Scottish Covid-19 Inquiry

Statement of Norman Provan

Associate Director (Employment Relations)

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 Employment Relations in Scotland (RCN Scotland). I am providing this statement to the Inquiry to give 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, the engagement by RCN Scotland with the Scottish Government in respect of each relevant Term of Reference. It will look at areas that impacted RCN members and, in particular, issues of PPE and its effectiveness, financial schemes provided for nurses, risk assessments and guidance for employers and the impacts on RCN Scotland's Black and Minority Ethnic (BAME) members. 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. In my role as Associate Director (Employment Relations) I manage the trade union and legal provisions for RCN members in Scotland. This includes negotiating on behalf of our members with Scottish Government and health and social care employers on pay,

terms and conditions of employment and workforce policies and practice. I ensure RCN members receive representation with individual employers and legal representation, where required, on issues such as regulatory law, employment law, personal injury cases and criminal matters. I have been employed in this post since 2009.

3. I qualified as a registered nurse in May 1987, I have a Bachelor (BA) in Nursing, a post-graduate Diploma in Management and have completed a post-graduate leadership development qualification (The Hult/Ashridge Process).

4. My previous experience includes working clinically as a nurse in acute and forensic psychiatry and in clinical psychotherapy. I subsequently worked in various management, senior management, and leadership roles within the NHS in Scotland. Prior to my current role I was Associate Director of Nursing within NHS Lanarkshire. I remain a registered nurse on the Nursing and Midwifery Council register, and I am required to revalidate every three years to remain registered. I last revalidated in May 2022.

5. In Spring 2020, the Scottish Government established several committees and groups to assist with decision making in managing the NHS and Social care responses to the Covid-19 outbreak and subsequent pandemic. The Scottish Government has a track record of engaging with NHS Scotland's health trade unions on matters which affect their members. This is underpinned by a staff governance standard where NHS employees are guaranteed consultation on matters which affect them.

6. Within the first weeks of the outbreak in March 2020, the Scottish Government established a strategic group, the *Workforce Senior Leadership Group* (WSLG). The group had representation from Scottish Government, NHS, and Local Government employers, third sector employers, and trade unions representing the interests of their members working in health and social care. I was one of several trade union representatives on this group.

7. This group was required to work dynamically and at pace to inform decisions on managing the workforce's response to what became the Covid-19 Pandemic. Initially the group met at least daily and often decisions made were applied across the health and social care workforces with immediate effect, on occasion from the very next day. This was the primary group in which I was engaged, although I did represent the RCN on other groups which were subsequently established.

8. Over time several other groups with more focused remits were established including:

   - *Clinical Professional advisory group (CPAG)*
   - *Louisa Jordan Programme board - I represented the RCN & our members on this group*
   - *Pandemic Response in Adult Social Care Group*
   - *National PPE Oversight Group*
   - *Health and Social Care Winter Planning and Response Group*
   - *Rapid Response Action Group*
   - *Infection Prevention and Control Subgroup*
   - *Staff Recovery Short Life Working Group*
   - *Community Nursing for Adults Group*

9. This list of groups illustrates the complexity and volume of work areas which were required to manage the myriad issues facing heath, social care and the staff working for these agencies during the pandemic.

10. The RCN acknowledges the inclusive partnership working process which the Scottish Government adopted and how this provided an opportunity to influence decision making on behalf of service users and our members across sectors and on a multi-agency basis.

11. That being said, it should be noted that while our involvement provided an opportunity to influence decisions, the decision-making responsibility remained with the Scottish Government. RCN Scotland had no veto on these decisions. Therefore, although there were issues where I feel that RCN Scotland was listened to, and our concerns were adequately responded to, there were other issues where I would argue that the Scottish Government did not, but could have, and should have, acted on our concerns.

RCN Scotland's engagement with the Scottish Government on issues that impacted its members following the Inquiry's Terms of Reference

2(a): impacts of pandemic planning and exercises carried out by the Scottish Government.

12. I understand the Scottish Government undertook pandemic planning and exercises, including modelling and desk top exercises, before the advent of Covid-19. RCN Scotland was not involved in these planning processes.

13. However, the RCN was involved in joint planning with Scottish Government and across sectors and agencies during the pandemic as a key stakeholder in helping to manage the pandemic response.

14. Workforce planning to ensure the supply of suitable numbers of registered nurses and other clinical staff is an area which should have been better managed. The NHS in Scotland has for a long number of years had high numbers of unfilled vacancies within the NHS Scotland. The whole-time staffing required to provide a good level of service was in deficit at the start of the pandemic. Publicly available figures will show that at no time during the pandemic was the whole-time equivalent nursing staff level in the NHS able to reach the numbers required to run the service in normal times, never mind in the exceptional additional pressures brought on by the pandemic itself. The Scottish

Government did take action to try to increase capacity during the pandemic for example by asking retired nursing staff to return to work. However, this was insufficient to bridge the gap between capacity and demand.

15. This lack of suitably skilled nursing staff (registered nurses and nursing support workers) had a significant impact on the NHS's readiness to deal with the sudden shock to the system of many more patients needing to be treated and with much more complex care requirements than in normal circumstances.

16. The consequence of not having enough staff working in the NHS meant those nursing staff who were available to work felt compelled to work harder and longer, 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. Often this impacted on their ability to de-stress from work or spend time with their families.

17. The number of nursing staff available to work was further depleted by the fact that many contracted Covid-19 at least in part due to the increased exposure to Covid-19 at work. Throughout the pandemic sickness absence levels were high due to Covid-19 infection of staff and due to reported high levels of stress and mental health problems experienced by staff providing clinical care in extremely difficult circumstances.

18. This situation was mirrored in other care settings such as community care, social care, and care homes. Vacancy levels, particularly in the care and nursing home sectors, for which figures are also publicly available, are even more challenging than the NHS, where poorer pay and terms and conditions of employment contracts compound recruitment challenges. These are systemic challenges which need to be addressed if we are to recruit and retain enough staff for the health and social care sectors in future.

19. Many nurses reported to us feeling under significant pressure to work in areas different to those they normally worked in, as hospitals had many more patients with respiratory illness. Nurses were quickly required to transfer from different specialist areas to work with Covid-19 patients, some in very specialised area such as intensive care units (ICU).

20. Members reported to the RCN that they often felt they didn't have the skills or experience to work with this patient group. This provided both the professional dilemma of being asked to work beyond the scope of their practice and their fear of making clinical errors for which they would be held accountable for by their governing body the Nursing and Midwifery Council (NMC), if the care they delivered was below the high standard that the public have the right to expect.

21. RCN Scotland is calling on the Scottish Government as a matter of urgency to develop and implement a Nursing Retention scheme to tackle the deficit of the workforce exodus of nursing staff from health and care services. The key drivers of nursing workers leave appear to be: staff shortages resulting in pressures, workload and work schedules, pay, support during education and on entry into the nursing workforce. The Nursing Workforce in Scotland report 2022 (RCN Scotland, 2022a) highlighted how the COVID-19 pandemic had made workforce pressures that existed before the pandemic worse.

22. My colleague Eileen McKenna through her evidence to this inquiry will provide further detail of the impact this had on nurses and nursing support workers and the sources of our knowledge of this.

2(b): the decisions to lockdown and to apply other restrictions and the impact of those restrictions

23. At the beginning of the pandemic when decisions were made to enter 'lockdown', nursing and other health and social care staff continued to work to provide care for the public. RCN Scotland accepted the need for lockdown and accepted that health and social care staff would be required to work during the pandemic. It was clear that the pandemic was going to have multiple impacts on the NHS and social care staff working through the pandemic.

24. For many nurses and nursing support workers this meant daily interaction in providing direct personal care to patients many of whom were or became infected with the Covid-19 virus. There was initially no reliable diagnostic testing for patients. It was a time of fear for many staff. There was fear of getting Covid-19, fear of dying, fear of passing Covid-19 to their family members and fear of being unable to offer the best care and treatment to the patients they looked after. The commitment and professionalism of these staff should be acknowledged and recognised.

25. During the pandemic there were many nurses and social care workers who contracted Covid-19. Some died as a result of contracting the virus. Some have gone on to suffer from 'long Covid' which continues to cause them harm. Many of these staff were RCN members and, in some cases, they continue to suffer physical and emotional pain and distress as a consequence of Long Covid. Some face financial detriment and some are now unable to work. It is highly likely that many of these staff will have been infected by Covid-19, possibly several times, in their workplace while providing care to patients who were themselves infected. This occupationally derived infection is termed 'nosocomial infection', where it is recognised that their infection happened in the workplace. The word 'nosocomial' means 'originating in a hospital'.

RCN does not hold figures for deaths by occupation and sector. These figures are held by National Records of Scotland (NRS). However, having had sight of the figures RCN Scotland noted that in terms of occupation a disproportionate number of nurses and nursing support workers across the health and social care sector died or were infected when compared to other occupations.

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

26. When a test was developed to confirm Covid-19 infection, staff who were symptomatic were sent for polymerase chain reaction (PCR) testing in one of the regional testing sites which had been set up in Scotland. In a matter of months and certainly by December 2020 this was replaced by individual self-testing through diagnostic test kits supplied by the Scottish Government. Nurses and other health and social care staff were initially asked to self-test twice weekly.

27. At the Workforce Senior Leadership Group on behalf of our members I raised concerns regarding the lack of reporting to the Health and Safety Executive (HSE) in situations where nurses may have been infected at their workplace. I had previously written to employers to remind them of their obligation to report possible occupationally derived illness through the RIDDOR reporting mechanism (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).

28. Had the process for testing of staff in the NHS, as provided for in guidance from Scottish Government, been more robust, the HSE may have been in a position to intervene. Firstly, by inspecting workplaces and then issuing compliance notices to employers to help manage the risks of nosocomial infection. They may have challenged the hierarchy of infection control precautions (these are a series of escalating steps taken to manage infection) which were in place and may have

demanded alternative control mechanisms which RCN Scotland considers may have reduced nosocomial infection risks for staff.

29. Through the Workforce Senior Leadership Group, the Scottish Government did provide guidance to NHS boards on reporting to the Health and Safety Executive via the RIDDOR process where staff may have occupationally derived Covid. However, that guidance suggested that a PCR test should be completed by the staff and by this time PCR testing was not the methodology that was being used by Health Boards for staff to test, as it had been replaced by the self-testing process. This anomaly likely meant that for nurses who contracted Covid and may very well have contracted it at work, their infection was never reported to the HSE because a PCR test had not been undertaken. Subsequently the potential for the HSE to be more involved with Scottish Government and employers around control mechanisms was lost.

30. The RCN believes that the absence of accurate reporting to the Health and Safety Executive and consequent lack of risk mitigating action meant that nurses and nursing support workers may well have gone on to contract Covid-19 at their work. Some of those nursing staff continue to be affected, particularly those with long Covid. In some cases, they are unfit to work. These individuals continue to suffer. They are not being compensated for that harm and are now left with the prospect of having to go through expensive legal processes, such as personal injury cases, to be compensated for the harm that they have suffered. RCN Scotland has lodged and sisted personal injury cases on behalf of members against NHS Scotland health boards. The RCN would like to see a different approach other than costly and lengthy legal processes to compensate nursing staff who have been harmed at work because of working in the pandemic response.

2(d): the design and delivery of a vaccination strategy.

31. In principle, the RCN supported all health and social care staff being vaccinated against COVID-19 when the vaccine was developed. This was to ensure that staff were protected against the virus, and to help ensure that as many people as possible were fit to work in both the NHS and social care during the pandemic. The RCN did not, however, support compulsory vaccination. This position reflected the wishes of our membership, some of whom were reluctant to be vaccinated. It is important to recognise that staff wearing appropriate PPE in clinical settings would have vastly reduced any risk of cross infection.

32. The creation of vaccination teams, when the vaccine was produced and available, had an immediate and positive effect on the mass vaccination of the general population. Vaccination clearly played a large part in controlling and reducing the spread of the virus, however creating these teams relied on many nursing and other NHS staff being redeployed to staff these teams. It must be recognised that health and social care staff, who are already under huge pressure and working way beyond their capacity, were being asked and expected to step up yet again to support the increased vaccination programme. This reduced the availability of staff with the knock-on effect of increasing the demand on direct clinical care in both health and social care settings.

33. RCN Scotland considers that it was mostly nursing staff who delivered the vaccination programme but some of the approaches to pay had a negative impact on them.

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

34. After the first cases of patients being hospitalised due to Covid infection, PPE supply and demand immediately became an issue. The numbers of patients requiring hospital

care increased quickly and the NHS in Scotland was unprepared for the sudden requirement for the additional volume of PPE required.

35. A great volume of PPE was required as it had to be replaced between patient interventions, to reduce cross infection. That PPE had to be available in all health and social care settings, from acute hospital wards, through primary care and community settings and care homes. While some settings reported adequate PPE, for example, intensive care setting in acute hospitals, this was not the experience shared by all nursing staff. Those working in care homes were particularly impacted by problems with stock availability and the slow distribution of PPE. At the beginning of the pandemic this was the number one concern expressed by our members. The supply of PPE, which items of PPE should be worn and the implications of increased risk to staff who were caring for infected patients all day every day. Our members were fearful of getting the virus and the implication for themselves and their families.

36. Initially, difficult decisions were being made about re-using PPE and using PPE held in the NHS supply centre which had passed its safe use expiry date.

37. I raised these issues through the Workforce Senior Leadership Group (WSLG) reporting mechanism and actions were taken to try to mitigate the risks. For example, increased laundry capacity was sought to launder staff uniforms and bed linen. Tests were undertaken to check the safety of expired PPE before it was released into the system and a mechanism was developed to increase the supply through national and international supply chains.

38. Over time, as the supply chain for PPE was secured by the NHS through their National Shared Services board, a more sophisticated system was developed to ensure that both NHS Boards and the WSLG could see what PPE was 'in stock' but centrally held in the distribution warehouses and what had already been distributed to boards. This

was useful in managing the supply in a way which stopped stockpiling and ensured a more constant supply of PPE.

39. Through the WSLG, the Scottish Government set up community hubs where smaller care providers in social care settings could access additional PPE if their supplies ran short or their distribution networks were unable to meet demand. This was helpful as small providers struggled to secure enough PPE as larger systems like the NHS secured supply more easily as they were buying in enormous volumes.

40. The wearing of PPE all day every working day was difficult for many staff. It was in some cases bulky, hot, uncomfortable to wear for prolonged periods and, at times it was also a barrier to effective communication with patients, especially in clinical areas where patients had cognitive impairment or lacked capacity to understand the need for staff or themselves to wear PPE.

41. The types of PPE were also at times problematic. The FFP3 type mask required to be 'face fitted' for each member of staff who wore it. It was often reported to the RCN that many of these masks were manufactured to a type that fitted more easily on men, with female staff reporting it was difficult to properly secure the mask in a way which formed a proper seal.

42. In addition, different staff were offered different levels of PPE depending on what area they worked in. This was based on Scottish Government strictly following the advice of the Antimicrobial Resistance & Healthcare Associated Infection (ARHAI); an advisory group which continually reported that Covid was a droplet spread infection rather than an airborne infection. Health boards therefore only routinely offered higher levels of protection, such as FFP3 masks in areas where aerosol generating procedures were routinely performed. In other clinical areas fluid resistant surgical masks were supplied. These masks did not form a seal with the skin and allowed air to get in at the side of the mask.

43. From early in the pandemic the RCN raised this issue through the WSLG, directly with the Cabinet Secretary for Health and at various other infection control groups. We wrote directly to Scottish Government citing international gathered evidence to support our position in March 2021, but at no time did the Scottish Government suitably address our concerns. Through internationally recognised research the WHO eventually acknowledged that Covid is an airborne infection. In the view of RCN Scotland, is without question that many nursing staff across health and social care will have contracted Covid-19 due to inappropriate PPE provision. It further considers that cross contamination between staff and patients will have happened for the same reason.

44. The Scottish Government had a hierarchy of control with increasingly effective actions to manage transmission of the Covid-19 virus. PPE was the least effective but arguably the easiest measure to put in place, and together with elimination, would have been the most effective. Engineering control sat somewhere in the middle. This would be controls that were used to isolate staff from the hazard, for example, through social distancing, ventilation and reducing contact. In clinical settings where patients were receiving care the more effective controls were the hardest to achieve. In these circumstances the RCN argued that increasing the PPE protection offered would help to further mitigate risks. FFP3 masks, visors and additional PPE would at a minimum have been a reasonable precaution. As detailed before the Scottish Government never accepted our concerns or acted upon them despite the evidence that we submitted to support our concerns. Throughout the pandemic not one nurse I spoke to, and I spoke to many, described appropriate engineered ventilation processes being put in place in their clinical areas to ensure the frequent exchange of air.

45. Early in the pandemic it was reported that people from a Black, Asian, and Minority Ethnic (BAME) population were having more severe illness and higher rates of death than the population as a whole. I raised this at the WSLG as there were potential

negative implications for NHS staff from the BAME population. The Scottish Government responded positively to this concern. They quickly developed a BAME risk assessment tool and used the scoring mechanism to identify staff at higher risk. Those staff were offered additional PPE, prioritised to work in areas with lower risk of contact with patients who were known to have or suspected of having the virus and in some cases, staff were offered to shield if their risk profile could not be sufficiently managed through workplace mitigations. The RCN was supportive of this action which we felt was proportionate and effective in helping to manage risk.

2(f): the requirement for shielding and associated assistance programmes, provided or supported by public agencies.

46. The RCN raised issue of staff working within the NHS who met the shielding requirements via the WSLG. The Scottish Government response was immediate and helpful. Staff who were required to shield were quickly reassured that they could shield at no financial detriment. That is all NHS Scotland staff who were required to shield or who went off sick with Covid were paid 'as if at work' throughout their period of shielding or sickness. The same provision was later put in place for social care staff via the WSLG through the creation of the social care support fund which came into place from June 2020.

47. This provided financial support for staff and was very welcome. The RCN did have some concern from members working in care homes about the application of the process for securing payment. The funding was claimed by employers to be paid to staff who were eligible. A small number of our members told us that their employers refused to claim this on their behalf and therefore they did not receive this support. I did raise this with Scottish Government through the WSLG, however, there was no mechanism for individuals to claim themselves. The Scottish Government were unable to alter the scheme to remedy this.

2(g): 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.

48. The RCN was not involved in decisions regarding the transfer of patients to or from care and nursing homes.

49. In relation to nurses and other RCN members in such homes, their experience was at times quite different than that of those working in the NHS. I have covered issues such as access to PPE and staff support earlier in my statement. However, there are issues in this area which deserve to be considered. The RCN stated in June 2020 that "Care homes have in many ways borne the brunt of this crisis, despite the commitment of staff, communities, residents, families, and friends to try to keep everyone as safe as possible. Too often in the past few months care homes have been behind the curve when it came to solutions – shielding, staffing, access to PPE, testing, have all 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."

50. 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.

51. The RCN often heard from nurses in care or nursing homes that they felt that the unique environment they worked in was perceived quite differently from those working in the NHS. The nature of their client group meant that many were elderly and often immunocompromised or had multiple co-morbid health conditions. These clinical environments do not have the range of multi-disciplinary health professionals, diagnostic services, or equipment available in an acute NHS hospital setting.

52. Nurses reported to the RCN that deaths in care homes were reported more critically in the media. Difficult decisions regarding care home visiting left staff often feeling criticised when they played no part in the making of those decisions. Their therapeutic relationship was, at times, difficult to maintain with residents who were expected to remain isolated from others, wear PPE and were unable to receive visits from their loved ones. Nurses often reported finding this stressful, distressing, and often reported that, where other health staff were being portrayed as heroes, they felt they were often seen as villains. I think it is important to acknowledge this and I would like to personally acknowledge their contribution to providing care in the most difficult of circumstances. These feelings were compounded by the ongoing criminal investigation into deaths in care homes (Operation Koper). Although I make no comment about the necessity of Operation Koper, I can confirm the impact that many nursing staff feel about how they are perceived differently based on their area of work during the pandemic response.

2(k): the delivery of education and certification

53. Nurses in health and social care reported to us that their designation as key workers did enable them to contribute more fully to the pandemic response. School closures and visiting restrictions between households would have made it impossible for those with school aged children to attend work without the support of access to education hubs, which were open to accommodate the children of key workers. This is acknowledged to have worked well but there were some concerns about the lack of consistency between local authorities about how this provision was applied.

Lessons to be learned

54. RCN Scotland believes there are many lessons to be learned, but in order for Scotland to be ready for the next pandemic, it highlights that the greatest lesson to be learned is to ensure that there is a suitable health and social care workforce in place. RCN Scotland considers that the Scottish Government must continue to engage with key stake holders, including unions and representative bodies of the workforce that will be required to step up to respond to any future pandemic. All decisions taken by the Scottish Government, in particular those relating to guidance and efficacy of infection control measures, involve collaboration with key stake holders to ensure national guidance is robust, fully informed and most importantly evidence based.

55. RCN Scotland asks that the ongoing consequences of the Covid-19 pandemic which are still being experienced by a significant number of the health and social care workforce as a consequence of the impacts of the strategic decision making of the Scottish Government are acknowledged and addressed.

56. Long Covid, along with the continuing psychological symptoms, being experienced by RCN Scotland members mean that there is large number of the workforce now unable to practice. Across the UK, 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. We would ask that this be recognised and that measures are put in place to address this.

Statement of Truth

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

Name: Norman Provan

Job title: Associate Direction (Employment Relations), RCN Scotland

Signed: **Personal Data**

Date: 04/03/2024.