RCN response to the consultation on proposing to introduce regulations that would stop the movement of staff between care settings

The Royal College of Nursing is the largest professional body and trade union for nursing staff in the world. We represent 450,000 members who are registered nurses, midwives, students, and nursing support workers.

Introduction and Summary:

Social care is an incredibly important yet often overlooked pillar of public service. Social care services have experienced years of underfunding, despite increasing demand within the population. This had led to widespread unmet needs, and a high level of complexity of care being handled by services. In his first speech as Prime Minister, Boris Johnson MP committed to fix the crisis in social care, and finding a cross party consensus on reform, and yet urgent action is still needed in a number of areas.

The RCN has significant concerns about the Department's proposals to regulate movement between care settings, as we anticipate the regulations in their current form will have a significant negative impact on social care staff, on staffing levels in social care settings and in other public services, as they are based on out-of-date evidence.

The social care sector is in a workforce crisis. Skills for Care estimate there are 112,000 vacancies in social care settings in England alone, representing a vacancy rate of 7%.[1] Between 2012/13 and 2019/20, Skills for Care estimate that the number of registered nurse jobs in in adult social care has fallen by 30% (accounting for 15,000 nursing jobs).[2] Over 12% of nursing posts were vacant and four in ten nurses were leaving their posts each year.

During the first wave of the pandemic, infection prevention controls were rapidly deployed in all health and care settings to reduce the risk of infection for staff and residents. Following the first wave, there was criticism that the restrictions in care homes were too strong as many families were unable to visit loved ones for several months.

With the rising number of cases currently, the Department of Health and Social Care has put forward proposals to prevent outbreaks in social care settings. One of these proposals would place restrictions on staff members moving between social care settings. The proposals are supported by additional funding to Local Authorities, to support care home provider's infection control measures. However, this has not reduced the impact on staff members, and it is insufficient to meet the costs of robust infection control measures, including ensuring the workforce and residents do not suffer detriment.

RCN Recommendations:

[1] https://www.skillsforcare.org.uk/About/News/News-Archive/Social-care-needs-to-fill-more-than-100000-vacancies.aspx

[2] https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England.aspx

- Decisions regarding the deployment of the nursing and care workforce must be taken on the basis of a professional nursing risk assessment; accounting for the balance of infection control measures with the risks posed by a loss of continuity of care to residents' health, safety and wellbeing.
- There must be absolute assurances, in the form of legislative safeguards, to ensure that no nurse or care worker suffers any detriment to their pay, terms and conditions of employment, or future work arrangements arising from this temporary policy. Any staff who give up other work must be given an assurance that they will be properly compensated and suffer no financial or long-term detriment as a result.
- Short-staffing must be managed in the best interests of preserving continuity of care and safeguarding the health and safety of residents The Government must consult on a fully-funded strategic workforce plan for social care, to ensure the delivery of safe and effective care for all.

The scope of the Department's proposals:

In the current form, the proposals put forward by the Department of Health and Social Care may reduce the movement of staff between sites, however significant changes are required to ensure that these measures do not have a negative impact on staff, the wider nursing and care workforce, and residents' health and safety.

It is noted that these restrictions do not cover all staff working in a care home setting, and it is important that these restrictions should also be imposed on registered managers and on staff who do not have direct care-giving roles.

The Department's proposal is also based on redundant evidence drawn up at a time when there was no comprehensive provision of appropriate PPE, no regular testing programmes in care homes, and poor support and advice over best environmental infection control measures.

In addition, other professionals working across different sites such as CQC inspectors, community nurses or staff who work in the NHS are not proposed to have movement restricted. The proposals do not reflect standard practice across health and care settings. For example, NHS hospital nursing staff are moved across green and red areas on a daily basis to ensure safe staffing levels.

Finally, evidence from Governments across the world has focused on the importance of regular testing, PPE, infection control measures, adequate staffing levels, and isolation and zoning to limit the risk of cross-infection in care homes; rather than limiting essential workers' movement between sites.[3]

Implementing the Department's proposals:

The RCN believes that implementing the Department's proposals is likely to be very difficult for providers.

[3] See Appendix 1 below.

The RCN believes that these proposals conflict with the statutory duty on care providers to provide safe and effective person-centred care.

Employers and our members advise us that as many as 75% of staff in the care workforce have more than one job. Many will have multiple jobs across different sites, different providers, and with the NHS and other employers. Having members of staff that work in other areas is an asset to any care home. They often bring additional clinical skills (particularly if their other post is an acute NHS hospital), there is mutual sharing of best practice, clinical advice and support and their professional networks aid the navigation of health and social care for residents.

Given the low wages in the sector as a whole – with many staff on minimum or low wages – staff often need to work 50-60 hours per week in order to make ends meet.

A number of employers have already advised RCN members that there is no money to compensate them for loss of other work, and our members report understandable fears about losing their contracts and employment rights with other employers as a consequence.

For these proposals to be workable it is essential that there is direct funding to impacted employees and a guarantee of future employment for those who have to temporarily relinquish their posts. Further, some of our members report a breach of their statutory employment rights, with employers asking them to give up statutory annual leave in exchange for working at basic pay rates.

Given the staffing crisis that already exists in social care, the RCN anticipates that care home providers will need to use the exemption to the proposed requirements on a daily basis in order to maintain safe staffing levels.

How Individuals and Businesses are affected:

Due to the make-up of the care workforce, the proposals will likely have a disproportionate impact on BAME groups, women, and older workers; all of whom are overrepresented in the care workforce relative to the general working population.

Furthermore, these proposals would negatively impact upon those in receipt of care services, as the proposals are likely to impair the delivery of safe and effective care by disrupting continuity of care and diminishing the available workforce.

Continuity of care, delivered by people that are familiar to the resident and they are familiar with the resident, the home they live in, its policies and procedures, is central to ensuring good outcomes. A break or replacement of permanent staff with temporary workers can have catastrophic effects on resident's health, wellbeing and premature end of life.

The RCN recommends that Department and employers are better able to mitigate the need to restrict staff movement and these negative impacts by:

- Undertaking professional nursing risk assessments weighing up the risk of cross-infection of their places of employment, their personal risk factors, and other factors such as risks posed by a loss of continuity of care to residents' wellbeing, health, and safety.

- Undertaking regular testing of residents, staff and visitors.
- Ensuring full sick pay for all staff who need to self-isolate due to sickness, symptoms, or test results.
- Ensuring strict, robust and best practice infection control
- Ensuring quarantine for new residents, and zoning in homes to keep strict separation for those with COVID-19 and their care and nursing staff.
- Ensuring full and adequate supplies of Personal Protective Equipment, in line with Government guidance and scientific evidence.
- Provision of adequate staffing levels which includes additional staff to tackle excess hours worked and ensure staff have access to breaks from work.

These proposals will also negatively impact other organisations who employ nursing staff. As previously stated, unions and employers estimate as many as 75% of care home staff have at least one other job.[4] Most of these will be in other care homes, and public services such as in the NHS, in schools or the fire service. The ban on multiple jobs would therefore lead to these organisations also experiencing workforce shortages.

To mitigate these negative impacts, the RCN proposes that nursing staff should not face a blanket ban on having another job. Instead, these decisions should be based on professional nursing risk assessment including NHS sectors. This should take account of mitigations including PPE and testing.

The Department must ensure that staff are fully compensated for loss of income, and that staff do not suffer any detriment as a consequence of giving up other employment.

In some cases, it may be possible for providers to offer their staff additional hours to mitigate the hours lost elsewhere. However, given that many providers are already only able to offer part-time hours to some staff, it is not likely this will be possible in each home. Furthermore, this will be also contingent on the availability and flexibility of staff.

Our members are reporting to us that their employers are advising them that the Infection Control Fund does not provide enough funds to ensure that they can be given full pay for COVID absences or compensated for the loss of other income or contracts.

Ensuring continuity of care:

The RCN has serious concerns about the ability of providers to ensure a safe service given the impact of these proposals. Due to the critical shortages in the social care workforce, it will not be possible to fill all the gaps that this policy would create with temporary staff. The nursing workforce is already under-staffed with 12% of registered nurse posts vacant in care settings. Restricting movement between care setting will only lead to further shortages of staff. The policy as it stands fails to take account of the critical importance of continuity of care to the delivery of safe and effective care.

The proposal to replace lost hours or gaps with contracted agency staff is deeply concerning. Staff who are part of the community and are familiar with the home and its residents are essential to delivering the best outcomes. We are not convinced that the

[4] Information drawn from joint union (RCN, GMB, Unison) membership pay and conditions surveys 2019 and October 2020 of care home members.

perceived benefits in terms of potential reduction of COVID-19 infection outweigh the impact on staff and resident's health and wellbeing.

The majority of residents living in care homes (with nursing) are older people. Up to 80% of residents have some form of cognitive impairment, most commonly dementia. This results in memory loss and difficulties articulating their needs and emotions. It is clinically important that staff caring for them form therapeutic relationships in to order to support their wellbeing and build mutual understanding.

Staff who work regularly in a care home develop a deep understanding of the residents including their preferences and usual abilities. This understanding enables the delivery of person-centred care and affords the timely identification of deteriorating condition allowing nursing staff to intervene to prevent hospital admission. Breaking this bond at time when many residents have restrictions placed on their usual activities and visiting will have significant negative consequences for their wellbeing and the local healthcare economy.

Families are required to place their confidence and trust in care home staff when a person moves into a care home. It is a major life decision that often brings a sense of guilt and fear. If family members feel a person is not likely to receive the care they require because a denudation of staff, they may decide to care the person themselves which can have serious implications in the wellbeing of both parties. We have seen safeguarding issues arising from this.

APPENDIX: Evidence of international strategies for preventing cross-infection in care home settings.

Fisman et al (2020) Risk Factors Associated With Mortality Among Residents With Coronavirus Disease 2019 (COVID-19) in Long-term Care Facilities in Ontario, Canada. *JAMA Netw Open.* 2020;3(7):e2015957. doi:10.1001/jamanetworkopen.2020.15957	Canada	Testing Provision of PPE Restructuring the health care workforce to prevent the movement of Covid-10 infection between long term care facilities
Tenet et al (2020) Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington. N Engl J Med; Med 2020; 382:2005-2011	USA	Testing Monitoring Infection control
Hsu A.T. and Lane N. (2020) Impact of COVID-19 on residents of Canada's long-term care homes – ongoing challenges and policy response. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 23 April 2020.	Canada	Infection control Adequate staffing levels Limiting the movement of healthcare workers between multiple sites
Pierce M, Keogh F and O'Shea E (2020) The impact of COVID-19 on people who use and provide long-term care in Ireland and mitigating measures. Country report available at LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 13 May 2020.	Republic of Ireland	Additional support to maintain staff availability and wellbeing

Bigelow et al (2020) Outcomes of universal Covid-19 testing following detection of incident cases in 11 long term care facilities. *JAMA Intern Med.* Published online July 14, 2020. doi:10.1001/jamainternmed.2020.3738	USA	Universal testing – not based on symptoms
Rolland et al (2020) Prevention of the COVID-19 Epidemic in Long-Term Care Facilities: A Short-Term Prospective Study. *J Nutr Health Aging* 24, 812–816 (2020). https://doi.org/10.1007/s12603-020-1440-2	USA	Physician support PPE Training on hygiene Containment in resident's rooms Use of temporary workers Compartmentalisation within zones for both residents and staff
Dutey-Magni et al (2020) Covid=10 infection and attributable morality in UK Long Term Care Facilities: Cohort study using active surveillance and electronic records (March – June 2020). https://doi.org/10.1101/2020.07.14.20152629; this version posted July 15, 2030	UK	Active surveillance Testing Changes in staffing Changes in occupancy
Escobar et al (2020) Mitigation of a Coronavirus Disease 2019 Outbreak in a Nursing Home Through Serial Testing of Residents and Staff. Clinical Infectious Diseases ciaa1021, https://doi.org/10,1093/cid/ciaa10212	Unknown	Universal testing
Frazer el al (2020) A rapid systematic review of measures to protect older people in long term care facilities from COVID-19. doi: https://doi.org/10.1101/2020.10.29.20222182	UK	Mass testing (regardless of symptomology) Use of PPE Isolating residents Re-designation of specific staff to care for isolates residents (compartmentalisation) Symptom screening Visitor restrictions Hand hygiene Resident cohorting
Tan & Chua (2020) Strategies to stop and prevent COVID-19 transmission in long-term care facilities (LTCFs). QJM: An International Journal of Medicine, 2020, 1–2 doi: 10.1093/qjmed/hcaa265	Singapore	Mass screening of all staff and residents Pooled screening (defined as mixing several samples together in a "batch" or pooled sample, then testing the pooled sample with a diagnostic test. This approach increases the number of individuals that can be tested using the same amount of resources). Training in donning of PPE

		Conducting swab tests Thorough review of infection control measurses Segregation of staff and residents – sometimes referred to as compartmentalisation
Kim, H (2020) The impact of COVID-19 on long-term care in South Korea and measures to address it. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 7 May 2020.	South Korea	Extensive testing and tracing Nationwide monitoring Cohort quarantines in selected facilities Temporary reimbursement packages Low cast masks Provision of guidelines
Tsoungui et al (2020) Preventing COVID-19 spread in closed facilities by regular testing of employees – an efficient intervention in long-term care facilities and prisons. https://www.medrxiv.org/content/10.1101/2020.10.12.20211573v1	USA	Comprehensive testing