcare professionals better support through policies, guidance and occupational health provision.** In addition, the RCN calls for a key worker compensation scheme to provide financial support to healthcare professionals suffering from Long Covid.

Reducing bureaucracy

232. **Closer integration between health and care services to reduce bureaucracy within the system.** The pandemic frequently and clearly highlighted the detrimental impacts on patient care when the NHS and social care services are not joined-up. We welcomed the various local, regional and national initiatives that were implemented throughout the pandemic to work across existing siloes for the benefit of patient safety. We are hopeful that integrated care systems (ICS) can be further embedded and developed so that the government can address the backlog, improve efficiency, address health inequalities and future-proof against future variants. Many nurses also welcomed the removal of bureaucracy when delivering patient care and appreciated its agility of decision making both within organisations and between organisations, enabling them to focus on patients and supporting each other.

Addressing the inequity of health outcomes for different patient groups

233. **Provision of sufficient learning disability nurses to effectively work with and advocate for individuals across all health and care settings.** The pandemic has highlighted the inequity of health outcomes for different groups, including those with learning disabilities, and the difficulties such groups face in getting their mental, emotional and physical health needs met. Lessons must be learned so that the same injustices are not allowed to continue.

Copies of all reviews or reports authored by the RCN in relation to 'lessons learned' where those are relevant to the scope of Module 3

234. We consider the following documents relate to lessons learned in relation to the matters covered in Module 3:

a) Consultation response – Letter to Baroness Armstrong, Chair Public Services Committee dated 31 July 2020 regarding lessons learned **[PC/015 - INQ000328768]**
b) Undated – RCN Wales report on lessons learned from first wave – **[PC/129 - INQ000328769]**
c) Health and Sport Committee - Resilience and emergency planning RCN Scotland submission **[PC/130 - INQ000328770]**
d) 'Guidance for Health Leaders During the Recovery Stage of the Covid-19 Pandemic A Consensus Statement' **[PC/131 - INQ000328771]**
e) RCN Wales report 'Nursing and the Covid-19 pandemic' **[PC/129 - INQ000328769]**

Closing remarks

I would like to thank the Inquiry Chair, on behalf of the RCN, for the opportunity to provide evidence in relation to Module 3 of the UK Covid-19 Inquiry. We recognise that this Inquiry presents a unique opportunity to identify and put in place actions to ensure that learning from the UK's experiences of the Covid-19 pandemic is implemented. This is crucial to ensure that the UK is properly prepared, as well as it can be, for future pandemics (where the only question is when, not if, the next pandemic will hit). Nurses and health care workers will be on the frontline of the next pandemic and the RCN has a responsibility to ensure anything that went wrong or things that could be improved are reported on and acted upon in the interests of nurses, our wider health care colleagues, and the patients to whom they provide care. The pandemic gave the public the opportunity to demonstrate their tremendous support for nurses which sustained them through a very challenging time and is a profession that must continue to be valued.

The RCN is committed to working with the Inquiry throughout its investigations and we are happy to assist with any further requests.

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: 25 April 2024