Scottish Covid-19 Inquiry

Statement of Eileen McKenna,

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Royal College of Nursing Scotland

on the impact of the Covid pandemic on the nursing workforce

1. I am employed by the Royal College of Nursing (RCN) as Associate Director for Nursing, Policy and Professional Practice in Scotland. I am providing this statement to the Inquiry, about RCN Scotland's views on the impacts of the strategic decision making in respect of Health and Social Care in so far as they fall within the Inquiry's Terms of Reference. I make this statement on behalf of RCN Scotland and confirm that I am duly authorised to do so. This statement will discuss the impact of the decisions taken by the Scottish Government on RCN members and will illustrate the key concerns that were raised by members throughout the duration of the pandemic. This statement is based on my personal recollection and review of records and documents related to my role representing the interests of the 40,000 RCN Scotland members during the Covid pandemic. It should be noted that the current membership for RCN Scotland has risen to 49,500.

Background

2. The RCN is both a professional Royal College and a certified trade union. I lead the Royal College arm of the organisation in Scotland (RCN Scotland) and manage the Nursing; Policy; Learning and Development; and Knowledge and Research Departments. The role includes identifying, influencing and advising on the implications of Scottish, UK and international health and social care policies and strategies on current nursing practice and service delivery in Scotland; informing and

contributing to the development of RCN UK strategies; negotiating on behalf of our members with Scottish Government and other stakeholders (i.e. Health Improvement Scotland and NHS Education Scotland) on professional practice and workforce policies and practice; and supporting the continued professional development of registered nurses (RNs) and nursing support workers[1] (NSWs) across Scotland. I have been employed in this post since October 2018.

3. I qualified as a registered nurse in November 1982, and completed a post registration Certificate in Critical Care in1986, I have a Master of Business Administration (1995) and completed the taught component of a Doctorate in Nursing Studies (2000 – 2004).

4. My previous experience includes working clinically as a nurse in acute surgical and intensive care units where I held the positions of Staff Nurse, Senior Charge Nurse, and Clinical Nurse Manager. I subsequently worked in various management, senior management, and professional leadership roles within the NHS in Scotland and was employed by Scottish Government within the Chief Nursing Officer Directorate between 2006 - 2008. Prior to my current role, I was Associate Nurse Director within NHS Tayside in which I had professional responsibility for nursing and midwifery staff and practice within a large acute teaching hospital and community services across Dundee City. I was concurrently a member of the acute services Senior Management Team and the senior nurse on Dundee City Health & Social Care Partnership Integrated Joint Board. I also held a corporate portfolio with regional responsibility for clinical governance and care assurance; person centred care; research and practice development; education and continuing professional development; and nursing and midwifery workforce planning and development.

[1] Nursing Support Worker (NSW) is a term to describe staff who are employed to work within nursing teams to assist and support the delivery of patient care under the supervision of Registered Nurses. Other terms used to describe this role are Health Care Support Worker (HCSW) and Clinical Support Worker (CSW).

5. I remain a registered nurse on the Nursing and Midwifery Council register. I am required to revalidate every three years to remain registered, I last revalidated in November 2021.

Role through the pandemic

6. Within the first weeks of the outbreak in March 2020, the RCN established a four-country senior group to proactively address issues which members would encounter whilst working in a variety of hospital, community, academic and social care settings. The purpose was to closely monitor the emerging situation, government(s) policy and guidelines and ensure our members were provided with up to date, evidence-based information. The group also tracked and responded to issues raised by members from across the four countries of the United Kingdom. I represented RCN Scotland on this group and co-ordinated the flow of information from that group to the senior team, wider RCN Scotland staff group and members in RCN Scotland.

7. This group was required to work dynamically and at pace to inform decisions on managing the response to the Covid 19 Pandemic. Initially the group met at least daily and often the decisions that were made were communicated across the health and social care membership with immediate effect, on occasion the very next day.

8. Throughout the pandemic the RCN received enquiries from our members regarding COVID-19. Members contacted us using our online or electronic platforms which were discussed in the statement of my colleague, Colin Poolman, and included RCN Direct, Sensemaker and Members Surveys. These enquiries covered a wide range of issues including:

- *Equipment/health and safety* – such as provision and guidance in respect of equipment, PPE, working times, and other health and safety related concerns.
- *Members at risk* – in particular pregnant members or those with underlying health conditions.
- *Members Raising Concerns* – for example issues surrounding patient care and staffing concerns.
- *Self-Isolation* – queries regarding whether a member had to self-isolate, or a dependant had to and guidance in respect of what to do.
- *Personal Issues* – which covered all calls raising concerns that do not fall into the above categories but are relevant to the member. Examples being, travel problems due to guidance on travel restrictions, time off for dependants, and school closures/ issues of child-care.
- *Vaccination* – this includes all contact in relation to the delivery of Covid-19 vaccines.
- *Miscellaneous Workplace/Employer Concerns* – which covers all calls that aren't covered in the above categories and are relevant to the employer, e.g. pay, annual leave.
- *Long Covid* – queries arising from contact from members who have been impacted by Long Covid.

9. I also represented RCN Scotland on several Scottish Government groups and at meetings with more focussed remits. These groups included:
    - *Clinical Professional Advisory Group (CPAG)* – in respect of Care homes
    - *Infection Prevention and Control (IPC)*
    - *Task and Finish which was a sub-group of the Clinical and Professional Advisory Group for Care Homes (CPAG)*

- *Louisa Jordan Programme Board*
- *PPE Modelling Clinical Short Life Working Group*
- *HSC Winter Planning and Response Group*
- *Community Nursing for Adults Group*
- *System Wide Real Time Staffing Risk Assessment(s) and Escalation Groups*
- *Health and Social Care Workforce Wellbeing and Mental Health Network Oversight Group Staff Recovery Short-Life Working Group*
- *ICU Bed Baseline Short Life Working Group*
- *Nursing & Midwifery and Allied Health Professions Rapid Action Student Placement Oversight Group*

10. This list of groups illustrates the complexity and range of work which was required to ensure the myriad of issues facing heath, social care staff and students working in these agencies during the pandemic were addressed.

11. RCN Scotland acknowledges the working in partnership process which the Scottish Government adopted. This approach provided an opportunity for RCN Scotland to influence decision making on behalf of our members.

12. It should be noted, however, that although our involvement provided an opportunity to influence decisions, the decision making ultimately remained with the Scottish Government. RCN Scotland had no veto on decisions. Therefore, although there were areas where we feel that RCN Scotland was listened to, and our concerns were adequately addressed there where areas in which we would argue that the Scottish Government did not but could have and should have acted on our concerns. It is in those areas that the impact on RCN Scotland's members was greatly felt. My statement intends to illustrate those impacts under reference to the respective Terms of Reference.

Impacts on RCN Scotland members using the Inquiry's Term of Reference

2a: the impact of pandemic planning and exercises carried out by the Scottish Government on RCN Members

13. Although RCN Scotland was involved in many meetings and groups to assist with the response to the COVID- 19 pandemic, we were not consulted or involved in any planning that took place before end of March 2020.

14. The COVID-19 crisis has demonstrated the unique value of the nursing profession within health and social care. Registered Nurses, Nursing Support Workers and Nursing Students have worked and are continuing to work under sustained, heightened pressure. This continues to have a significant impact on the physical and mental health of staff and a collateral effect on the quality of care being delivered to patients and residents. However, this is not a new phenomenon. The pressure on the nursing workforce has been rising for many years due to the increasing demand for services. This is the case in Scotland's care homes, community care settings and hospitals and underlines the inadequate planning or response to the growing crisis in the nursing workforce. Put shortly, there are simply not enough nursing staff to provide the level of care that our population needs now, or indeed, before and during the pandemic. The impact this is having on our members is a situation that RCN Scotland has been gravely concerned about for some time – and well before the pandemic hit.

15. Publicly available data for the NHS in Scotland, held on the National Education for Scotland (NES) Turas system, shows that the four years between December 2015 – December 2019 the registered nursing workforce grew by 2.7% (41,090 to 42,240

whole-time-equivalent (w.t.e.))[2]. However, this upward trend does not tell the whole story. Over the same period the number of vacancies and the vacancy rates rose steadily, including for long-term vacancies (posts unfilled for three months or longer). At no point was the planned establishment (number of w.t.e. staff required to meet clinical activity) across the NHS achieved. In fact, the increase in vacancies indicates that the gap between planned staffing and actual staffing widened with vacancies for registered nurses rising during this period from 1,623 (3.8%) to 2,625 (5.9%) w.t.e. The workforce of Nursing Support Workers was in a similar position with vacancies rising from 484 (3.1%) to 869 (5.4%) w.t.e.

16. Publicly available data for the social care sector, published by the Scottish Social Services Council, shows that between 2014[3] and 2019 there were 380 fewer (calculated by headcount) registered nurses in care homes for adults. The Scottish Social Services Council and Care Inspectorate reported[4] that 40% of care homes for older people services were reporting nursing vacancies in December 2019 (Care Inspectorate and Scottish Social Services Council (2020) Staff vacancies in care services 2019)[5]. At the same time, clinical need is increasing. The COVID-19 pandemic has brought into sharp focus the workforce crisis facing Scotland's care home sector and the need for more registered nurses working in care homes to deliver care to residents with increasingly complex health needs.

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[2] NHS Education for Scotland (NES) (2023) *NHS Scotland workforce 30 September 2023;* Edinburgh: NHS Education for Scotland. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/05-december-2023-workforce/dashboards/nhs-scotland-workforce/?pageid=10601

[3] Scottish Social Services Council (SSSC) (2015) *Scottish social service sector: report on 2014 workforce data*. Dundee: Scottish Social Services Council. https://data.sssc.uk.com/data-publications/22-workforce-data-report/99-scottish-social-service-sector-report-on-2014-workforce-data

[4] Scottish Social Services Council (SSSC) (2020) *Scottish social service sector: report on 2019 workforce data*. Dundee: Scottish Social Services Council. https://data.sssc.uk.com/data-publications/22-workforce-data-report/239-scottish-social-service-sector-report-on-2019-workforce-data

[5] Scottish Social Services Council, Care Inspectorate (2020) *Staff vacancies in care services 2019 report*. Dundee: Scottish Social Services Council. https://data.sssc.uk.com/data-publications/30-vacancy-reports/247-staff-vacancies-in-care-services-2019-report-2

17. In November 2019 RCN Scotland published a report that highlighted that members across Scotland, in the NHS, GP practices and care homes reported that they were feeling overworked in under resourced environments[6] . Almost two thirds reported they were too busy to provide the level of care that they considered necessary. They also didn't feel their contribution was valued by those in positions of power. As one Band 5 staff nurse put it:

"*The most upsetting and stressful part of my job is being unable to give good patient care due to poor staffing levels … and unfortunately it has become 'normal' to work under this constant stress. Never have I felt pressure like this in my career and have never felt so undervalued."*[7]

Band 5 nurse, NHS hospital ward (pre-pandemic 2020)

18. We appreciate this report predates the pandemic but provides context for the feelings in the workforce shortly before we entered the pandemic. From March 2020 the nursing workforce rose to the challenge. Nursing staff of all grades delayed retirement; returned to work; were redeployed to unfamiliar clinical environments; and redesigned their service delivery model to maintain services to patients, residents in care homes, and the wider community. The impact on the nursing workforce and nursing students cannot be underestimated.

19. The impact of nursing staff delaying retirement and returning to work after having retired can be seen in the rise in the number of Registered Nurses in post in the NHS in Scotland between December 2019 and December 2021 with this number rising from 42,240 to an all-time high of 44,530 w.t.e. The increase in Nursing Support Workers

[6] RCN Scotland (2019) 'Employment survey 2019: Scotland'
[7] RCN Scotland (2019) 'Employment survey 2019: Scotland', page 21

numbers during the same time period was initially achieved by nursing students entering the workforce on paid placements during 2020 prior to recruiting additional Nursing Support Worker posts.

20. However, despite this rise in the number of nursing staff, the demand for nurses also rose resulting in the gap between the number required to meet the clinical and service needs and available staff also increasing. The numbers of vacancies in NHS Scotland rose to over 4,000 w.t.e. between 2021 and 2022 although more accurate post-pandemic reporting by NHS Education Scotland stated vacancies peaked at over 4,600 w.t.e. between March and September 2022.

21. Co-ordinating the return of large volumes of nurses was challenging. That being said, many nurses had a positive experience and felt that they had 'done their bit' in supporting the response to Covid-19. However, the experience of those nurses volunteering to return to the workforce was not always positive. Feedback from our members highlighted that for some there were barriers put in place. For example, some reported that they didn't feel their skills and knowledge were recognised by employers, while others reported being asked to work outwith their scope with limited or no induction and training. Many gave up trying to secure employment.

22. The RCN held webinars with staff returning to the workforce which I attended highlighting this issue. I recall an example of a Registered Nurse who retired weeks before the pandemic and who had worked at Band 6 within a particular specialty. When the call for nurses came to return, they volunteered to return to their previous clinical environment and they were interviewed for the post and offered a Band 5 post, paid at the lower end of the pay scale. However, on return she was working at the same level as before her retirement.

23. Staffing gaps were exacerbated by nursing staff having to self-isolate due to underlying health conditions and the sickness absence rates due to staff developing Covid-19 symptoms. As a result of not having enough staff working across health and social care, those nursing staff who were available to work had to work in increasingly difficult circumstances with reduced numbers of staff. It also contributed to staff receiving increasingly higher workloads, often in unfamiliar clinical environments or with staff who had been redeployed from other specialties. This resulted in nursing staff often working more hours than they were contracted to work. They worked under very significant pressure to try and ensure safe services were provided to the public and were left frustrated by their inability to provide care to the standard that they wanted to. This often impacted on their physical and mental wellbeing.

24. The RCN gathered the views of nursing staff during the pandemic through Members Surveys. This methodology was used from October 2020 and continuously captured the lived experience of nursing staff using both qualitative and quantitative methods.

25. Three surveys were conducted in 2020, 2021 and 2022 which highlighted consistent themes amongst nursing staff, in all settings, working beyond their contracted hours and not being paid. They demonstrated nurses feeling they were unable to provide the level of care that they felt was required, being concerned about staffing levels, not feeling valued by government, and wanting to leave the profession.

26. The lived experience of nursing staff and students captured from October 2020 through both qualitative and quantitative data highlighted that as the pandemic was entering another wave nursing staff were still worried about their personal and loved ones'

safety, ability to care for family i.e. children and elderly relatives particularly if they became ill themselves, and about their ability to provide high quality patient care. Below are some examples of the experiences of nursing staff taken from the surveys:

"Unrelenting pressure. Unpaid breaks and overtime. Patients sick and alone and some wanting family, even at a door to see them."'

Registered nurse, Adult Acute Ward, (December 2020)

"My ex-wife (also a nurse) volunteered to help out in ITU and got COVID in work. She was so poorly that she had to be admitted to hospital for treatment herself. I was at home caring for our young children, unable to go to my work as a nurse in the Emergency Department. What happens if I now become unwell too? Who will look after our children? We nurses risk so much for society, please, please look after us too."

Registered nurse, A&E/Urgent and Emergency Care (November 2020)

"My ward (dementia assessment) had a Covid-19 outbreak. We were able to avoid any cases during the first wave, but this outbreak has affected every patient and half the staff including myself. I'm currently at home with Covid when I could be at work helping my patients, it's frustrating and upsetting."

Charge nurse, Inpatient Mental Health Ward, (November 2020)

27. Nursing staff relied on the support of colleagues in their team, this sense of team was important to them but was negatively impacted by the redesign of services and redeployment to unfamiliar settings. When redeployed, nursing staff reported that they often felt they didn't have the skills or experience to work with unfamiliar patient groups and this caused stress by being asked to work out with their normal scope of practice

and the fear of making clinical errors for which they would potentially be held accountable for by NMC:

"Having been redeployed to ITU during the coronavirus pandemic (with no prior ITU experience) and other clinical areas over the past year this has caused increasing anxiety which is really only coming to a head now and having a detrimental impact on my mental health. Although I am now back in my own substantive post, I have flashbacks of the time spent in ITU which conjures up feeling of angst, vulnerability, fear, dread, panic as well as the emotional and physical aspects of dealing with death daily, supporting colleagues and families and managers. Wearing PPE which was cumbersome and exhausting added to the burden. Moreover, the environment was chaotic and I was expected to up-skill, learn new devices, equipment and routines to ensure patients were kept safe. Fear of contracting Covid-19 and bringing this home to my family every day added to the stresses and strains as well as trying to work within my 'sphere of competence' in accordance with NMC guidance. Managers treated staff like 'herding cattle' with no thought for personal capability or personal impact. I am now exhausted and off work with stress as I am also trying to manage my own service with a reduced staffing level due to sickness/absence. The impact on nurses must not be under-estimated."

Registered Nurse, Adult Acute Ward, April 2021

28. Another worrying theme that emerged through capturing the lived experience of Registered Nurses, Nursing Support Workers and Nursing Students was the rise in violence and aggression towards them by patients, families, carers and in some instances the general public. The RCN recognises that the restrictions placed on the public in terms of visiting restrictions, delays in elective treatment etc. were stressful, however it was often the nursing staff who bore the brunt of these frustrations. Members reported to us the following:

"The level of violence and aggression I have had to deal with has been significant this week. A very aggressive patient has hit me with pieces of equipment, drawing blood at one point, tried to break my arm and verbally abuse me and other staff and patients. When patients are cognitively impaired, I can accept that this sometimes causes them to be violent but when they are not, I don't think we are supported by senior staff to deal with it - 'can't call the police as they are a patient'. Also had to put up with verbal abuse from relatives over the telephone. I recognise they are worried and call because they can't visit but when I explain the nurse looking after their relative is busy with another patient and I will get them to call them back ASAP I have been sworn at, called names etc. We are trying our best to look after more patients than we are staffed for but it feels like all the support the public felt at the beginning of the pandemic has melted away. I have also seen this on social media sites i.e. when it was announced we are getting a £500 payment from SG I saw a lot of negative responses including they get paid to go to work - they weren't furloughed so why should they get anything!!They didn't look after people with COVID with a paper mask for PPE or see colleagues get ill."

Health Care Support Worker, Older Peoples Ward (December 2020_

"This last week has been intense, difficult and most definitely more challenging. The demand on myself and my Nursing colleagues is to work smarter! Patients are seen as being verbally more abusive and question what GPs are doing, why things aren't back to the way it was before the Pandemic (we've had our vaccines now). My work is mostly face to face and has been for several months, visiting shielding patients at home, they are presenting with multiple problems. I can honestly say that I am exhausted, miss breaks and forget to hydrate. I know which GP colleagues have supported me this week even though I know I've saved yet another appointment for them."

Practice Nurse, General Practice, June 2021

29. The impact of the Government's pandemic planning on RCN Scotland's members cannot be understated. The above illustrates the demands felt on RCN members throughout the pandemic which were exacerbated by a depleted and overworked workforce. It is imperative that the Scottish Government considers a structured approach to workforce planning that ensures we have the right number of registered nurses and nursing support staff with the right knowledge, skills and experience in the right place at the right time should we ever be faced with a future pandemic.

2 (c): the impacts of the delivery of a system of testing, outbreak management and self-isolation

30. RCN carried out a testing survey April 2020[8] which highlighted that Health and Social care staff needed more information to understand the options available to them for testing. The survey was open from 6pm Friday 24 April and closed at 12pm on Tuesday 28 April 2020.) Findings from the survey showed that 44% of staff did not know how to access testing. While this was conducted at a UK level, it reflected the views being echoed by RCN Scotland members.

31. However, there were differences between permanent staff and those working as bank, temporary or agency staff. Higher numbers of temporary staff had not been offered testing compared to permanent staff. Those working outside the NHS were less likely to have been offered testing by their employers. While the survey showed that the majority of staff who had been offered testing had no problem with access, we were clear that more work was required to make testing as accessible as possible for all

[8] RCN COVID-19 Staff Testing Survey Findings, April 2020

health and care staff, regardless of employment status or geography, in hospitals, and the community.

32. My colleague Norman Provan will provide further information regarding the RCN's position and actions relating to this aspect of the inquiry.

2(e): the impacts of the supply, distribution, and use of Personal Protective Equipment (PPE)

33. During the first few months of the pandemic, RCN Scotland and others repeatedly raised concerns around the supply of and guidance around the use of PPE across both Health and Social care settings. These concerns centred around three main issues: supply and access to PPE, guidance around the use of PPE and the re-use of single use PPE or the use of expired PPE.

34. In March, April, and May 2020, we wrote to and had meetings with the First Minister, Cabinet Secretary for Health and the Chief Executive of the Health and Safety Executive amongst others to discuss these concerns. In the early phase of the pandemic Scottish members who responded to an RCN survey on PPE[9] in April 2020 told us that there was a lack of access to essential PPE. The survey also found that 25% of those working in high-risk environments still did not have their FFP3 mask fit tested. Many staff, particularly females, failed the fit testing for FFP3 masks as they were designed for larger male faces. Further, some respondents said they had failed the fit test due to wearing a religious hijab or headscarf, or as a result of having a beard. For some with facial hair the option of shaving this was removed due to their

[9] Personal Protective Equipment: Use and availability during the COVID-19 pandemic, April 2020

religious beliefs. Similarly, removal of the hijab or headscarf was also not possible on religious grounds. 31% had not had training in putting on and taking off masks and other PPE. 47% of those working in high-risk settings had said they had been asked to re-use single use PPE. These issues took several months to improve as global supply of PPE was increased and national distribution networks were established.

35. PPE guidance was frequently updated which caused confusion and inconsistency amongst RCN Scotland members. In March 2020, the guidance was revised from full PPE (i.e. FFP3 mask, long sleeved fluid resistant disposable surgical gown, two pairs of sterile gloves and eye/face protection required to be worn by all staff entering the room of a suspected/confirmed case of Covid-19) to a table that set out different PPE requirements for different settings. For example, out with hot spot areas, such as critical care units, fluid resistant surgical masks, disposable plastic apron and disposable gloves were all that was required when working in a room or cohort area with suspected/confirmed cases of Covid-19. If not in direct contact within that criteria then no PPE was required[10].

36. The RCN disagreed strongly with this guidance and believed that it put our members and other health care staff at increased risk and anxiety as it was contrary to WHO advice and was based on the premise that Covid-19 was transmitted via droplets and not aerosols. There were many meetings and correspondence between RCN Scotland and Scottish Government representatives discussing this issue.

37. The Scottish Government maintained that there was a hierarchy of infection control with five levels, often presented in a pyramid design to represent the efficacy of the level of protection. They considered the aim of employers should be to reduce risk to

[10] Health Protection Scotland, Infection prevention and control advice for acute care settings: Acute respiratory illness from novel or emerging pathogens (Coronavirus (COVID-19)) Version 9.0

the lowest reasonably practicable level and protections should be put in place from the most to least effective. The levels of protection (in order of most to least effective) are elimination, substitution, engineering controls, administrative controls, PPE. PPE was the least effective but arguably the easiest to put in place, with other controls achieved through social distancing, ventilation and reducing contact. In clinical settings where patients were receiving care, the more effective controls were the hardest to achieve. Following pressure from RCN Scotland there was a commitment from Scottish Government that risk assessments would be carried out in all clinical areas, assessing ventilation effectiveness etc. and would be made available to all staff, we have yet to see any of these risk assessments displayed or communicated to staff.

38. The RCN developed its own Covid-19 risk assessment resource for its members to align IPC and Health and Safety requirements and provide clarity of the position of Health and Safety legislation which remained current throughout the pandemic[11]. It launched in 23 December 2021. The workplace risk assessment toolkit clearly describes the RCN's evidence in relation to the risk of Covid-19 being transmitted by aerosol and the legal requirements for employers to protect their staff. The RCN argued that increasing the PPE protection offered by ensuring staff had access to respiratory protective equipment (RPE) such as FFP3 masks would help to further mitigate risks as the other controls in the hierarchy were difficult if not impossible to implement in healthcare settings. One member described their experience as follows:

"Wearing basic PPE as per policy and guidelines to visit patients in their own homes. Patients very unwell with long term conditions and not displaying Covid symptoms. Admitted to hospital and confirmed Covid positive. I work very close to patients to provide essential hand on nursing care. Majority of hospital admissions are directly from patient's home. I'm concerned that me and my colleagues may not be adequately protected in an under reported high risk

[11] Respiratory risk assessment toolkit | Royal College of Nursing (rcn.org.uk)

environment where other professionals and services are limiting/reducing their face-to-face contact."

Registered Nurse, Community Nursing, (March 2021)

2(g): the impacts of nurses in care and nursing homes: The transfer of residents to or from nursing homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections.

39. The RCN was not involved in the discussions or subsequent decisions to transfer residents to or from care homes with nursing (previously known as 'nursing homes') or care homes without nursing (previously known as 'residential homes'). However, we recognise the detrimental impact that restrictions on visiting had on care homes residents and their families, particularly for residents living with dementia or learning disabilities, in terms of loneliness and isolation.

40. In relation to nurses and other RCN Scotland members working in the care home sectors their experience was at times different than that of those working in the NHS. They reported significant issues with accessing appropriate PPE and guidance on infection prevention and control. They were overwhelmed by the sudden deterioration of residents and the number of residents who they were caring for dying from Covid-19. The staffing crisis which as described previously was there before the pandemic but was made much worse by staff shielding and developing Covid-19 symptoms themselves. The pandemic brought into sharp focus major problems that pre-date the beginning of this crisis. The consequences and impacts of these problems were greatly felt due to the pandemic and require to be addressed in the event of another.

41. Care homes in many ways bore the brunt of this crisis, despite the commitment of staff, communities, residents, families and friends to try to keep everyone as safe as possible. There were numerous press stories of staff living in the care home or within temporary accommodation on site, to protect the residents from infection. RCN Scotland were concerned about the impact this practice had on staff, with staff feeling pressurised to stay and feelings of guilt if Covid-19 entered the home. Too often care homes were behind the curve when it came to solutions. Shielding, staffing, access to PPE and testing all have proved especially problematic for nursing and care staff in Scotland's care homes. The consequences have been tragic for many. That cannot be changed now but what has happened should not be forgotten.

"I work in elderly care in a nursing home and it's a job I used to really love. But all the difficulties we experienced with COVID and PPE and lack of visiting for relatives and now getting vaccinations and trying to get people to work is getting ridiculous. I am never off my shift on time and if there is no agency cover, I just have to stay overnight, not often but a couple of times. Who does that in a job? You don't even get to sleep because if staff know you are there they come and wake you to ask about issues. I wanted to drop my shifts as it was getting too much, but the management (it's a private nursing home) say I will have to drop to a staff nurse/ not senior anymore. I understand that they want full time cover but is seems unfair that I have to drop to a staff nurse and less wages, because "I am not dealing with my stress". I care about my residents and the other staff but if I talk to the managers they tell me other staff can manage and are not complaining. I begin to think it's me and I mustn't be a very good nurse anymore and I am worried that I will make a mistake. I decided that I should ask my doctor to sign me off my work, but then I feel I will look like I am not coping, so instead I know I will just go back. It seems there is never an answer, you just have to try to do your best and struggle through."

Registered nurse, Care home (February 2021)

42. The problems care homes have faced during the crisis have, in many respects, been symptoms of how the sector and the people that live and work in it have been undervalued by society for far too long.

43. In May 2020, the Cabinet Secretary for Health wrote to the NHS Board Nurse Directors across Scotland detailing the decision to extend the Nurse Directors role requiring them to be accountable for the provision of; nursing leadership, support and guidance within the care home and care at home sector. Through attendance at Scottish Care's Strategic Nursing Group and Scottish Governments Clinical and Professional Advisory Group – Care homes, I heard first hand of the impact this had on the sector. Although meant as a means of supporting the sector some managers and staff reported that they felt undervalued. There was also confusion with the role of NHS oversight teams and their visits feeling like inspections. There was a perception that NHS staff did not understand the context of care within a care home and focussed on making the environment more clinical and as a consequence received conflicting advice/information from the oversight teams and Care Inspectorate inspection teams.

"My last week of nursing has been really challenging for me, I feel that as a clinical lead and deputy manager that I have the skills and experience to carry out my job well. However, the last week threw me a curve ball and even though I did everything I could possibly do to rectify the situation, it was unresolved and left me feeling rather hopeless and frustrated. It is very clear to me that there is still a blame culture towards care homes and this needs to change, It made questioned myself on why I actually do this job, Its thankless! The reality is I make a difference in people's lives every day, sometimes I have to dig deep to remind myself of that. My background is A+E, high dependency, acute medicine and cardiac arrest team lead and it's through this experience that I am able to

do my role now. I use my clinical decision skills on a daily basis, I don't have a ward full of doctors to ask or 5 other nurses and nurse practitioners. I am expected to know everything about 55 residents and manage their conditions as well holistic care for not only residents but relatives. Yet I am treated as if I am " just a care home nurse", " can you manage a catheter?", will you manage to take a cannula out?". I am the equivalent of a band 7 in a hospital setting but often treated as a student nurse."

Nurse Manager, Care Home, (July 2022)

44. Another problem the COVID-19 pandemic has brought to the fore is the recruitment crisis facing the care sector. This is another long-term issue that hasn't received the widespread attention it deserves. The need for registered nurses within care homes has increased. Registered nurses have the clinical skills and knowledge to respond to residents' changing needs, managing medication, monitoring deterioration and overseeing infection control. Their leadership and oversight supports the wider team of carers and care assistants.

45. The imperative to deliver safe, quality care to residents of care homes with increasingly complex health needs is not new. More people are talking about it since COVID-19 threatened the fabric of society at all levels and in all environments. But it would be a failure of huge proportions if we do not learn the difficult lessons of the pandemic and tackle head on many issues which have, for years, been placed in the 'too hard to do' box.

2k: the impact of the delivery of education and certification.

46. Nursing students are required to complete an undergraduate degree programme of 3 or 4 years duration. During this time, they must meet the Nursing & Midwifery Council

(NMC) requirements for registration. These include completing 2,300 hours of mandatory theory/academic study and 2,300 hours of practice placement. There are four fields of nursing that lead to registration on different parts of the NMC register i.e. Adult, Mental Health, Learning Disability and Children. Nursing students across all four fields had their undergraduate programme disrupted due to the pandemic.

47. From the outset of the Covid-19 pandemic at March 2020 nursing students were reporting a level of anxiety due to lack of clarity surrounding their status while on clinical placement or ability to maintain their academic study and meet academic deadlines. Other concerns included: deployment, testing and risk assessments, payment of bursaries, registration, pay and sick pay, PPE, access to death in service payment, and stress levels. Those already with children experienced childcare difficulties).

48. On 19 March 2020 the four UK Chief Nursing Officers and the Nursing and Midwifery Council (NMC) took steps to expand the nursing workforce in response to the COVID-19 emergency[12]. The NMC published emergency standards[13], enabling paid placements for pre-registration nursing and midwifery students to support the workforce. In Scotland, all year two to four nursing and midwifery students were invited to take up the offer.

49. This was a really challenging time for all our members including our student members as they waited to find out more about how they would be impacted by the announcement that undergraduate nursing programmes were changing as part of efforts to expand the nursing workforce and the academic component of their programme would move to on-line.

[12] Joint statement on expanding the nursing workforce in the Covid-19 outbreak - The Nursing and Midwifery Council (nmc.org.uk)
[13] Recovery and emergency programme standards - The Nursing and Midwifery Council (nmc.org.uk)

50. Nursing students had many questions about what these changes meant in practice. In particular, what options were open to them during the crisis and what this ultimately meant for their education, completing their degree and gaining their NMC registration. Throughout this time, as plans were firmed up and details were announced, the RCN was clear that individual nursing students must be able to choose whether or not to work clinically on placement and must not feel any pressure to do so.

51. We know that many nursing students wanted to and did work clinically with over 4,800 nursing and midwifery students choosing to do so. They were committed to making the most of the learning opportunity this presented and made a valuable contribution to care. But there were students with all sorts of personal circumstances that meant they were unable to work on the frontline at this time, including their own underlying medical conditions, concerns for vulnerable members of their family or caring responsibilities.

52. The RCN, along with our RCN UK Student Committee members for Scotland, worked hard to ensure that the voice of students was heard by the Scottish Government. We engaged with students through a variety of methods i.e. social media and direct contact with our elected student committee members and network of student ambassadors. We published a set of FAQs for students in Scotland and updated these regularly as new information became available.

53. The Scottish Government published guidance[14] explaining the approach that was taken in Scotland for nursing students. This set out the different approaches for year 1 students, year 2 and 3 students not in the final six months of their programme and year 3 students in their final 6 month of their programme. Students not in first year or not in the final six months of pre-registration programme were invited to opt in to extended paid placements (Band 3 AfC) until 31 August 2020 with the arrangement to spend no more than 80% of time in clinical practice and 20% in academic study. Students in the final six months of the programme were invited to opt into an extended paid placement (Band 4 AfC) until 30th September (similar to normal timelines for graduation and NMC registration) with an arrangement to move into clinical practice during the emergency period. These changes meant a change in the students' status. They were no longer 'supernumerary' - that is, additional to the number of nursing and Nursing Support Worker staff needed to provide safe and effective care. Supernumerary status allows them, in normal times, to focus on fulfilling the learning requirements of their nursing education programme while on placement directly supervised by a registered nurse.

54. Instead, they were students on a paid clinical placement, 'included in the numbers' of the nursing team for the ward or care home or another workplace to which they had been posted. The RCN lobbied government to ensure that those students who chose to opt in did not have their nursing education compromised and those who did not opt in were not disadvantaged due to the reduction in clinical placement hours. When they were in clinical practice, we argued that each student must be supported and supervised, their work delegated to them appropriately by a registered nurse, that they not be expected to work outside their skills or capabilities and they must have protected learning time.

[14] Coronavirus (COVID-19): guidance for medical, nursing and midwifery students - gov.scot (www.gov.scot)

55. These imperatives were essential to ensure that throughout the emergency period, students were safe in clinical practice and able to continue their progress to qualifying as registered nurses. This unfortunately did not always happen. Students reported a sense of being abandoned, not having time or energy to complete the academic requirements of their programme or those who did not opt in, not meeting the clinical component of their programme. This resulted in students not being able to register with the NMC at their expected completion date. This had financial implications, as those requiring an extension to their programme no longer were eligible for the student bursary. The RCN lobbied the Scottish government and secured an extension to bursary payments for these students. Through our Sensemaker system we captured the experience of some students. These are direct quotes of student nurses.

"I felt that there was far too much workload to keep up with and not able to provide what I would like due to time constraints and staffing issues and rather unsupported and no guidance. Extremely busy and fast paced. Second year student nurse"

Nursing Student, Adult Acute Ward, (January 2021)

"Caring for patients who have been intubated to help treat covid pneumonia. Staff are under so much pressure, there is risk of patients being in danger if this is not addressed."

Nursing Student, Adult Acute Ward, (January 2021)

"I feel completely broken, I couldn't keep up with the 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 it's made me wonder if nursing is where I want to be."

Nursing Student, Adult Acute Ward, (January 2021)

56. In 2020 NHS Education for Scotland published a report *'Deployment of Student Nurses and Midwives in Extended Paid Placements- Covid-19: Lessons Learned'* which echoed the feedback that we had received from students that year. The report lists the key lessons as:

- *The overall experience for students was positive but there was confusion around role clarity (student v NSW)*
- *The rapid pace of decision making with multiple changes led to confusion.*
- *Excellent examples of collaboration were acknowledged but multiple channels of communication resulted in organisations not receiving information at the same time.*
- *There were challenges in using the Covid-19 Accelerated Recruitment Portal (CARP) for student nurses and midwives.*
- *The large numbers of student entering the workforce presented significant pressure on individual and organisational processes such as HR, OH and Payroll.*
- *Commence future planning now to minimise the number of rapid decisions if there is a further crisis and link to the centralised communication hub.*

57. While the NMC emergency education standards were withdrawn in September 2020 and replaced with recovery standards, the pandemic continued to impact on nursing students. COVID-19 continued to be prevalent in practice learning environments, the impact of paid placements on students to complete their degree programmes on time, and academic programmes delivery continued to include virtual and online content replacing face to face learning. Although paid placements concluded in autumn 2020, nursing students continued to be asked to contribute to the workforce during the pandemic through additional paid employment. This was intended to be separate from their studies and clinical placements and supernumerary status was to be retained.

58. As the pandemic progressed and challenges continued, in January 2021, the NMC reintroduced optional emergency education standards. This provided the option for the four countries for full time student deployment for final year students. The Chief Nursing Officer issued an open letter to students setting out that Scottish government did not believe it was appropriate to authorise full time student deployment again, but instead invited students to take up part time paid employment, separate from study and clinical placements. The Deputy Director of the Health Workforce Directorate in Scotland then wrote to all healthcare students about applying to join the bank at their local NHS Board.

59. Nursing students continued to share their experiences with us, reporting that their supernumerary status as learners was not being recognised in practice areas, ongoing challenges from COVID restrictions on their practice learning experiences to personal concerns such as shielding, being unable to complete placements, feeling unsupported and at risk.

"Student nurses do NOT have supernumerary status. For the past week I have clearly been counted in the ward numbers and have looked after patients on my own- I cannot honestly say that I have had any individual learning opportunities or any teaching. My overriding concern is for my patients, and I will work all day every day for them but there needs to be a balance and there is none. I am a Year 3 student who is preparing to graduate in the summer- do I feel ready? No. I don't want, nor expect, my hand to be held but I do expect a clinical overview where I feel supported and mentored. There is no time for that. I am on placement in Acute Care so the pressures are immense with no respite. I'm exhausted and feel disillusioned. I don't think the CNO has a clear, realistic view of

what student nurses are doing in the wards etc- not do our lecturers who are working from home. Student nurses are forgotten within this pandemic and we are feeling this acutely."

Nursing Student, Intensive Care Unit/ High Dependency, (January 2021)

"If I'm supernumerary; why do I have blisters on my feet! If I'm supernumerary; why do my hands hurt so much with being cut due to the unlimited hand washing. If I'm supernumerary why does my body ache so much, that I lay I bed at night with my full body throbbing, with the thousands of steps I have rushed around doing. If I'm supernumerary; why can't I spectate with onsite procedure as ward is to short staffed for me to leave for a half hour! If I'm supernumerary; why do csw ask me if I've changed the bins! If I'm supernumerary; why do staff say they don't know what they would do without the students! If I'm supernumerary; why do patients rely on me assisting them for 12.5hrs a day!"

Nursing Student, Adult Acute Ward, (January 2021)

60. The experiences of joining NHS banks was also not without challenges, and we are aware that nursing students have experienced difficulties in the administrative arrangements to take up paid part time hours via NHS nurse banks as well as the impact of paid work on their studies. An RCN Scotland survey of students completed during 2023 highlighted that 90% student nurse respondents were working more than 11 hours per week with 20% working between 26 to 36 hours per week on top of their clinical and academic hours. Many report that having to work for financial reasons is impacting on their ability to meet the academic requirements of the program and are having to make difficult choices regarding working or studying and reducing paid employment whilst on clinical placement, 58% of students stated that financial concerns were making them consider leaving the programme.

61. Nursing students who were studying during the pandemic are now the registered nurses of today. The COVID pandemic has shaped their experiences as nursing students and impacted on them as individuals and continues to have a lasting impact on their experiences as registered nurses.

Lessons to be learned

62. This statement details the impacts on RCN members as a consequence of the strategic decision making of the Scottish Government. There are many lessons to be learned that I touch upon above. However, it is clear that **in order for Scotland to be ready for the next pandemic**, and for detrimental impacts to be minimised the greatest lesson to be learned is to ensure that there is a suitable health and social care workforce in place.

63. What is needed is a structured approach to workforce planning that ensures we have the right number of registered nurses and nursing support staff with the right knowledge, skills and experience in the right place at the right time. It would be a failure of huge proportions if we do not learn the difficult lessons of the pandemic and tackle head on many issues which have, for years, been placed in the 'too hard to do' box. High numbers of nursing staff are leaving the profession every year, and too few are joining to replace them. At the same time, the demand for health care continues to increase. It is therefore vital that the Scottish Government deploy a range of interventions to improve nursing workforce retention, alongside action to boost domestic nursing supply. The number of vacancies and long term effects of the Covid pandemic (such as Long Covid), the country's health service and its workers are struggling to cope at present and certainly could not cope with another pandemic.

64. There are associated lessons on pandemic planning on properly researched PPE, research into the impact of Long Covid on the nursing and healthcare workforce and work on not only recruitment but how to retain staff in the workforce over the longer term. My colleagues Norman Provan and Colin Poolman have addressed these issues in their statements.

Statement of Truth

65. This statement is true to the best of my knowledge and belief, based on the information available to me at this time.

Name: Eileen McKenna

Job title: Associate Director, Nursing, Policy & Professional Practice, RCN Scotland

Signed: **Personal Data**

Date: 4th March 2024