Royal College of Nursing written evidence: APPG for Coronavirus

The Royal College of Nursing (RCN) is the largest trade union and professional body in the world, representing 450,000 members across the UK. Our members have been at the fore of the response to COVID-19, leading treatment and care in hospitals, our communities and supporting people in their own homes.

Throughout the pandemic, we have been continually calling for the UK government to ensure that the safety of staff and people in their care is overriding in all decisions. To mark the first 100 days of the pandemic, we published a blueprint for the returning and reopening of health and care services.[i] It sets out our expectation of how governments across the UK, relevant agencies and employers must commit to safeguarding staff as health services begin to resume. The blueprint includes access to adequate Personal Protective Equipment, mental health support and comprehensive risk assessments as well as ensuring the safe return of nursing staff to their substantive roles.

This submission details the most pressing and significant challenges nursing staff faced throughout the COVID-19 pandemic and our expectations of how learning will be captured and acted upon. It is essential that the government constantly reflect on lessons learned so that staff and patient safety is not further compromised, and that more nursing staff do not lose their lives.

Whilst the scope of your inquiry is predominantly focused on the response to COVID-19 in England by the UK government, it is important to note that many of the issues detailed below were, at least in part, experienced by nursing staff in all nations of the UK.

Personal Protective Equipment (PPE)

Availability and quality of PPE

At the beginning of the COVID-19 pandemic, nursing staff across the UK consistently raised concerns around the availability and quality of PPE. The lack of appropriate PPE has been and continues to be one of the biggest barriers that our members face in providing safe and effective care. Whilst some settings reported adequate PPE, for example in intensive care, there were widespread and significant variations in the availability and quality of PPE with some NHS Trusts relying on donated stocks. Care homes across the country were left particularly vulnerable which further highlighted the inequity of adequate supply between the NHS and wider health care services. Without adequate and proper PPE, nursing staff are putting their own lives, and the lives of their families and patients, at risk. Furthermore, changes to Public Health England's (PHE) guidance, particularly on the re-use of single use PPE [ii] - which under no circumstances does the RCN endorse - led to heightened anxiety and left many working in unsafe environments.

To date, we have undertaken two UK- wide surveys to understand our members' experiences, across all settings, on accessing and using PPE during COVID-19. The first was in mid-April and the second was in early May 2020.

In April our survey found that:

- 30% of respondents said there is not enough eye/face protection for them to use for the duration of the shift.
- A further 28% said they have enough now but are concerned for the supply for their next shift.

- More than one in four respondents (27%) said there are not enough fluid-resistant surgical face masks for them to use for the duration of the shift.
- 14% said they were lacking surgical masks. A third of respondents (32%) said they have enough surgical masks for them to use for the duration of the shift but are concerned for the supply for their next shift.

Our second PPE survey conducted in May found that in general the supply and distribution of PPE had improved across the UK, but that this was not consistent across sectors, or the experience of staff from all backgrounds. The survey highlighted that:

- almost a quarter (24%) of respondents are concerned about the supply of face masks for their next shift, with a further 11% saying there are already not enough for them to use.
- One in five respondents are concerned about the supply of eye/face protection, with a further 12% are concerned that that are not enough of those items for them to use.
- For nursing staff working in high-risk environments (including intensive and critical care units), only 43% of respondents from a BAME background said they had enough eye and face protection equipment. This is in stark contrast to 66% of white British nursing staff.

The provision of insufficient and inadequate PPE is a direct breach by NHS and social care employers as they are failing to follow statutory obligations in relation to PPE. In an open letter to the Chief Executive of the Health and Safety Executive (HSE), we called for their intervention to ensure the adequate availability of fit testing, and that employers comply with Regulation 4 of the PPE at Work regulations (1992) which stipulates '*that suitable PPE must be provided to employees who may be exposed to a risk to their health and safety while at work..* [iii]'. We received an unsatisfactory response and expected the HSE to act given the terms of the situation being extremely serious. All staff, irrespective of the setting in which they work, must have access to fit testing and adequate supplies of PPE now and throughout the duration of this crisis.

When raising concerns regarding the quality of PPE supplied, our members have reported that the process is confusing and complicated as there are two ways in which they are required to report defective items, depending on the problem, to the HSE or Medical and Healthcare products Regulatory Agency. We have asked Cabinet Office for the development of a single process to aid reporting and central oversight of PPE issues and to inform learning for a potential second wave. We are awaiting a response to this request. Finally, there must also be clear and accountable mechanisms in place for staff to raise any concerns regarding PPE in the knowledge that they will be dealt with without fear of redress.

Procurement of PPE

Procurement of PPE for all settings has and continues to be a longstanding problem and we are clear that specialist procurement nurses must be included in national and local supply decisions so that stocks acquired are adequate and fit for purpose. Currently the two largest drivers for the selection and use of PPE are the UK infection prevention and control guidance and the procurement of PPE as led by the Cabinet Office.

Adequate and sufficient supplies of PPE will be essential to cope with a potential second wave or localised outbreaks of COVID-19. We know that supply lines have been established but with PPE in demand from all sectors including retail and education, it is vital that health and care services have the equipment they require and that stockpiles are replenished without delay. Members continue to report concerns regarding items supplied although the amount of PPE procured has improved. For example, specific concerns raised by our members related to what was or was not considered an aerosol generating procedure and therefore what level of PPE was required. It remains unclear as to why the government did not procure and stockpile adequate and correct levels of PPE given the learning available from previous highly infectious viruses and in advance of Brexit.

Guidance on using PPE

Guidance is crucial to health protection and keeping COVID-19 under control. Guidance must be based on the available scientific and clinical evidence with stakeholder engagement to ensure that it can be implemented across the system. Unfortunately, we believe that stakeholder engagement has been limited, resulting in uncertainty from front line staff on how to use or implement the guidance effectively. Following concerns raised by members regarding discrepancies between the World Health Organisation and PHE guidance, RCN published transparent information on requests to support the development of guidance.

COVID-19 testing for health and care staff

Health and care workers are being exposed to COVID-19 in their workplaces and in their communities. Testing to identify health and care professionals symptomatic with possible COVID-19 is also vital in supporting infection prevention and control decisions, including the necessary use of PPE and the correct isolation of patients. The testing infrastructure took too long to roll-out across acute Trusts and the wider health and care system. This meant that nursing staff took the precaution of self-isolating when presenting with symptoms, unable to access a test. As a result, in early April, some Directors of Nursing in London were reporting staff sickness rates of over 20%. This presented a significant staffing challenge and placed additional pressure on already overburdened staff. Furthermore, startling discrepancies existed between the offer and accessibility of COVID-19 testing for those working in the NHS compared to those working on temporary contracts or outside the NHS, while other members told us that a lack of transport to remote testing sites prevented them from accessing testing facilities during the peak.

We are clear that the UK Government and devolved governments must prioritise testing of all health and care staff. Testing must be universally available to all staff when required, including agency and bank staff, irrespective of whether they present with symptoms or have been caring for patients with COVID-19 so that their safety, and the safety of the people in their care is protected.

Staffing for Safe and Effective Care

Going into the pandemic, there were approximately 40,000 nursing vacancies in the NHS in England alone. [iv] Since 2012, the number of registered nursing posts in social care has decreased by 15,000, which equates to a 29% drop.[v] The reduction of posts could be due to issues with supply, recruitment and retention, service closures or withdrawal of 'nursing' care from services. The total number of care worker/senior care worker posts continues to increase, which may suggest increasing reliance on nursing assistant roles.

The workforce was not prepared for the pandemic and the workforce shortages meant that staff were already working in challenging circumstances. The Nursing and Midwifery Council were granted powers to set up a temporary register to enable thousands of nurses to return to practice and nursing students to voluntarily opt into extended clinical placement to support the emergency. Many staff were also redeployed – for example sexual health specialists and school nurses - to support the surge in critically unwell patients leaving other essential services on pause.

In our most recent membership survey, which garnered just over 42,000 responses and asked nursing staff about their experiences of working during COVID-19 and what would make them valued. A worrying 37% of respondents are now considering leaving nursing. In the same survey, 88% of respondents agree they are passionate about the nursing profession, but 91% are concerned about the wellbeing of those in the nursing profession generally, with over 50% concerned about both their own physical and mental health.[vi] Worryingly, a third of staff said they felt less valued by Government during the pandemic than before, and a quarter felt less valued by senior management in their organisation.

In addition, we have seen a dramatic increase in calls to our membership helpline relating to stress, burnout and mental health. We 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 last year.

To support our nursing workforce in the future and beyond the pandemic, the government will need to invest in and value the profession commensurate with the essential and highly skilled work nurses do. For example, valuing staff who worked during COVID-19 will involve more than clapping. We expect governments across the UK to:

- Begin immediate Agenda for Change pay negotiations so that nursing staff can have a meaningful pay rise before 2021;
- Introduce legislation to set out clear roles, responsibilities and accountabilities for workforce planning and supply at all levels of the system so that we can begin to close the workforce gap which impacts both staff morale and patient safety.
    - Whilst Wales has legislation, Scotland's implementation has been delayed. England and Northern Ireland must publish legislation with urgency.

In England, we expect the UK Government to fund our future registered nurses so that everyone who wants to become a nurse can afford to do so. We expect the UK Government to build on the training grants of between £5000-£8000 as announced in December 2019, by committing to:

- reimburse tuition fees or forgive debt for all current nursing, midwifery, and allied healthcare students;
- abolish self-funded tuition fees for all nursing, midwifery, and allied healthcare students starting in 2020/21 and beyond, in recognition that they will be supporting vital public services; and
- introduce universal, living maintenance grants that reflect actual student need.

Unequal impact of COVID-19

COVID-19 has uncovered and exacerbated existing structural inequalities and barriers which exist across health and care, but also across wider society. Currently, 19.7% of all staff working in the NHS are from BAME backgrounds. In nursing, 21.8% of registered nurses, health visitors and midwives are from a BAME background, [vii] and 38% working in adult social care are from a BAME background.[viii]

Data from the NHS Workforce Race Equality Standard (WRES) in England shows that BAME nurses are disproportionately concentrated at band 5 of the Agenda for Change pay bands in England.[ix] Nurses in this band tend to deliver the frontline care to patients. Therefore, given the concentration of BAME nurses at this level, it means that their exposure to the viral load of COVID-19 was increased. Research from Public Health England as well as ONS has highlighted the elevated levels of risk that those in direct contact with the public face such as bus drivers and other occupations.[x]

The WRES data along with information from BAME nurses and staff provide compelling evidence and powerful narratives about the need for significant and systemic change to improve outcomes for BAME staff and to improve their lived experience at work. This information is yet to be fully synthesised and implemented into a clear change programme by the NHS. However, we remain hopeful that the interim People Plan will start this process and deliver change in the long-term.

From the outset of the pandemic, we have been calling for the government and relevant bodies to collect and publish data on the number of nursing staff who: contracted COVID-19; received hospital treatment for COVID-19 after testing positive and died by due to COVID-19 nationality, ethnicity and occupation. The lived experience and emerging research provided early insight into the fact that BAME health and care staff were at increased risk of contracting COVID-19, becoming critically ill as a result and dying. However, employers and government were slow to respond with coherent strategies and actions designed to mitigate

and manage these risks and were compounded by a lack of data on death rates which impacted their ability to understand the true picture.

It is imperative that both the UK Government led inquiry and cross-government Commission into the impact of COVID-19 on different communities is transparent, engages with stakeholders and BAME communities. Any recommendations made must result in tangible action, be measurable and be evaluated in full and align with our calls for a UK public inquiry.

The impact of COVID-19 on mental health

The impact and challenge of delivering care during the pandemic is likely to significantly affect staff's mental health and wellbeing. For those caring for the escalating numbers of critically unwell patients as well as distressed family members virtually, this is likely to be even more traumatic. Many of our members have expressed the high levels of stress working through the height of COVID-19 has had on them, with many telling us they are on the cusp of burnout. The psychological impact of caring for increased volumes of very sick patients and distressed relatives must not be underestimated. The RCN expects all employers to make available and fund timely access to confidential counselling and psychological support for all staff. Such support must also be responsive to the needs of a diverse staff cohort and provide culturally-competent psychological support to ensure that all staff are able to benefit.

The impact of UK Government funded initiatives to support staff mental health during the first wave of the pandemic such as the "our frontline" helpline should be evaluated, including accounts from staff and employers who have used the services and an assessment of the level of take up. A new fully costed package of support should then be made available for the continued delivery of counselling and psychological support. This costing should include promotion to all health care staff across all settings to raise awareness of the resources available.

A Future Inquiry

At Prime Minister's Questions on 15 July 2020, the Prime Minister confirmed that some form of public inquiry into COVID-19 will take place, but he would not be drawn to comment on any details about how an inquiry would be funded and or whether it would be UK-wide or England only. We set out below our initial expectations for such an inquiry.

We are clear that UK government should initiate a public inquiry into the preparation and management of COVID-19. The inquiry should cover all related UK reserved issues that are within the control of the UK government, including:

1. Pandemic preparedness at a UK level
2. Effectiveness of specific coronavirus legislation and regulations across the UK
3. UK coordination of the management of the outbreak including border control decision making.
4. Procurement of PPE and testing kits internationally.
5. The operation and output of SAGE in terms of decision-making, along with how evidence was gathered, prioritised, presented and used.
6. The quality and effectiveness of public information and communication
7. Information sharing and communication between the UK Government and devolved administrations
8. UK coordination of data, especially relating to infection and deaths rates
9. Development of clinical and professional guidance at a UK level
10. Ongoing preparedness measures for future pandemics

There should be a cross sector inquiry panel with a diverse range of socioeconomic and ethnic backgrounds. The panel must include representation from registered nurses.

Representatives from across health and social care settings, including nurses and other medical and clinical professionals, as well as local government and public health experts, should be facilitated to give evidence to the inquiry.

The inquiry should be initiated when the COVID-19 UK alert level reaches level 2 (number of cases and transmission is low, minimal social distancing) and should generate recommendations for the UK Government within an appropriate timescale.

Devolved administrations across the UK should also initiate separate public inquiries into their preparedness and the measures undertaken to control/manage the COVID-19 pandemic, covering all related devolved issues. Note: these issues will need to be included in the UK inquiry specifically relating to England. These should include:

1. Management of the outbreak, lockdown, testing prioritisation, border control, PPE, track and trace
2. Care Homes: support, response and role in future waves
3. Staffing and resources in health and social care
4. Procurement and long-term sustainability of national stockpiling
5. Impact on mental health
6. Impact on education
7. Impact on palliative care
8. BAME deaths and the interaction with wider societal factors which should include issues of deprivation
9. Accurate data, especially about infection and death rates
10. Memorialising the experience of families and individuals
11. Management of non-COVID medical treatment/ social care delivery including domiciliary care
12. The deployment of emergency capacity (in particular the 'Nightingale' hospitals – although they are not all called this)
13. Impact on wider health services
14. Impact on the health and care workforce, including disproportionate impact on BAME staff, deaths of staff and the effectiveness of measures to protect staff from exposure
15. Effectiveness of engagement and interaction between central and local government
16. The role of workplace regulators
17. Quality and effectiveness of public information and communication relating to the pandemic (including accessibility, dissemination, timeliness)

For more information about this submission, please contact: Rachael Truswell, Public Affairs Adviser on Rachael.Truswell@rcn.org.uk

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[iii] RCN, *An open letter to Sarah Albon, Chief Executive of the Health and Safety Executive,* March 2020. Available here: https://www.rcn.org.uk/covid-19/rcn-open-letters

[iv] NHS Digital, *NHS workforce statistics,* April 2020. Available here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/april-2020

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[ix] https://improvement.nhs.uk/documents/6181/wres-nursing-strategy.pdf

[x] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020