Written evidence submitted by Unite the Union, Royal College of Nursing and Mental Health Nurse Academics (DEL0036)

Joint submission

This is a joint submission to the House of Commons Health and Care Committee from three organisations: Unite the Union, the Royal College of Nursing and Mental Health Nurse Academics UK.

Summary

The pandemic is increasing population distress, including amongst people working in health and social care: many of whom have serious anxieties over their own and their families' safety. Responses should include a range of universal and more targeted social, public health, psychological and workplace approaches. During the immediate crisis this should include the provision of adequate PPE for staff and for people using services.

People with severe mental illnesses are at elevated risk during the COVID-19 crisis, and the principle of parity of esteem means core services for this group should be protected. People with dementia and their families are at risk of poor and insensitive communication, poorly informed decision-making and insufficient support in the community.

This pandemic has happened during a global and national nursing workforce crisis. Mental health nursing numbers are perilously low, and effective action needs to be taken urgently to improve recruitment and retention and to increase the supply of both students and their educators working in universities.

Health and social care during, and after, the pandemic

We share the Health and Social Care Committee's concern at the impact of the pandemic on population and individual-level wellbeing, and also with the pandemic's impact on the provision of core health and social care services.

We welcome the Committee's specific interest in better understanding how mental health services, including services for people living with dementia, are being affected during the current crisis. We also welcome the Committee's concern to understand the likely effects of the pandemic on the provision of core services in the future.

Our combined evidence is as follows:

Recognising and responding to psychosocial distress

1. We recognise that the pandemic is increasing psychosocial distress, and that many people will be fearful and anxious. Many people's anxieties will relate not only to the fear of the coronavirus itself (and, for some, to the experiences of having had invasive treatment in the case of severe infection), but also to fears over the loss of employment, reduced finances and to uncertainties over the future. Many people will be traumatised and bereaved, and concerns have been expressed that the pandemic

will increase rates of suicide. Not all sections of the community will be affected equally, and psychosocial distress is likely to be stratified reflecting social inequalities.

2. People working in health and social care are particularly vulnerable to distress. This group includes the large numbers of nursing, midwifery and allied health professional students who have chosen to 'opt in' to the NHS in response to the call for their assistance. Initial results from a recent survey of 2,600 nurses and midwives in the UK, published on April 21st 2020, show that during the coronavirus crisis 74% feel their personal health is at risk and 92% are worried about risks to family members due to their clinical role. Up to 33% report severe or extremely severe depression, anxiety or stress.
3. Responses to this distress should include a range of universal and more targeted approaches, and acknowledge that social protections (for example: income and housing security, meaningful work and community inclusion) are critically important. Responses should span social, public health, psychological and workplace approaches, and reflect the evidence base where this exists. Responses should not be limited to medical interventions. Support for people who are traumatised (including health and social care staff) through the COVID-19 crisis should expect to receive skilled help and support far into the future, in recognition that distress may not manifest until many months after the crisis has abated.
4. We are very concerned that mental health services, including psychological interventions for people with common mental health difficulties and psychosocial support for people with severe mental illnesses, may be vulnerable in the long run if cuts are made to public services during a post-COVID economic downturn. We strongly urge that mental health services be not only protected but also expanded in recognition of elevated levels of demand.
5. We are collectively concerned at the elevation of the risk of suicide amongst nurses and other health and social care workers during, and following, the pandemic. We ask the Committee to recommend that accurate records be kept of the ethnicity of all people who take their own lives, as a matter of urgency, in addition to the demographic information already collected. This is particularly relevant to mental health nursing, which is a diverse workforce with a large proportion of practitioners from BAME communities.

Supporting health and social care staff

6. In the case of health and social care staff, the survey findings noted in (2) above suggest that many of the anxieties currently felt by staff are linked to the risks associated with working in clinical roles. Staff need to be (and to feel) safe, which in the pandemic means having access to adequate supplies of personal protective equipment (PPE) reflecting WHO guidance.
7. We do not know what effect this pandemic will have on future recruitment and retention of health and social care staff, but we recognise that staff who are inadequately protected, or who have difficulties in accessing coronavirus tests, may feel failed by their employers and be less likely to remain in the workforce in longer term.

Supporting people with severe mental illnesses

8. People with pre-existing mental health difficulties, particularly people with severe mental illnesses such as schizophrenia and bipolar disorder, are a particularly vulnerable group. People with severe mental illnesses often experience significant co-morbidities, and have been described as being at elevated risk during the COVID-19 crisis.
9. Linked to (7) above, the principle of parity of esteem remains as important as ever during the pandemic. People with ongoing mental health difficulties need and deserve access to high-quality care, the provision of which (in both the community and in hospitals) should be protected by essential staff remaining in their usual workplaces and not being redeployed.
10. We recommend that Public Health England and equivalent bodies across the devolved nations are supported to expand the scope of their PPE (and related) guidance to meet the needs of people with severe mental illness, and the staff who care for them. This is in recognition of the fact that in mental health settings many people in receipt of care are ambulant, exhibit challenging behaviour and may be subject to restrictive physical interventions.
11. We recommend that the guidance on the use of PPE, and (critically) access to adequate supplies, is extended beyond the NHS to include social care and the private sector.
12. There is a role for researchers in revealing the true impact of the pandemic on the provision of core services and on how people using these are being affected. We alert the Committee to the Policy Research Unit for Mental Health's ongoing programme of COVID-19 related work. The Policy Unit is led by a team based at University College London and King's College London, and includes members with lived experience of mental health issues. The Unit's current work includes a survey into the impact of COVID-19 on services and on people's experiences, the findings from which will be particular interest to the Committee.
13. This pandemic has shown the interconnections between the health and social care systems, and we urge the Committee to explore how integrated working might be better promoted for the future. Proper planning and coordinated action have been shown to be vitally important.

Supporting people with dementia

14. In the case of people living with dementia and people living with other, less-recognised, neurodegenerative conditions we alert the Committee to recent guidance surrounding people with dementia and their carers in relation to COVID-19.
15. We are concerned at the use of selective treatment options in cases of COVID-19 amounting to palliative care (as opposed to active treatment, for example in ICU) irrespective of need. This raises the need for a wider emphasis on education in the area of care for people with dementia, and questions the use of dementia diagnoses as an overarching influencing factor for decisions through use of the Clinical Frailty Score.
16. We are concerned at reports of poor and insensitive communication about the use of advance care plans in decision-making about treatment. We are also concerned at

the risks of inappropriate treatment due to the isolation of people without capacity from people who know them well contributing to a lack of best interest decisions.

17. We have heard reports of staff caring for people in hospital, care home and domiciliary settings lacking access to PPE and reiterate that this needs urgently to be addressed.
18. Respondents to this consultation in our respective organisations report increases in the incidence of delirium (which is an increased risk for people with dementia) both as a result of COVID-19 but also due to undetected causes arising from reduced monitoring and support in the community.
19. Colleagues involved in the direct provision of expert helpline advice report family carers being unsupported and increasingly struggling with care. Carers and people with dementia will not always be computer literature, and will be struggling to access and make sense of public health advice and information. We recognise the potential of people being unsupported leading to increased risks of anxiety and depression, along with abuse, suicide and homicide. As we state in the context of core services to people with severe mental illnesses, the principle of parity of esteem means that services for people with dementia and other neurodegenerative conditions must be protected.
20. More generally, the pandemic has revealed that many of the nation's most important keyworkers are underpaid, undervalued and poorly rewarded. An example is staff without professional registrations providing residential and domiciliary care to vulnerable individuals including those living with dementia. Many in this group are employed on short appointments, are not paid for travel time and have limited access to education and training. The coronavirus crisis has shown how social care needs root and branch reform, with better pay and better support for staff and new models of provision.
21. We reiterate point (13) above, on the need for better health and social care integration, which applies particularly in the case of support for people with dementia and their carers.

Mental health nursing

22. This pandemic has happened during a global nursing workforce crisis. A report from the Royal College of Nursing in 2019 found evidence of 43,000 nursing vacancies in NHS England, with The Health Foundation, The King's Fund and the Nuffield Trust projecting a shortage of over 100,000 nurses by 2029 on current trends.
23. Mental health nurses are the most numerous of the professional groups working in specialist mental health services, but their numbers have depleted since 2010 to the extent that, prior to the pandemic, they were perilously low.
24. In NHS England's *Interim People Plan*, mental health nursing was singled out as a priority group for action to boost recruitment and retention. However, the most up-to-date data from NHS Digital shows the number of mental health nurses in the NHS England workforce was 37,477 in January 2020, a figure over 3,000 fewer than at the same period exactly ten years previously (40,719, in January 2010).
25. Faced with the uncertainty of the long-term impact of the coronavirus crisis on recruitment and retention, coupled with continued uncertainty over the UK's relationship with the EU post-Brexit, concerted action is needed to prevent a

deepening of the mental health nursing workforce crisis. In addition to publicity campaigns, practical action could include:

a. the removal of undergraduate degree fee payment for students of nursing in England and the reinstatement of bursaries; these initiatives are particularly important to encourage new applications from the mature and non-traditional groups which mental health nursing has previously attracted;
b. the removal of migrant health charges for staff working in mental health (and other health and social care) settings, the application of which contribute to a hostile environment; their continued use also jars with the observation that many on the coronavirus frontline are migrants or of migrant heritage;
c. improved pay and conditions, including better employment practices, to encourage nurses to remain the NHS beyond the immediate pandemic;
d. the use of incentives to encourage EU health staff to return to the UK.

26. As the Council of Deans of Health has shown in its recent academic workforce in health faculties report, amongst mental health nursing academics the single largest number are aged between 51-60. Excessive workloads, erosions in pay and worsening pension provision are making careers in universities less attractive for people who already have established careers in the NHS. Without university teachers there can be no students, and without university researchers there can be no new knowledge to underpin improvements in care, treatment and services.

We thank the Health and Social Care Committee for their consideration of this submission to its call for evidence.

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