Scottish Covid-19 Inquiry

Statement of James Colin Poolman,

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 the Director of RCN Scotland. The RCN is both a professional Royal College and a certified trade union. 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 strategic decision making by the Scottish Government on RCN Scotland members. This statement will describe RCN as organisation, the membership and the engagement with Scottish Government during pandemic to set the context and background against which the impacts were felt against each relevant Term of Reference. This statement addresses briefly some of the issues raised by members throughout the course of the pandemic which will be further expanded by my colleagues, Norman Provan and Eileen McKenna.

2. 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.

Acknowledgement to health and social care workers

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

Career history

4. I took up post as Director of RCN Scotland in September 2021. Over the pandemic my predecessors in the role of Director of RCN Scotland were Theresa Fyffe, in post until early 2021, and from then until September 2021 Susan Aitkenhead. I took up post firstly on an interim basis until my permanent appointment in September 2022.

5. I qualified as a registered nurse in June 1991 and am registered with the Nursing and Midwifery Council. I am due to re-register through revalidation in June 2024. I have been employed by the Royal College of Nursing since April 1999 working in a number of roles. Prior to working with the Royal College of Nursing I was employed by NHS Tayside in a number of clinical posts. From registering as a nurse in 1991 I worked initially as a Staff Nurse in what was termed at the time as elderly care before moving in 1993 to work as a Senior Staff Nurse and then Charge Nurse in forensic psychiatry at Murray Royal Hospital, Perth.

The Royal College of Nursing

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

7. The RCN is the world's largest professional body and union for nursing, with a membership of over half a million registered nurses, midwives, health visitors, nursing students, nursing support workers[1] and nurse cadets. The RCN's members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN supports members across all four countries of the UK and internationally, and has offices in Scotland, Northern Ireland, Wales and nine regions across England.

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

9. RCN Scotland is a distinct directorate operating within the UK-wide RCN rather than a separate legal entity. As the Director for Scotland, based in Edinburgh, I have strategic

[1] [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).

and operational responsibility and autonomy in the Scottish context. As a member of the RCN Executive team I also have responsibility for the broader strategic approach and operational requirements of the RCN as a whole.

10. RCN Scotland deals with Scottish nursing matters, including pay and conditions, and campaigns on issues of concern to nursing staff, influencing health policies at local, NHS Scotland and Scottish Government levels. Members of RCN Scotland work across health and social care settings including NHS hospitals and specialist health facilities, care homes, general practice, the community and private healthcare sector, among others.

RCN Scotland's engagement with members throughout the pandemic

11. The pandemic impacted nearly every aspect of our members lives both in work and in their personal lives. It had a significant impact on their mental and physical health and wellbeing. This included, but was not limited to, professionals who were pregnant, clinically vulnerable, had caring responsibilities or were redeployed. Many suffered from Covid themselves, often on multiple occasions. In some cases, this means that they continue to suffer from 'Long Covid'. We also must remember our colleagues who died from Covid and related symptoms.

12. During the pandemic RCN Scotland engaged with its members through the RCN's existing interactive support services via a call centre and online platform, known as RCN Direct ("RCND"). We received over 2,500 Covid-19 related calls from nursing staff in Scotland during the period from March 2020 to the end of June 2022.

13. The impact of the pandemic on our members can be by seen through a sample of the myriad of issues and concerns members sought advice on during the pandemic through RCN Direct. This included;

- Guidance on the extended periods of time nursing staff spent wearing PPE caused damage to their skin and contributed to fatigue and heat stress.
- Issues in relation to mental health, feeling depressed, anxious and stressed; and reporting experiences indicative of a probable post-traumatic stress disorder.
- Information and guidance in relation to changing national guidance and advice relating to the pandemic.
- Advice on professional dilemmas, such as whether or not to treat patients without wearing PPE.
- Advice on delegating tasks appropriately; whether or not to undertake work at a higher level than they were familiar with, and ensuring they balanced their unpaid overtime with considerations of patient safety so that overwork and exhaustion did not present a risk to that safety.
- Nursing staff from ethnic minorities sought specific support as in the general population they suffered poorer outcomes of Covid-19 infection, exacerbated by existing structural inequalities and institutional bias within the healthcare system.
- The pandemic worsened the financial difficulties experienced by many RCN members who sought guidance on support available. Including issues relating to pay and sick pay, indemnity and life assurance.
- Nursing students raised concerns and sought advice about academic deadlines, clinical placements and deployment in workplaces.
- Issues and concerns in relation to testing and vaccination especially as the pandemic developed.

- Pregnant members and those on maternity leave raised queries about their rights and obligations in relation to attending work in high-risk areas, and those already with children experienced childcare difficulties.
- Members contacted and continue to contact the RCND in large numbers with queries about the consequences of Long Covid.

14. We also used available communication channels to communicate with our members both directly and indirectly. This included emails, comprehensive web-based advice guides, social media and the use of wider news media channels. During and since the pandemic we have also engaged with our members through techniques using surveys and interactive tools such as 'Sensemaker®' to gain direct member experience. RCN Scotland uses Sensemaker® as the tool to capture and analyse members' stories. Sensemaker® is a software tool hosted by Cognitive Edge which captures qualitative and quantitative data related to personal experiences, observations, and situations.

15. RCN Scotland is recognised as the 'voice of nursing' within civic and wider public life in Scotland. During the pandemic we influenced and campaigned on behalf of our members and nursing as a profession, highlighting the impact on nursing staff and the need to learn lessons. We regularly briefed MSPs ahead of relevant debates and provided evidence to the Scottish Parliament's Health and Sport/Health, Social Care and Sport Committee and the Scottish Affairs Committee in Westminster.

RCN Scotland's engagement with Scottish Government throughout pandemic

16. Before and during the pandemic my predecessors had regular contact with Scottish government ministers particularly the Cabinet Secretary for Health and Sport, as well as MSPs from all political parties. I have maintained this regular contact since my appointment as Director, RCN Scotland.

17. At the outset of the pandemic in 2020 the Scottish Government established several committees and groups to assist in 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.

18. RCN Scotland participated with other stakeholders in these groups during the pandemic. Within the groups we lobbied the Scottish Government on behalf our members on the issues nursing faced from the outset. There were a number of groups that included;

- *Workforce Senior Leadership Group* (WSLG) - multiagency group with Scottish Government officials;
- *Clinical Professional Advisory Group (CPAG)* - Care Home specific with range of stakeholders and Scottish Government
- *Louisa Jordan Programme Board* – Multi-agency group, equivalent to the Nightingale Hospitals
- *Pandemic Response in Adult Social Care Group* (PRASCG)
- *National PPE Oversight Group* - supply and products, not guidance
- *HSC Winter Planning and Response Group*
- *Rapid Response/Action Group (care homes)*
- *Infection Prevention and Control Sub-group*
- *Short Life Working Group on Intensive Care Units*
- *Staff Recovery Short Life Working Group*
- *Community Nursing for Adults Group; and*
- *Mobilisation Recovery Group*

19. 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. The various groups provided an opportunity to influence decision making on behalf of service users and our members across sectors and on a multi-agency basis.

20. The frequency and nature of that contact varied with the stages of the pandemic and with the various lockdown rules but once established became regular in nature. This provided an opportunity for the RCN to raise members' concerns directly with Scottish Government officials and Ministers.

21. As the Scottish Government had put in place weekly meeting structures to bring stakeholders together to deal with the pandemic, these became RCN Scotland's primary conduit for engagement with Scottish Government. My colleagues within RCN Scotland, Norman Provan, Associate Director for Employment Relations, and Eileen McKenna, Associate Director for Nursing, Policy and Professional Practice, can provide further detailed evidence to the Inquiry of the detailed work of the various groups.

22. It should be noted that our involvement provided an opportunity to influence decisions, however, the decision-making responsibility remained with the Scottish Government. RCN Scotland had no veto on these decisions. Many of our issues were addressed but there were concerns and RCN recommendations which we believe were in the best interests of our members and patient care that were not addressed.

23. My predecessor, Theresa Fyffe, was, from an early stage, also in regular contact with Scotland's Chief Nursing Officer with a similar frequency to that of her contact with the

Cabinet Secretary. Where necessary she also sent formal written correspondence to follow up on issues or concerns on behalf of members.

24. Through our dialogue with the Scottish Government, we worked to highlight members' concerns on safe staffing, access to PPE and staff wellbeing. In many cases we worked along with other stakeholders, such as the Royal College of General Practitioners, the British Medical Association and Scottish Care to highlight these concerns.

25. Over a sustained period of time prior to the pandemic, RCN Scotland raised a number of issues in relation to the state of the nursing profession in Scotland. This included significant concerns regarding the size of the current and future workforce. The pandemic was not the cause of these issues, but it clearly magnified the issues further, including the continued sustained number of nursing vacancies and an inability to both retain and recruit for nursing posts across health and social care settings.

26. The consequences of not having a sufficient nursing workforce had a considerable impact on those responding to a pandemic, given the considerable restrictions on the availability of resource. This led to many registered nurses having to be redeployed during the pandemic to unfamiliar environments to support direct patient care when they did not necessarily have the skills or experience to work in these clinical areas.

27. Responding to the pandemic had a significant impact on the mental and physical wellbeing of nursing staff. While the Scottish government and employers took steps to provide additional wellbeing support and facilities, in many cases it should not have taken a pandemic for these resources to made be available. The pandemic

exacerbated the issue of excessive demands on a nursing workforce already at risk of stress and burnout. Over 50% of our members who responded to a 2020 survey said they were worried about their mental health, while 58% said they were worried about their physical health[2].

28. My colleagues Norman Provan and Eileen Mckenna will provide further detail in their evidence to the inquiry on the significant impact this had on individuals and the profession.

29. As the country moved to recover and remobilise from the pandemic, we warned the Scottish government of the need to recognise that nursing staff were exhausted and worn down by the challenges of responding to the pandemic. We highlighted that the long-term impact on the wellbeing of the workforce will take some time to establish and this must be taken account of when planning for service recovery.

Impacts on RCN Scotland members by numbered Terms of Reference

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

30. In terms of the planning for a pandemic and the associated planning and resilience exercises, RCN Scotland was not involved which is, in hindsight, an area for review. We hold the view that previous resilience planning, both nationally and locally, has not adequately incorporated the community and care home sectors.

[2] RCN Members Survey, August 2020

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

31. RCN Scotland generally supported the Scottish Government's approaches to lockdown and restrictions. However, these decisions, whilst of to the benefit for the population, had significant impacts on nurses, nursing support workers and student nurses working on the frontline. A real example is where nurses isolated themselves for weeks away from their own support networks of family and friends to ensure they could work. Some actually moved into accommodation that was part of their workplace. Early in the pandemic, in response to members' concerns about access to basic provisions, the RCN wrote to the supermarket CEOs calling for priority access for those working in health and social care.

32. The unintended consequences of the lockdowns on the nursing workforce were considerable on the nursing workforce.

2 (c): the impacts of the delivery of a system of testing, outbreak management and self isolation; and 2(d): the design and delivery of a vaccination strategy

33. RCN Scotland was supportive in general of the Scottish Government engagement in terms of access to testing and vaccination for health and social care staff and guidance for nurses and others during the pandemic. We pushed for the roll out of asymptomatic testing and for equity of access for those working in non-NHS services. We were supportive, in principle, of all health and social care staff being vaccinated against COVID-19 when the vaccine was available, however we were not in support of the

principle of compulsory vaccination. Throughout, we made the case for clear, easy to access guidance for nursing staff as the systems developed and evolved.

34. The pandemic did increase our health and safety concerns and the Health and Safety Executive's role in investigating the impact of Covid-19 on staff and the unsatisfactory approach by some employers to the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR).

35. The fact that the rate of death amongst nursing staff was significantly higher than the general population when compared with those of a similar age group highlighted the need to properly investigate why, and to give nursing staff the protection they needed. All frontline staff deaths related to Covid-19 should have been reported as occupational fatalities as a precaution. Further, there was confusion arising from the infection control guidance at UK level as agreed by the four nations.

36. As a profession, nurses led the way in reducing the transmission of infection by prioritising infection prevention and control measures. These measures are fundamental to nursing, meaning the profession was uniquely able to understand the importance and methods to reduce infection rates.

37. Prior to, and during the Covid-19 pandemic, the RCN was not fully involved in the design of national guidance on PPE and infection control. After considering the impact we believe full and proper engagement with the nursing profession on infection control would help to ensure future national guidance is robust, fully informed and, importantly, evidence based.

38. As the largest part of the health and social care workforce qualified to give vaccinations, nursing staff were critical to the delivery of the programme. This made

them subject to similar risks to their own health as those they had faced in earlier stages of the pandemic. It also placed a further strain on the already stretched workforce.

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

39. During the pandemic a significant impact of the strategic decisions taken in respect of Health and Social Care were those made in relation to Personal Protective Equipment (PPE). Early in the pandemic RCN Scotland argued that more 'heavy duty' PPE was required for health and social care staff, to ensure their protection for the procedures with which they were involved and their extensive exposure to Covid-19. Specifically, this meant the provision of FFP3 masks as a default for staff. It was also related to the RCN's position that Covid-19 is an airborne virus rather than being spread through only by means of droplets, or by way of a limited number of 'aerosol generating procedures.

40. The Scottish Government resisted making FFP3 masks the default for some time, and eventually only conceded the point in part by way of recommending that FFP3 masks were allocated if a member of staff requested, which would involve a risk assessment. The later decision by the World Health Organisation to categorise Covid-19 as an airborne virus had vindicated RCN, but too late for those who caught Covid-19 as a result of inadequate PPE and the impact it had on individuals.

41. It is our view that a lack of clarity on use of the term "PPE", and confusion over the definition and purpose of source control combined with a culture of assumptions that historical influenza guidance was adequate, placed healthcare workers at unacceptable risk in the workplace. Challenges around distribution and the inequality

in supplies/distributions for community services, social care and other non-NHS services were among the main issues in Scotland.

42. Due to those challenges, there were reports from RCN members they had been required to reuse equipment, to use equipment previously marked as out of date, to clean old gowns with alcohol wipes and to use alternative equipment which had been donated and did not provide full protection.

43. RCN Scotland during this time regularly expressed our concerns in the appropriate groups and in correspondence to the First Minister and the Cabinet Secretary for Health and Sport regarding the difficulties members had in accessing adequate supplies of PPE.

44. Care homes were particularly affected by a lack of PPE due to not being able to access their usual suppliers.

45. The one-size-fits-all protective equipment was also a problem for frontline healthcare workers who had to wear this life saving equipment for up to 12 hours at a time. A number of brands were not producing masks to fit smaller faces, with the shape and design of masks causing many female nurses and doctors to fail the fit testing process. There were also concerns expressed by those members who wear headscarves. This also had a psychological impact on members as they did not feel reassured with the process or equipment.

46. Ultimately, RCN Scotland considers that there was a serious lack of engagement by the Scottish government to consider the growing international scientific evidence of airborne transmission of Covid-19 but this was ultimately dismissed in favour of droplet

transmission despite no evidence supporting this and the impact of these decisions require to be critically examined by this Inquiry.

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

47. Our experience was that, in general, support for employees in the NHS was quickly resolved in relation to pay and support arrangements for those who were required to shield. However, the pandemic worsened the financial difficulties experienced by many members working in the independent care sector, many reported concerns surrounding entitlement to sick pay. There were also issues surrounding the level of pay shielding members were entitled to from their employers. In addition, the requirement for many members to shield exposed the already depleted and struggling nursing workforce. RCN members expressed a lack of clarity of the guidance issued by both the Scottish Government and their employers in respect of high-risk individuals and shielding. Many members reported facing a moral dilemma between protecting themselves and not contributing to the difficulties faced by the growing staff shortages. RCN Scotland raised these issues through the Workforce Senior Leadership Group and other channels.

2(g): impacts 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. RCN Scotland was not involved in decisions regarding the transfer of patients to or from care and nursing homes. From March 2020 we repeatedly highlighted that, while a focus on acute hospital capacity was understandable, that community health and

care services, including district nursing and care homes, needed to be supported and to have adequate resources including staffing and access to PPE.

49. The issues in respect of care and nursing homes are interlinked with my previous evidence regarding the staff workforce and provision of PPE, the impact of both shortfalls was greatly felt in the care and nursing homes. During the pandemic RCN members voiced concerns about the arbitrary discharging, or prevention of discharge, from hospital into care homes and particularly for people returning to their own homes. During the initial time of the pandemic the guidance to nursing staff was not always clear. The pandemic has emphasised the need to ensure the community and care home sectors are properly represented in planning to scale up the nursing workforce for future pandemics and ensure a whole system approach.

2(h): the impact of the provision of healthcare services and social care support, including the Management and support of staff and the recognition, involvement, and support of unpaid carers.

50. As I have described, prior to the pandemic there was a significant shortage in the nursing and nursing support worker workforce and the impact of the pandemic only exacerbated the shortages. It led to the need to explore all opportunities to support the workforce this included unprecedented mobilisation of the student workforce and urging retired nurses to return to practice.

2(i) The delivery of end-of life care and the use of DNACPR (do not attempt cardiopulmonary resuscitation decisions)

51. The RCN's position has always been that there must never be blanket use of DNACPRs and that end-of-life care must always be delivered with the utmost compassion and as part of a personalised care plan. We reemphasised this position during the pandemic[3] (press release in late 2020).

2(j): welfare assistance programmes

52. The impact of the strategic decisions taken by the Scottish Government during pandemic on the personal lives of RCN members included an increase in the numbers reporting being worried about their financial circumstances.

53. Financial concerns were particularly acute among younger nursing staff and among staff from black or ethnic minority background as well as those employed on lower pay bands. The possibility of receiving only Statutory Sick Pay for Covid-related absences early in the pandemic clearly contributed to the risk of acute financial distress. Members were also concerned about whether they would be paid when self-isolating with a lot of ambiguity and lack of clarity in the beginning in respect of government guidance particularly for those in social care. Our position was clear that health and care staff should not suffer any financial detriment for being away from work to protect public safety.

54. RCN Scotland continues to support members with the symptoms of Long Covid. The impacts on the nursing profession, both in relation to financial detriment that is being felt by individuals, as well as the impact on workforce numbers, will be felt for some time. We have been active in supporting our members to raise personal injury claims where, for instance, there is a case to be made for negligence in exposing nurses to otherwise avoidable infection. 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(k): the delivery of education and certification

55. As I have described, the impact of the pandemic on student nurses was in large part a consequence of the staff shortages which resulted in the mobilisation of student nurses to the workforce across health and social care. Feedback from within this group highlighted the main concerns during and since the pandemic as being a lack of clarity surrounding academic deadlines, clinical placements and deployment, testing and risk assessments, bursaries, registration, pay and sick pay, PPE and options available to them. Some nursing students in Scotland felt so concerned about the future of their degrees that they wrote and raised these directly with the First Minister. RCN Scotland has continued to engage with Scottish Government to suggest ways in which the student nurses impacted during the pandemic can be supported as they move into their careers, having trained in a time of extreme challenge. This is discussed in more detail by my colleague, Eileen McKenna.

56. RCN Scotland, as with all stakeholders, has a responsibility to ensure anything that went wrong or things that could be improved are reported on and acted upon in the interests of nurses, our wider health care colleagues, and the patients to whom they provide care.

Lessons to be learned

57. RCN Scotland considers that, in order to be properly prepared for a future pandemic, key stakeholders in the provision of health and social care require to be involved in the influence of key decision making and guidance. As mentioned, prior to, and during the

Covid-19 pandemic, RCN Scotland was not fully involved in the design of national guidance on PPE and infection control. After considering the impact we believe full and proper engagement with the nursing profession on infection control would help to ensure future national guidance is robust, fully informed and, importantly, evidence based. More importantly, the government must identify ways to address the staffing and recruitment crisis faced by the health and social care workforce across a number of clinical settings. Without an adequate number of medical, clinical and healthcare workers with the right mixture of skills and who are able to deliver the appropriate standard of patient care to meet the demand of the country at the present time in the ***absence*** of a pandemic, then there is no chance at all that the demand created by any future pandemic will come close to being met.

Statement of truth

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

Name: James Colin Poolman

Job title: Director, RCN Scotland

Signed: **Personal Data**

Date: 4 MARCH 2024