

OPUS2

Scottish Covid-19 Inquiry

Day 27

March 20, 2024

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1 Wednesday, 20 March 2024
2 (9.44 am)
3 THE CHAIR: Good morning, Mr Poolman. Good morning,
4 Mr Gale.
5 MR GALE: Good morning, my Lord.
6 THE CHAIR: One minute, please, I haven't been provided with
7 my notebook. (Pause)
8 That's a most unusual mistake, I'm sorry.
9 (Pause)
10 Thank you very much indeed. My apologies to you
11 both.
12 MR GALE: My Lord, we have three witnesses today. They are
13 all office-holders of the Royal College of Nursing. The
14 first of the witnesses is James Colin Poolman, whose
15 witness statement is SCI-WT0497-000001.
16 MR JAMES COLIN POOLMAN (called)
17 Questions by MR GALE
18 MR GALE: Mr Poolman, your full name is James Colin Poolman,
19 I think.
20 A. That's correct.
21 Q. And your details are known to the Inquiry. You provided
22 a statement with the reference I've just given and you
23 are content that that statement, as amplified by the
24 evidence you're about to give today, will constitute the
25 material you wish to place before the Inquiry?

1

1 A. I am.
2 Q. You provide this evidence as the director of the
3 RCN Scotland?
4 A. I do.
5 Q. I'll use the abbreviation "RCN". I think we all use it.
6 I'm sure you do.
7 A. Yes.
8 Q. Before we go into any detail, there's something that you
9 have provided me with prior notice of. I think there is
10 something you would like to publicly say before you give
11 your evidence to the Inquiry.
12 A. I would and I thank you for the opportunity in doing so.
13 I think it's important for myself personally and on
14 behalf of the Royal College of Nursing Scotland to offer
15 our condolences and our heartfelt thoughts to everyone
16 who has lost loved ones during the pandemic. Of course
17 we will never forget the sacrifice of front-line
18 workers, including those in nursing, across health and
19 social care who passed away as a result of the pandemic,
20 selfless individuals who, in our view, were just trying
21 to do their best for their patients and paid the
22 ultimate sacrifice. We also have many others who
23 contracted COVID in their workplaces who have gone on to
24 suffer long COVID and continue to experience
25 debilitating effects of illness, and we must ensure we

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1 support them as we go forward.
2 Of course the Inquiry will do its job and you'll
3 learn from the pandemic, but we all in society owe
4 a debt of gratitude and must never forget the dedication
5 shown by thousands of health and social care workers to
6 their patients and their professions and the impact that
7 the experience has had on them.
8 Thank you for giving me that opportunity.
9 Q. Thank you. Now, just a few preliminaries, Mr Poolman.
10 Firstly, your statement is relatively brief, but within
11 it it's quite detailed, and I do want to make the point
12 that, if there are parts of your statement that we don't
13 touch on in the course of your oral evidence today, that
14 does not mean that those parts of the statement are
15 ignored. The whole of your statement will be considered
16 and taken account of by the Inquiry team, analysed and
17 utilised, so please be assured of that.
18 Secondly, we do have a general restriction order in
19 place which prevents the naming of other people. So
20 I don't think there's a great deal of difficulty, having
21 looked at your statement, because the only other people
22 you name are in fact the two other witnesses who will be
23 giving evidence today, and that's fine. You can name
24 them. I think also you may have named some politicians.
25 So, beyond that, please don't name other people you may

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1 have had conversations with or something like that. If
2 you do, it doesn't make a great deal of difference.
3 We'll just have to stop proceedings. But if you can
4 just be mindful of that.
5 Now, you're authorised, I understand, to give this
6 evidence about the RCN's views on the impacts of the
7 strategic decisions made by Scottish Government in
8 respect of health and social care; is that right?
9 A. That's correct.
10 Q. And your colleagues, Norman Provan and Eileen McKenna,
11 will expand on certain areas. We will hear from them
12 later today. But there will inevitably be certain
13 overlap between some of the things that you'll be
14 talking about and things that they may be talking about
15 but in greater detail.
16 A. Indeed.
17 Q. Some personal information first of all if, we may. You
18 provide your career history in paragraphs 4 and 5, from
19 which we can see that you took up the post of director
20 of the RCN in Scotland in September 2021. You took it
21 up initially on an interim basis?
22 A. That's correct.
23 Q. And your appointment was made permanent
24 in September 2022?
25 A. That's correct.

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1 Q. So during that period, it obviously coincides with some
2 considerable period of the pandemic. Can you tell us
3 a little about what the post of director involves?
4 A. The post of director for the Royal College of Nursing
5 Scotland, first of all, I'm responsible for leading the
6 organisation in Scotland in all aspects of our work in
7 relation to both the representation of our members,
8 whether that be in workplaces or indeed working with
9 other stakeholders such as Scottish Government, and
10 working with fellow trade unions and professional
11 organisations. I'm responsible for co-ordinating that
12 work in Scotland. But also, as the director of the
13 RCN Scotland, I am a member of the RCN executive team
14 and I'm involved in the UK workings of the College in
15 relation to my executive responsibilities.
16 Q. You also do tell us a little about the RCN Scotland and
17 we can see that it is both a Royal College, having been
18 granted its Royal Charter in 1929, and it's also
19 a special registered trade union.
20 A. That's correct.
21 Q. Your colleagues also give this background and, just for
22 the avoidance of repetition, I'll just take this
23 information from you rather than going through it with
24 other witnesses. Can you tell us a little bit about the
25 membership of your organisation?

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1 A. Well, the membership is made up -- at the time of the
2 pandemic, we were over 40,000 members. It's increased
3 since then. Our members are drawn from the nursing
4 profession. We have three categories of membership in
5 Scotland, and that is we have the category of full
6 members, which are registered nurses, who are on the
7 Nursing and Midwifery Council register; we also have
8 those who are nursing support workers or other terms
9 that are used in relation to that. There are multiple;
10 and we also represent student nurses, who are at the
11 start of their careers and going through their
12 education.
13 Q. And I think, just for the avoidance of any doubt,
14 a nursing support worker is defined by you in the
15 footnote at the bottom of page 3 of your statement.
16 A. That's correct.
17 Q. In paragraph 3 and also paragraph 11 you provide us with
18 a general overview of the burden that your members
19 carried during the pandemic and the impacts that it has
20 had on them and, perhaps reflecting some of the points
21 you made in your initial statement, you say in
22 paragraph 3 that members reacted in extraordinary ways,
23 like coming out of retirement, putting aside their
24 studies and being redeployed to specialised clinical
25 areas.

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1 A. That's correct. Our members work in all parts of the
2 health and social care system, so that's from hospitals,
3 care homes, general practice in the community and
4 beyond, and they -- the nursing community responded just
5 as nurses expect to respond to whatever is thrown at
6 them, but they were extraordinary in the ways that they
7 did that and there was much asked of them and they stood
8 up to what was asked at the time.
9 Q. You make the point that "we" -- and I think you probably
10 mean by that the general public -- should not forget the
11 dedication of health and social care workers and
12 remember that many passed away, that many continue to be
13 affected physically and mentally by the experience of
14 working through the pandemic, and I think that's
15 reflected in what you said initially.
16 A. Yeah, I think it's really important for us never to
17 forget what people gave individually and collectively in
18 their experience and I think the other important point
19 to just recognise is many of our profession, both
20 individual and collectively, have not had the time to
21 really reflect about the impact on themselves of the
22 pandemic because they very quickly moved into recovery,
23 and I think it's aspects like this Inquiry and other
24 things that have been in the media recently that are
25 actually making people look back to what they

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1 experienced and the considerable impact it had on them
2 and their colleagues and their families.
3 Q. Can I just ask you one point? I think we can probably
4 all remember standing on our doorsteps and clapping for
5 you and your fellow workers. How did you feel about
6 that?
7 A. I think at the time people were obviously -- it was the
8 recognition and the recognition from the public about
9 what our colleagues were doing to basically fight
10 against this horrendous virus and pandemic that we had,
11 and over the period of time it was truly, you know,
12 acknowledged and colleagues felt recognised, but -- and
13 during that time it went on -- it went on for some time,
14 if you remember.
15 Q. Yes, it did.
16 A. Every week it went on and people were thankful for the
17 appreciation, but ultimately that moved on very quickly,
18 I have to say, once the pandemic was over.
19 Q. When you say it "moved on very quickly ... once the
20 pandemic was over", is there an inference in what you
21 say that perhaps it might have been forgotten about?
22 A. Well, I think society has moved on and, as I say, we've
23 moved on in relation to -- I think, I talk about health
24 and social care, to deal with the pressures that are
25 within there at the moment. I think we have forgotten

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1 about the impact on, as I say, not only society but the
 2 impact on our profession and health and social care
 3 itself of the pandemic because it's been considerable.
 4 Q. Yes. Can I move on to ask you about RCN Direct that you
 5 refer to in paragraph 12 and then give some further
 6 details in paragraph 13 of your statement. Can you just
 7 explain what RCN Direct was and why it was established,
 8 if it was established specifically during the pandemic?
 9 A. It wasn't established because of the pandemic. It
 10 was — RCN Direct is a contact centre that we have set
 11 up for our members to contact us initially on any
 12 concerns or any issues that they're seeking advice and
 13 guidance on and it's manned on a daily basis, and our
 14 members can contact, as I say, directly — not only
 15 through a telephone line but they can also contact us
 16 through email in relation to any queries or questions or
 17 looking for guidance that they may have in relation to
 18 individual or collective questions that they may have
 19 through the experiences they're having within their
 20 workplace at that time.
 21 Q. What you set out at paragraph 13 of your statement is
 22 a series of — well, various issues that were raised by
 23 your membership during the pandemic through contacting
 24 RCN Direct. I wonder if I can just focus on a few of
 25 these, please. Firstly, could I refer to what you say

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1 about — well, you mention issues in relation to mental
 2 health. You say:
 3 "... feeling depressed, anxious and stressed; and
 4 reporting experiences indicative of a probable
 5 post-traumatic stress disorder."
 6 Can you give us a little bit more detail about that
 7 from your knowledge, if you have it?
 8 A. Yeah, many of our members would phone to talk through
 9 their own personal feelings and experiences of work and
 10 the pressures that the pandemic was putting on them in
 11 their own mental well-being and their mental health, and
 12 talking around about, you know, the symptoms that we
 13 would describe of anxiety — you know, many things they
 14 experienced. For example, in the first time in their
 15 careers, having to work 12-hour shifts with full PPE,
 16 that had an impact on them. Experiencing, I have to
 17 say, levels of dealing with death that many colleagues
 18 had not experienced had a significant impact on many.
 19 And these — and colleagues would phone for advice and
 20 support and we would try to provide as much as we
 21 possibly could in relation to that, as well as the
 22 advice and support that we offer, whether it's from our
 23 own organisation but also signpost to other support that
 24 was available.
 25 Q. Yes, that was actually going to be my next question.

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1 What support do you offer or did you — do you offer
 2 still I presume?
 3 A. We continue to offer support to our members for all
 4 aspects of their work life and personal life, in fact,
 5 when they're experiencing difficulties with either
 6 physical or mental health. We provide support within
 7 the workplace as well as we provide, for example,
 8 a counselling line that our members can approach for
 9 their psychological support, if required.
 10 Q. During the pandemic, did you see an increase in the
 11 number of your members who were contacting RCN Direct in
 12 relation to mental health issues?
 13 A. Yes, absolutely.
 14 Q. Has that decreased with the cessation of the pandemic?
 15 A. I think the levels are — because other things are
 16 impacting people so it's difficult to say from the type
 17 of issues that come through because it's not always
 18 apparent that somebody is coming through with ultimately
 19 actually it's their mental health. They come with
 20 a situation and, as you talk through with the member,
 21 you find out the impact it's had on them. But, yeah,
 22 these issues are unfortunately coming through on a much
 23 too regular basis with the pressures that they're under
 24 within their workplace and their own lives, of course.
 25 Q. I think you give a little bit more information about

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1 this at paragraph 27 of your statement. I think we can
 2 say there that you say:
 3 "Over 50% of your members responded to a 2020 survey
 4 said they were worried about their mental health ..."
 5 A. We routinely survey our membership on many things, but
 6 in 2020 that was one of the things that we surveyed our
 7 members on in relation to their own mental health and,
 8 as you say, 58% of that survey in 2020 said that they
 9 were worried about their physical and mental health.
 10 Q. I can perhaps just inform you, Mr Poolman, that the
 11 Inquiry is aware of research that has been done in
 12 relation to the impact on the mental health of the
 13 nursing and care profession and we are aware of various
 14 research projects, including some collaborative research
 15 carried out by the Universities of Dundee and Edinburgh
 16 in relation particularly to the incident of PTSD,
 17 I think, affecting nursing in intensive care units. So
 18 we are aware of this and we will be looking at that in
 19 the context of impact.
 20 Two other matters that you refer to. I'm quite
 21 interested in the redeployment of nurses to areas that
 22 were beyond their usual areas of expertise. Now, that
 23 is something that you raise and indeed your colleague
 24 Mrs McKenna raises in her evidence. Just from your
 25 perspective, what was the RCN's view on nursing staff

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1 being redeployed, presumably at short notice, to
 2 situations that were not within their usual area of
 3 expertise or comfort?
 4 A. To set into context, prior to the pandemic there was
 5 significant issues with the nursing workforce — across
 6 health and social care, there was significant vacancies.
 7 That in itself contributed to the requirement, as the
 8 pandemic developed — the requirement for staff to work
 9 in specific areas, for example, ICU, and that required
 10 many staff to be redeployed because of the need, because
 11 of how things were developing, but of course they
 12 required a period of time of adjustment because not all
 13 individuals that were moved obviously had the recent
 14 experience of working in these areas, and that in itself
 15 was difficult for the staff. Although they were given
 16 support and education to allow them to go into these
 17 areas, it was extremely difficult because they were
 18 being asked to move in areas that, to be quite frankly,
 19 wouldn't have been their area of choice to work in, but
 20 they were moved from all types of areas. Part of that
 21 was because we didn't have a sufficient workforce.
 22 Q. That's something that your colleague Mrs McKenna will
 23 deal with in a little bit more detail —
 24 A. She will.
 25 Q. — about the deficiencies in the numbers of the nursing

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1 workforce which was pre-existing the pandemic.
 2 Could I just take you a little further on that, if
 3 I may. The idea of a nurse with a specialised training
 4 being — or possibly not having a specialised training,
 5 and being deployed into an area which one would normally
 6 expect there to be specialised training, does the RCN —
 7 I suppose put it this way — accept that as a necessity
 8 or do you disapprove of it?
 9 A. Well, I think the issue is that people shouldn't be put
 10 in places they don't have the competence to work in, and
 11 of course nurses have a general level of education for
 12 qualifying and then their experience is built on that,
 13 but, as you move in to areas, there is additional
 14 training that requires to be given and people need time
 15 to acclimatise and get used to working in these areas
 16 and to build up the knowledge and expertise to be
 17 proficient, and of course we would always suggest that
 18 people should be given the time and induction and the
 19 support to do that when they move to a new area. But
 20 because of the necessity, as you say, of the pandemic,
 21 that had to happen really quickly and many staff were
 22 not — there wasn't a lot of choice. The issue was they
 23 were — well, they were asked to be moved in the most
 24 positive way, but then they were moved to areas they
 25 weren't used to working in.

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1 Q. I'm not going to ask you what effect that might have had
 2 on patient safety but I am going to ask you what view
 3 your members took as to whether they felt fully equipped
 4 to deal with patient safety in those situations.
 5 A. I think many members have expressed that they didn't
 6 feel that they had adequate time or they did get support
 7 but wasn't it adequate enough because it was done at
 8 such rapid pace and that had a significant impact on
 9 individuals when they would have been asked to be moved.
 10 And, as I say, they were asked to move, but to all
 11 intents and purposes people were redeployed because that
 12 was what the system needed at the time.
 13 Q. They were told to move?
 14 A. Basically.
 15 Q. You also mention professional dilemmas and you give the
 16 example of whether or not to treat patients without
 17 wearing PPE. Can you just expand on that a little?
 18 A. I think, as you'll definitely hear from my colleague in
 19 relation to PPE and infection control guidance, the
 20 guidance changed on a repeated basis throughout the
 21 pandemic and that led people to not — you know, to have
 22 some concerns around about, you know, what PPE they
 23 should use. That didn't — let's not go into the issue
 24 about the availability of it, but that dilemma about
 25 what PPE should be used, how you should care for

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1 somebody, of course that brought dilemmas in relation to
 2 it.
 3 It also brought dilemma in relation to individuals
 4 in relation to their attendance at work; for example, if
 5 they were experiencing symptoms themselves. And
 6 especially in the very early stages of the pandemic when
 7 there wasn't testing, that of course led people to the
 8 professional dilemma about being at work if they
 9 suspected they had one symptom, if you like, of the
 10 virus itself. So that did leave people with dilemmas
 11 around about attending work, how they conducted
 12 themselves at work, because there was a crisis building
 13 and of course there was a lack of workforce.
 14 Q. Yes. I think one of the issues that your colleague,
 15 Mrs McKenna, touches upon is — and quotes from some of
 16 your members, making the point that they felt that they
 17 were unable to give of their best in certain situations.
 18 Was that something that was a repeated concern for your
 19 membership?
 20 A. Yeah, that definitely came through in one-to-one contact
 21 but also in our surveys in relation to members, one,
 22 didn't feel prepared but they also didn't feel that they
 23 had, for example, the right guidance. And PPE was
 24 a significant issue because there wasn't the provision
 25 that we believe there should have been.

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1 Q. Your colleagues will deal with that ---
 2 A. They will.
 3 Q. --- in more detail.
 4 The other point I'd like to ask you about in this
 5 list at paragraph 13 is the comment you make in relation
 6 to nursing staff from ethnic minorities. You say that
 7 such staff:
 8 "... sought specific support as in the general
 9 population they suffered poorer outcomes of Covid-19
 10 infection, [and this was] exacerbated by existing
 11 structural inequalities and institutional bias within
 12 the healthcare system."
 13 Now, you've got a perception, obviously, of what
 14 structural inequalities and institutional bias within
 15 the healthcare system amounts to. Can you tell us what
 16 it is?
 17 A. Well, in relation to our colleagues, they experienced
 18 different things. So, for example, if you look at the
 19 evidence in relation to pay, they're usually employed in
 20 the lower grades; they usually find it more difficult to
 21 get promoted, for example. So they don't, I would
 22 suggest, feel they get as equal opportunity as other
 23 colleagues in relation to healthcare.
 24 Q. And what's the root cause of that?
 25 A. I think some of them it's societal in relation to that

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1 and I think we, as an organisation --- diversity and
 2 inclusion is a huge issue to us, in relation to make
 3 sure everybody is recognised equally, but evidence would
 4 show that that doesn't happen and at times there is ---
 5 whether it's known or unknown bias, bias is shown
 6 towards individuals who are not from ethnic minorities
 7 and, I think, as I say, that is shown through if we look
 8 at individuals who are in senior positions, for example.
 9 Q. You also --- sorry, having said that was the last point
 10 from paragraph 13, there's another one, and that's
 11 long COVID. You mention it and it's something that your
 12 colleagues deal with in more detail, but from your
 13 strategic viewpoint and as we're progressing on, what
 14 concerns do you have of the impact that long COVID is
 15 having on the workforce?
 16 A. I think there's a number of concerns. One is the true
 17 recognition that long COVID exists within the workforce
 18 and people are --- because people are presenting with all
 19 different types of symptoms. I think that's one
 20 significant concern. I think it's also the concern
 21 around about how we support individuals who are
 22 experiencing across health and social care the symptoms
 23 of long COVID to, one, support them and hopefully to
 24 keep them within employment. I think that's something
 25 that's hugely important. I do think also it's about the

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1 recognition in law and it being recognised as an
 2 industrial illness and also how people are --- if they do
 3 have to leave their employment, are compensated for
 4 what, in essence, for many was an illness that they
 5 contracted at work.
 6 Q. Is that something about which your college is
 7 campaigning?
 8 A. Indeed it is.
 9 Q. Can I ask you, is it something that you're campaigning
 10 successfully about?
 11 A. I don't think we've been successful enough up to this
 12 point. There's much the governments can do and we'll
 13 continue to do that both in Scotland and across the UK.
 14 Q. Can I move on to talk about your engagement with the
 15 Scottish Government? Obviously you had a pre-existing
 16 engagement with the Scottish Government and, from what
 17 I read from your statement, that was a fairly ---
 18 bluntly --- fairly good engagement; would I be correct in
 19 that?
 20 A. Yes, I think we're fortunate in Scotland in that we do
 21 have quite proactive conversations with both Government
 22 at ministerial level but also at department level. So,
 23 for example, the Chief Nursing Officer's department, we
 24 have regular engagement and have done over a number of
 25 years, which is generally a positive way to communicate

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1 and do business.
 2 Q. You provide us with a list --- quite an extensive list of
 3 various groups that the RCN was involved in. Can I just
 4 ask you about one, please, and that's CPAG? That's how
 5 I've heard it referred to. I don't know whether it's
 6 divided out. "C-P-A-G" is the second that's referred
 7 to. It's the Clinical Professional Advisory Group and
 8 it's said to be care home specific with a range of
 9 stakeholders and Scottish Government.
 10 Can you tell me --- I know your colleague Mrs McKenna
 11 was on that group, was your representative on that
 12 group ---
 13 A. She was.
 14 Q. --- can you tell us a little bit about it from your
 15 strategic perspective?
 16 A. Well, it was an opportunity for us to raise specific
 17 issues within that care --- for that care environment,
 18 and Mrs McKenna obviously raised a number of concerns
 19 that we had, for example, the provision of PPE within
 20 the care home sector. That was one of the significant
 21 issues very early on that was raised and many other
 22 issues that developed within that specific area of care.
 23 Q. Yes. Obviously these groups were established to address
 24 various issues within the pandemic and, clearly, your
 25 organisation --- the membership stretches across both the

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1 NHS, into the care sector, both care homes and care in
 2 the community sector. So far as you are concerned and,
 3 again, from your strategic perspective, do you feel that
 4 sufficient information was obtained and taken on board
 5 for the care sector at the outset of the pandemic?
 6 A. No, I think on reflection that's certainly not been the
 7 case for a number of issues. If I take two issues in
 8 specific that might be worthy of note to give example.
 9 Q. Yes, please.
 10 A. PPE provision, for example, huge difficulty in both
 11 procurement and availability of PPE within the care home
 12 sector. I mean, it was an issue within the NHS as well,
 13 of course, but it was more of an issue -- I would say
 14 more acute -- in areas of the independent and social
 15 care areas.
 16 One of the other issues was round about how the
 17 workforce was supported. Within the NHS, very quickly,
 18 around about terms and conditions -- although there
 19 was -- I would say there was definitely issues in
 20 relation to some of the guidance that was provided to
 21 individuals who, for example, had to self-isolate -- we
 22 very quickly dealt with, for example, pay terms and
 23 conditions in the NHS and dealt with that so people
 24 shouldn't suffer detriment, although there was some
 25 issues that came up during the pandemic. But we did

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1 deal with it quite rapidly because we had existing
 2 structures, whereas, for example, in the social care
 3 sector, those who cover for -- when they were absent in
 4 relation to pay, it was sporadic around about -- not
 5 only statutory sick pay was paid but there was very
 6 little occupational sick pay, therefore it put huge
 7 pressure on individuals to make choices.
 8 You've got to remember, a lot of individuals we
 9 would class as low paid and social care had to make very
 10 difficult decisions about coming to work or not coming
 11 to work and the lack of pay, and I have to say it took
 12 Scottish Government quite a period of time to deal with
 13 that. Ourselves, through Mr Provan, through the
 14 Workforce Senior Leadership Group and others and other
 15 organisations, actually campaigned with
 16 Scottish Government to try and make a difference, which
 17 they did ultimately, to be fair, but it took more time
 18 than it should have.
 19 Q. One thing I've heard -- and I'd like your comment on it,
 20 Mr Poolman -- is that at the outset of the pandemic
 21 there was nobody representing the care sector at the
 22 same level as, for example, the Chief Medical Officer or
 23 the Chief Nursing Officer. There was nobody
 24 representing the care sector at that level. Would you
 25 agree with that and do you see that as a deficiency?

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1 A. I think there is a deficiency across the system about
 2 where the care sector linked in and I think the pandemic
 3 has shown that to be the case. I'm sure colleagues --
 4 the Chief Medical Officer and the Chief Nursing Officer
 5 would say that they have a responsibility across the
 6 entirety of health and social care, but I do think there
 7 was an issue of around about where key individuals from
 8 key groups linked in. So, for example, the Workforce
 9 Senior Leadership Group, it took a bit of time before
 10 they were invited in to the group. So I think that was
 11 an example of the two systems not exactly meeting each
 12 other and having equality from day one.
 13 Q. To put it crudely, was the care sector seen as something
 14 of a poor relative?
 15 A. I wouldn't like to describe it as that, I have to say.
 16 Q. No, I'll take that responsibility.
 17 A. From the point of view of did the care sector have more
 18 difficulties in having their issues addressed, I would
 19 say that's been very apparent, both at the time and
 20 since the pandemic.
 21 Q. Could I go to paragraph 30 of your statement? You make
 22 the point there that, in terms of planning for the
 23 pandemic and resilience exercise, RCN Scotland was not
 24 involved.
 25 A. No.

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1 Q. It may seem rather strange.
 2 A. I think -- when you look at it in hindsight, I think it
 3 was, but I think the one thing that ourselves in this
 4 generation now know, that planning is essential. But,
 5 no, we were not involved in planning for a pandemic or
 6 the resilience exercises either locally or nationally,
 7 and actually, you know, we absolutely believe as a key
 8 stakeholder that going forward we should be.
 9 Q. Let's take hindsight out of it. Let's go back to the
 10 time of the pandemic, the start of the pandemic. It's
 11 not going to take a genius to work out that your
 12 membership are going to be at the front line of the
 13 treatment and care of persons infected with the virus
 14 and in various ways and that very likely that is going
 15 to place an incredible burden on your membership.
 16 Surely it didn't need hindsight to suggest that your
 17 organisation should have been involved in giving your
 18 input into how things could be structured for the
 19 response to the pandemic.
 20 A. I couldn't agree more. I mean, at the end of the day it
 21 was very clear our members would be at the centre of any
 22 response to any type of epidemic or pandemic, but we
 23 weren't involved in detailing the planning for it.
 24 Q. And in practical terms what would you -- if you were
 25 saying, "We want to plan for a future pandemic of

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1 a similar type as the COVID-19 pandemic" — let's assume
 2 it's going to be the same type — if you're going to
 3 plan for that, what sort of involvement would your
 4 organisation wish to see having in that exercise?
 5 A. Well, we would want to be involved in all the
 6 discussions around about the development of the
 7 protocols, procedures, the guidance in relation to what
 8 the workforce and the public should be given. We'd want
 9 to be involved in that because I think — of course
 10 hindsight does come into it in respect of what we've
 11 learned, so we think we would play quite a key role in
 12 the support and expertise that both our organisation and
 13 our membership could bring to that aspect of planning,
 14 but also to plan for the more practical elements in
 15 respect of both the support, development and preparation
 16 of the workforce to be able to react to a future
 17 pandemic if it does come that we need to deal with that.
 18 One of the things that we need to do is also think
 19 around about the workforce that you would require to be
 20 able to fight a pandemic and the flexibility of that.
 21 We clearly already had vacancies and the pandemic
 22 increased the requirement and need for especially
 23 healthcare staff to look after people. So being
 24 involved in how you do that and being involved in
 25 thinking around about how we were to react we think

25

1 would be a key role for a stakeholder like ourselves.
 2 THE CHAIR: Can I interject, Mr Gale?
 3 MR GALE: Certainly, my Lord.
 4 THE CHAIR: Mr Poolman, this may sound a harsh question.
 5 It's not intended to be a harsh question, but it's
 6 perfectly obvious from what you just said in response to
 7 the questions by Mr Gale that you were not involved and
 8 I understand what you say about that. But the RCN is
 9 a large organisation, obviously, and, as you have just
 10 said, you would have a desire to be involved in any
 11 future planning and I can understand that desire.
 12 Did you, as an organisation — I suspect I know the
 13 answer — but did you as an organisation do any internal
 14 pre-planning for pandemics of any sort prior to the one
 15 we've just experienced?
 16 A. Not in the detail, I would suggest. If you look at it,
 17 some of our guidance that we produced to members, could
 18 it be used in the pandemic? Absolutely. But we didn't
 19 have, if you like, an exercise to plan for a pandemic,
 20 so, no, we didn't.
 21 THE CHAIR: Thank you. Sorry, Mr Gale.
 22 MR GALE: Not at all, my Lord.
 23 Another — or an area of dispute with the
 24 Scottish Government was the question of whether COVID
 25 was an airborne virus rather than one spread by

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1 droplets. I think you make reference to this in
 2 particular at paragraph 40 of your statement. Can you
 3 just explain how that disagreement manifested itself?
 4 A. Partly due to the guidance that was published in
 5 Scotland but across the UK in relation to PPE and the
 6 provision of what PPE should be used and when it should
 7 be used. Very early on, as in our view the evidence
 8 started to show that the transmission — and especially
 9 as the variants developed, we believe the evidence
 10 supported that the virus was airborne in its
 11 transmission, and that in itself would mean that you
 12 need to look at other aspects — well, you need to look
 13 at the aspect of PPE. But also an important aspect,
 14 which was the ventilation within healthcare environments
 15 where people were being looked after because of the
 16 transition route and then of course with individuals
 17 being exposed to the virus.
 18 So that became evident to us quite early on. We
 19 started to raise it both in a regular contact through
 20 the various groups, both informally and formally, with
 21 Scottish Government, but they, to be fair, didn't
 22 respond to that and didn't accept the position we were
 23 taking.
 24 Q. I think you put it fairly bluntly at paragraph 46 of
 25 your statement. You say:

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1 "Ultimately, RCN Scotland considers that there was
 2 a serious lack of engagement by the Scottish government
 3 to consider the growing international scientific
 4 evidence of airborne transmission of Covid-19 but this
 5 was ultimately dismissed in favour of droplet
 6 transmission despite no evidence supporting this and the
 7 impact of these decisions require to be critically
 8 examined by this Inquiry."
 9 Can you just give us a little flavour of how
 10 Scottish Government set its face against what you were
 11 arguing for and what you were saying had a growing
 12 international scientific evidence base for?
 13 A. Very early on there was a rapid review of literature in
 14 relation to the transmission of the virus and the
 15 Government preferred that, over the period late 2020
 16 into 2021, we ourselves actually commissioned an
 17 independent review of that process that actually came
 18 out and agreed with our position. And there was
 19 developing scientific evidence. Numerous papers were
 20 being published about the transmission of the virus and,
 21 as I say, as the variants changed, it became much more
 22 clearer that, for us, it was airborne transmitted.
 23 I have to say, the Government, they refused to
 24 really take that on board and change their guidance or
 25 evidence to reflect that, and that, I have to say, was

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1 and probably remains an area of dispute between
 2 ourselves and the Scottish Government.
 3 Q. Yes. I think the World Health Organisation categorised
 4 COVID as an airborne virus, which, as you say, in
 5 paragraph 40, vindicated the approach that you were
 6 taking.
 7 A. It did. It did. In our view, it should have been that
 8 you take the approach of risk and follow the evidence,
 9 and the evidence absolutely supported it was airborne
 10 transmission, which would have had and should have had
 11 an impact on the recommendations of what protective
 12 equipment the staff used and when they used it.
 13 Q. The last sentence of paragraph 40, you say that this
 14 was.
 15 "... too late for those who caught Covid-19 as
 16 a result of inadequate PPE and the impact it [has] had
 17 on individuals."
 18 That's something you stand by?
 19 A. Absolutely we stand by it. And of course you can't look
 20 forward and actually categorically say what the
 21 consequences are, but we believe that, if we had at that
 22 point in time recognised it fully in the guidance, that
 23 it would have made a difference for some and some
 24 individuals wouldn't have contracted COVID and the
 25 consequences that had on them.

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1 Q. Now, the inadequacy of the PPE is something that your
 2 colleagues will deal with, but are you able to just give
 3 us a flavour of what is being considered there?
 4 A. The inadequacy of PPE, I think, was well reported at the
 5 time and since. The inadequacy of it was staggering in
 6 some way when you look at it. There was members of
 7 staff who were being asked to reuse PPE that wasn't
 8 designed to be reused, for example, because there
 9 weren't adequate supplies. The distribution initially
 10 was poor as well as the provision of it.
 11 The type of PPE in itself was not always fit for the
 12 situation it was being asked to be used on, whether it
 13 should have been --- people should have had gowns and
 14 they were just given plastic aprons, for example, or
 15 indeed the design of some of the PPE. So nursing is
 16 a predominantly female profession and many of the masks
 17 were not designed in smaller sizes, so we had huge
 18 issues at times where they were doing the fit testing ---
 19 is what they called it --- for an FFP3 mask and many
 20 nurses were not passing the fit testing because there
 21 wasn't the design of mask available.
 22 Q. Yes, thank you. Could I just take you on, almost
 23 finally, to what you say in paragraphs 48 and 49
 24 regarding care and nursing homes and also the district
 25 nursing situation? You say that the RCN was not

30

1 involved in the decisions that were taken regarding the
 2 transfer to or from homes. We're talking here about the
 3 strategic decisions that were taken, not the individual
 4 clinical decisions that were taken. Can you tell us
 5 what could and indeed would have been your position had
 6 you been brought into that discussion?
 7 A. As I say, we weren't involved. These were decisions
 8 that were made at Scottish Government level. The issue
 9 for us, if brought in, would have been to absolutely
 10 establish what the evidence was at that time and what
 11 the evidence supported in relation to the risk of the
 12 transfers and what precautions could have been taken.
 13 These would be things that we --- it's difficult --- we
 14 weren't involved in these discussions or decisions so
 15 it's difficult for me to ascertain what we would have
 16 put in at the time, but ---
 17 Q. I appreciate that, but from the information that you
 18 gleaned from your membership, do you think that the sort
 19 of precautions that you're talking about had been taken
 20 into account in the decisions to transfer persons from
 21 hospitals into care homes and vice versa?
 22 A. I think initially quite clearly there was a decision
 23 made that there was going to be a need for hospitals and
 24 acute beds and I think the decisions were made on the
 25 basis of making sure there was availability to look

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1 after acutely ill people, and that had a major impact on
 2 what the Scottish Government and colleagues' decisions
 3 were at that time.
 4 Q. You do say in paragraph 49 that --- you refer to the
 5 concern expressed by your members regarding the
 6 "arbitrary discharging, or preventing of discharge" in
 7 that situation. Now, that seems to be suggestive that
 8 there was perhaps not the level of precaution taken, if
 9 it was arbitrary. Is that what you're trying to get
 10 across?
 11 A. I think the issue was that it was general --- the advice
 12 came from Scottish Government and then that had an
 13 impact about how that advice was carried through within
 14 the healthcare environment, and that left a lot of
 15 professionals to make very difficult decisions --- that
 16 they quite clearly were told to do something that they,
 17 when applying their clinical assessment, may not have
 18 made these decisions.
 19 THE CHAIR: For the avoidance of doubt, you've used the
 20 terms "advice" and "required to do", which are mutually
 21 inconsistent or potentially mutually inconsistent, and
 22 I just want to be clear what your understanding of the
 23 situation was. Advice was given in relation to
 24 discharge by Scottish Government and clinicians who
 25 ultimately had the responsibility for making a decision

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1 on a discharge and --- this is the important part --- they
 2 were influenced or they felt bound --- which is it? --- to
 3 a discharge?
 4 A. I think they felt influenced by --- and if I just go back
 5 and be very clear, I think it's the guidance that they
 6 received in relation to these processes at the time
 7 because they --- we were preparing or starting to deal
 8 with the outcome of the pandemic or the results of it.
 9 THE CHAIR: I do appreciate obviously the burden placed upon
 10 a clinician made with that decision. One presumably
 11 doesn't ignore advice or guidance from a government, but
 12 that is the situation that the clinician was in.
 13 A. Yeah, that's the situation clinicians were put in.
 14 THE CHAIR: Do you think that's right?
 15 A. I think we should always ---
 16 THE CHAIR: Perhaps it's not a question for you, to be fair.
 17 A. I think my own personal position would be I think at the
 18 end of the day guidance is provided but I think
 19 ultimately decisions in relation to patients being
 20 discharged or being admitted to hospital should be left
 21 with the clinicians who are dealing with the situation
 22 and their experience and knowledge to guide them on
 23 that.
 24 THE CHAIR: I understand that. Probably it was an unfair
 25 question to you, to be fair. We should ask --- no doubt

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1 we will ask the clinicians when we hear from them,
 2 Mr Gale.
 3 MR GALE: Yes.
 4 Just one point that perhaps follows on from what
 5 you've said in paragraphs 48 and 49. It's the last
 6 sentence in paragraph 49, where you say:
 7 "The pandemic has emphasised the need to ensure the
 8 community and care home sectors are properly represented
 9 in planning to scale up the nursing workforce for future
 10 pandemics and ensure a whole system approach."
 11 It's probably obvious but what is a "whole system
 12 approach"?
 13 A. I think you're right, it is obvious. I think we should
 14 absolutely look at the health and social care system in
 15 its entirety and not just elements of it and not prefer
 16 one over the other. But that's systemic in around about
 17 how systems work together and how they're set up, and we
 18 certainly need to make sure that the nursing element of
 19 that is recognised equally across both health but also
 20 social care.
 21 Q. Can I ask you now about do not attempt CPR? You've made
 22 your position on behalf of the RCN very clear in
 23 paragraph 51, that it had always been your position that
 24 there must never be a blanket use of such certificates
 25 and that "end-of-life care must always be delivered with

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1 the utmost compassion and as part of a personalised care
 2 plan". You refer to your own press release that you
 3 issued in the course of the pandemic. Was there
 4 a reason for issuing that press release?
 5 A. Absolutely. The reason was that it became an issue that
 6 had been raised through our membership in relation to
 7 the approach that was being taken in relation to these
 8 DNACPRs and we felt it was absolutely important that we
 9 emphasised the importance of individualised care in all
 10 circumstances. These should not be blanketly used and,
 11 you know, when you're going through end of life in
 12 whatever situation, you should be involving the patient
 13 if possible but of course their family and loved ones.
 14 In relation to any decision that's made, it should
 15 always be on an individual basis. That's been our
 16 position for some time and continues to be our position.
 17 Q. Yes, and I think you've probably answered what was going
 18 to be my last question on this, which was that this
 19 would involve, where appropriate, discussion with the
 20 patient and also discussion with the patient's family,
 21 if there was a family?
 22 A. Indeed. And of course the pandemic caused difficulties
 23 with that because of people's access to being in
 24 hospital or in a care home, but of course there was
 25 other ways of communicating and that's incredibly

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1 important for anybody's end of life, that it's done in
 2 the most compassionate way possible and to meet the
 3 wishes of the individual and their family.
 4 Q. Now, Mr Poolman, can I take you to your lessons to be
 5 learned? Again, this probably encapsulates several of
 6 the matters that you've addressed so far but I think
 7 probably it's best that I leave it to you to read
 8 paragraph 57 of your statement.
 9 A. Would you like me to read it out?
 10 Q. Yes, please.
 11 A. "[The] RCN ... considers that, in order to be properly
 12 prepared for a future pandemic, key stakeholders in the
 13 provision of health and social care require to be
 14 involved in the influence of [all] key decision making
 15 and guidance. As mentioned, prior to, and during the
 16 Covid-19 pandemic. RCN Scotland was not fully involved
 17 in the design of national guidance on PPE and infection
 18 control. After considering the impact, we believe full
 19 and proper engagement with the nursing profession on
 20 infection control would help to ensure future national
 21 guidance is robust, fully informed and, importantly,
 22 evidence based. More importantly, the government must
 23 identify ways to address the staffing and recruitment
 24 crisis faced by the health and social care workforce
 25 across a number of clinical settings. Without an

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1 adequate number of medical, clinical and healthcare
 2 workers with the right mix of skills and who are able to
 3 deliver the appropriate standard of ... care to meet the
 4 demand of the country at the present time in the absence
 5 of a pandemic, then there is no chance at all that the
 6 demand created by any future pandemic will [be] close to
 7 being met.”
 8 Q. Right. Thank you very much, Mr Poolman. As is the
 9 norm, I will ask you, is there anything that you would
 10 like to add to the material you’ve placed before the
 11 Inquiry in your statement and amplified in the
 12 discussion that we’ve had this morning?
 13 A. I think I would just like to amplify that absolutely
 14 having the benefit of attending and giving evidence to
 15 the Inquiry, the RCN wishes to participate and learn
 16 like everybody else in relation to the lessons that we
 17 need to learn as — across health and social care but
 18 also as a society of how we can, if we ever have to,
 19 react and deal with a pandemic in the future and my
 20 colleagues will add to my evidence as you take that from
 21 them this morning.
 22 MR GALE: Thank you very much, Mr Poolman. Thank you,
 23 my Lord.
 24 THE CHAIR: Thank you, Mr Poolman. 11 o’clock, Mr Gale.
 25 MR GALE: Yes, it’s Mr Dunlop who is taking the next

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1 witness.
 2 THE CHAIR: Very good.
 3 (10.47 am)
 4 (A short break)
 5 (11.04 am)
 6 MR NORMAN PROVAN (called)
 7 MR DUNLOP: Good morning, my Lord. This morning I have one
 8 witness, Mr Norman Provan.
 9 THE CHAIR: Good morning, Mr Provan.
 10 MR DUNLOP: For the benefit of, I suppose, the transcript
 11 and your own notes, my Lord, the reference number of his
 12 witness statement is SCI—WT0491—000001.
 13 Thank you, my Lord. Unless there are any
 14 preliminary matters?
 15 THE CHAIR: Please start.
 16 MR DUNLOP: Thank you.
 17 Questions by MR DUNLOP
 18 MR DUNLOP: Can you provide the Inquiry with your full name,
 19 please?
 20 A. Norman Provan.
 21 Q. Mr Provan, I think you wanted to say something before
 22 I got into the body of the questioning this morning.
 23 A. Yes. In Mr Poolman’s evidence, he gave an
 24 organisational statement giving the RCN’s condolences to
 25 those who lost loved ones during the pandemic and those

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1 who continue to be affected by it. I won’t go through
 2 the statement again but I would just reiterate that
 3 personally.
 4 Q. Thank you. Can you provide us with your position within
 5 the Royal College of Nursing please?
 6 A. I’m the associate director of the Royal College of
 7 Nursing in Scotland and my particular responsibilities
 8 are for the employment relations functions.
 9 Q. You’ve provided a statement to the Inquiry which
 10 contains a lot of detail and I don’t propose to go
 11 through all of that in the hour or so that we have this
 12 morning. You identify your qualifications and
 13 employment history at paragraphs 3 and 4 and thereafter
 14 you move on and you tell us at paragraph 6 of the
 15 statement that you’re part of a strategic group
 16 established by the Scottish Government in response to
 17 the pandemic and you say that that group’s role was to
 18 manage the workforce’s response to the pandemic. Can
 19 you tell me, who was the chair of that group?
 20 A. It was a senior civil servant in Scottish Government who
 21 chaired the group. When it was initially put together,
 22 it was the first group that was to get together in
 23 relation to pandemic response and then many of the other
 24 groups in my statement and indeed Mrs McKenna came from
 25 that because we were able to hive the work off to other

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1 groups to do a piece of work rather than the strategic
 2 group. So, for example, initially, when that group
 3 met — when it was first put together, we met twice
 4 a day seven days a week at the very beginning, and over
 5 time that lessened off and other groups were established
 6 to take on particular issues so that the group didn’t
 7 have to consider anything, but it was really was about
 8 the workforce response.
 9 Q. We may hear from Scottish Government witnesses later in
 10 the Inquiry process. You said it was a senior civil
 11 servant. Do you remember his or her name?
 12 A. I think the chair of it changed and I can’t recall, but
 13 it might come to me.
 14 Q. Don’t worry if you can’t remember.
 15 A. I think it was Gillian ...
 16 Q. I’m not going to ask you to guess.
 17 A. Russell — Gillian Russell.
 18 Q. Thank you. What kind of topics were discussed in the
 19 early stages of the pandemic? I’m really thinking kind
 20 of late March/early April at this group.
 21 A. It was a multi—agency group — I think that’s important
 22 to note — so it wasn’t just the NHS. So there was
 23 stakeholder involvement from primary care, secondary
 24 care and indeed the care home sector. Initially, very
 25 initially, it was largely about the workforce, having

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1 sufficient workforce, how we would deploy them, and
 2 particular issues in relation to the supply and
 3 distribution of PPE.
 4 Q. You've maybe answered my next question but I'll just ask
 5 you anyway. What kind of decisions were made? Was it
 6 just discussions in principle or decisions made about
 7 "what we're going to do about workforce" or "what we're
 8 going to do about PPE".
 9 A. It was about both. Some decisions we made on the day
 10 and they would be applied across the whole of the health
 11 and social care system, sometimes from the very next
 12 day. Other things we would decide would take longer to
 13 put in place, so, for example, in terms of the
 14 procurement of PPE gowns, for example, which are
 15 reusable, washable gowns, we were making decisions about
 16 stepping up the laundry facilities so that all of it
 17 could be bagged, sent to laundry and returned back into
 18 the system quite quickly. That didn't happen quickly,
 19 but the deployment of staff, some of those decisions
 20 were made immediately and were implemented, as I say, in
 21 some cases almost from the next day.
 22 Q. Thank you. We see in paragraph 8 of your statement
 23 there's a list of other groups that you're also a member
 24 of. I don't propose to go through those, but we see
 25 there's the National PPE Oversight Group. Those groups,

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1 did any of those — and it may have been too early in
 2 the pandemic to have been involved in it, but did any of
 3 those groups deal with long COVID?
 4 A. No, not at that point in time.
 5 Q. In paragraph 11 of your statement you identify that
 6 there were issues where the Scottish Government didn't
 7 act in relation to concerns raised by the Royal College.
 8 Could you give me a couple of examples and tell me when
 9 those concerns were raised?
 10 A. Sure. Most predominantly it was the issue about the
 11 supply of certain types of PPE. The Royal College of
 12 Nursing and other stakeholders raised their concerns
 13 about the use of, for example, fluid surgical resistant
 14 masks, which are open at the side, where we felt it
 15 would have been more useful for all staff to have access
 16 to FFP3 masks, which form a seal and are therefore
 17 better and — including issues such as aprons and
 18 visors. And that's the one thing out of all of the
 19 engagement that we had with the Scottish Government that
 20 I regret, that the Scottish Government did not act more
 21 fully on the concerns that we had.
 22 Within the first year of the pandemic, particularly
 23 as there was new variants appearing which were more
 24 virulent, they spread more easily and more quickly — we
 25 wrote in the January of 2021, almost a year into the

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1 pandemic, to say that there was emerging evidence about
 2 this not being a droplet—passed infection but an
 3 airborne one and urged them to change their guidance,
 4 and they didn't and to this day never have.
 5 Q. And did they explain why they didn't?
 6 A. They constantly said that, "We're convinced by the work
 7 of ARHAI", which was a Scottish group that was providing
 8 guidance for the whole of the UK in relation to the
 9 modality of the infection spread. We — in pure logic
 10 terms, there were some things — so if I could
 11 illustrate with an example.
 12 Fairly early in the pandemic, hospitals were being
 13 filled with people who had COVID so wards that did
 14 surgical interventions were being transferred into
 15 medical wards because that's what the need was. Many
 16 people would come into the hospital, would deteriorate
 17 and some of them ended up in ICU. So if you went into
 18 ICU, people had all of the gowns and the masks and the
 19 visors and the FFP3 masks.
 20 And I remember having a discussion very early at the
 21 Workforce Senior Leadership Group, and we raised an
 22 issue in relation to the Victoria Hospital in Kirkcaldy
 23 in Fife, where we pointed out that in the ICU, the
 24 department where they had all of the PPE, there was one
 25 member of staff off sick with COVID, and a medical ward

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1 that fed the ICU, for want of a better word, there were
 2 17 members of staff off sick with COVID, with different
 3 PPE. Simple logic tells you that actually the issue
 4 here is if they had better PPE ...
 5 So bear in mind that we weren't being listened to,
 6 the RCN then commissioned a report where we had experts
 7 look at the guidance and they were fairly critical of
 8 the conclusions that were reached by ARHAI in terms of
 9 the guidance that they produced and indeed the evidence
 10 base that they had used to make those guidance. So we
 11 had commissioned a specialist report which we furnished
 12 the Scottish Government with in February 2021, and again
 13 they didn't respond adequately to that. They insisted
 14 that their guidance was sufficient.
 15 Q. Correct me if I'm wrong, but I think you said that to
 16 date they still do not accept it was — is that correct?
 17 Did I pick you up correctly?
 18 A. I think now the pandemic is seen as being over, they
 19 accept the WHO's statement now that it's an airborne
 20 infection, but certainly during the whole of the
 21 pandemic and every iteration of the guidance that they
 22 put out maintained that it was a droplet infection and
 23 not an airborne infection.
 24 Q. Thank you. At paragraph 12 of your statement, you
 25 discuss pre—pandemic planning and you tell us that the

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1 Royal College wasn't involved in that pre-pandemic
 2 planning. With the benefit of hindsight, are you
 3 suggesting that it would have been advantageous if you
 4 had been involved in that?
 5 A. The RCN did have some involvement but not in the very
 6 specific exercises about how you would deal with an
 7 outbreak. We did have some discussions prior to my time
 8 in post about how the workforce would respond, but in
 9 terms of the type of desktop exercises and modelling
 10 that you would do based on other outbreaks in other
 11 countries, we were never invited to be involved in that.
 12 And certainly post this pandemic, I think that any
 13 exercises that they do to plan for future pandemics,
 14 there is learning about all of the stakeholders that are
 15 involved, and I certainly think that we would have
 16 something to contribute to that.
 17 Q. Okay. But you do say -- you go on to say in the next
 18 paragraph that you were involved in the pandemic, the
 19 planning, if you like --
 20 A. Yeah.
 21 Q. -- once it commenced. What type of planning were you
 22 involved with?
 23 A. Really the day-to-day decisions from the Workforce
 24 Senior Leadership Group and all the other groups that
 25 we've put. I think it's worth noting that the

1 Scottish Government's engagement model with trade unions
 2 and professional organisations like the RCN in Scotland
 3 is good. We are generally invited to the table for
 4 these things, and that was maintained throughout the
 5 pandemic. So ourselves, as Royal College, along with
 6 other royal colleges and other trade unions, were
 7 intrinsically involved with all of the groups that were
 8 managing it. We weren't doing our shouting from the
 9 sidelines.
 10 Q. It might be of benefit, the Royal College, is that
 11 simply a professional organisation or does it have
 12 a trade union side?
 13 A. It has both.
 14 Q. It has both.
 15 A. And there are very few that have both, a professional
 16 royal college and a trade union. In fact, in terms of
 17 our evidence, it's why myself and Mrs McKenna have given
 18 different evidence. We have different portfolios. So
 19 I manage the trade union, the legal aspects for the
 20 Royal College of Nursing, and Eileen manages the
 21 professional practice and learning elements of it.
 22 Q. This may actually be a question that would be more
 23 appropriately put to Eileen on that basis, but you say
 24 at paragraph 19 that nurses were required to transfer to
 25 the specialist areas that they didn't normally work

1 within. Did nursing staff require to receive training
 2 because of the pandemic?
 3 A. Yes. In simple terms, nursing, like many professions,
 4 after you originally qualify, then splits into a number
 5 of specialist areas. So, for example, if you're a nurse
 6 working in an orthopaedic trauma ward, you wouldn't
 7 necessarily be competent to go and work in a general
 8 medical ward, which was what was required during the
 9 pandemic. But of course all of the demand for the
 10 services was general medical and specialist ICU because
 11 that's -- everybody was getting COVID and everybody was
 12 being admitted to hospital for that. So many nurses
 13 were required to transfer from the specialist area that
 14 they were most competent and familiar in to work in
 15 areas that they were less confident or familiar in
 16 working in.
 17 Q. In terms of that training, how long -- maybe you can't
 18 say -- but how long would the training take for an
 19 average member of the Royal College?
 20 A. They weren't taken aside and trained before they were
 21 put in. They were put in and trained on the job because
 22 that was absolutely necessary. There are some areas
 23 that that would have been more difficult than others.
 24 There are certain transferable skills that all nurses
 25 would have a reasonable degree of competence in, but to

1 move from one area to an ICU where you would normally be
 2 expected to have a post-graduate qualification,
 3 a specialist qualification for nursing that type of
 4 patient -- there were nurses who went into ICU who had
 5 never managed to get that qualification during the
 6 pandemic because it simply wasn't possible to do so.
 7 They were certainly working under the direction of
 8 nurses who did have it, but they wouldn't have been as
 9 confident or competent as those nurses because they
 10 weren't trained to be.
 11 Q. Is there something that could be done for the future in
 12 terms of lessons learned?
 13 A. Difficult to say because pandemics happen so
 14 infrequently that, with anything, to keep your skills up
 15 to date, you could be academically trained in something,
 16 but, unless you're working in it every day, I would
 17 suggest it wouldn't be easy. You could perhaps do some
 18 form of rotation, where people rotated from different
 19 clinical areas, but that would then take away from the
 20 specialist aspect of people working in areas. So
 21 I think it's an issue worth considering but I don't
 22 think there's any simple answer to that one.
 23 Q. Moving on to paragraphs 24 and 25 of your statement, you
 24 go on to discuss testing and you identify that, in your
 25 opinion, there was no reliable testing at the outset of

1 the pandemic. Did the testing improve --- we're looking
 2 at the period essentially from the beginning of 2020 to
 3 the end of 2022. In your opinion, did the testing
 4 improve during that period and, if so, when?
 5 A. Yes, without question. I mean, there was no test
 6 initially for COVID. People were coming into hospital
 7 assumed to have COVID because of their clinical symptoms
 8 until such time as the diagnostic test was made
 9 available, and then it was PCR testing and those were
 10 regionally set up. So people would be asked to drive to
 11 Edinburgh Airport to be tested, for example, and there
 12 were sites all over Scotland for people to do that.
 13 There was a degree of testing in hospital, PCR testing,
 14 but there wasn't the lab capability to do that at scale.
 15 So over time it did get better, as the
 16 Scottish Government commissioned more lab ability to
 17 test those assays, and over time then, when the strip
 18 testing was put in place, the self-testing mechanism ---
 19 which was quite easily distributed to staff and they
 20 were asked to test twice a week. Then, by that time,
 21 the testing was reasonably sophisticated.
 22 Q. Thank you. In paragraph 25 --- and I'll come on to
 23 long COVID shortly --- but you state that there were many
 24 staff that essentially contracted long COVID and are
 25 facing financial detriment and some are now unable to

1 work. Do you have any statistics essentially of your
 2 members that have contracted long COVID?
 3 A. It continues to grow. We have 35 cases, personal injury
 4 cases, that we have lodged and are currently assisted(?)
 5 and we have about 15 more at the moment. But the
 6 arrangements that were put in place for people in the
 7 workplace for occupational triggers if they're off
 8 work --- people were treated as at work and paid as at
 9 work if they were off sick. But now many of those
 10 nurses are coming to the end of that and are being
 11 dismissed from their employment because they're not fit
 12 to return to work. So many nurses are now coming to us
 13 some years down the line, saying that they have been
 14 affected over a long number of years, haven't been fit
 15 enough to return to work or have attempted to return to
 16 work but haven't done so successfully and have now been
 17 dismissed from their positions.
 18 Q. Just to go back to the original question, you have
 19 identified a number of claimants and actions, but not
 20 necessarily everybody who has caught long COVID will
 21 have been or is a claimant. Do you have any database or
 22 statistics in relation to members who have contracted
 23 long COVID or is it simply those ones who are pursuing
 24 a claim for damages?
 25 A. I have the stats about the ones who have claimed for

1 damages, but we have many more members who complain of
 2 having long COVID and I think that will continue to grow
 3 as time goes on. I still see cases coming in where
 4 people are saying that they hadn't had any contact with
 5 us at the time because they were being paid
 6 occupationally as if at work and it's only now, when
 7 they're not, that they're coming to us and saying,
 8 "Actually I've had this now for two years".
 9 Q. Perhaps this might help identify the answer to my
 10 question because I'm really just interested in
 11 essentially if there is a number in terms of the members
 12 of the Royal College who have long COVID, but you
 13 identify in paragraph 27 of your statement that you
 14 raised concerns essentially that there was a lack of
 15 reporting of your members contracting workplace COVID
 16 and if the reporting --- what do you say, if it had been
 17 reported --- if workplace --- the reporting of COVID had
 18 been carried out the way you would have had it done,
 19 what difference would that have made, do you say?
 20 A. There were differences in the way that parts of the
 21 system dealt with it. I wrote personally to every chief
 22 executive of every NHS board in Scotland, reminding them
 23 of their responsibilities to record what might have been
 24 occupationally derived disease and to report that
 25 through the RIDDOR mechanism. I got different responses

1 from some of those chief executives, some of them
 2 setting out quite clearly that they had put mechanisms
 3 in place to try and ascertain whether or not somebody
 4 had nosocomial or occupationally derived infection and
 5 reporting it, and I remember another chief executive
 6 whose letter quite insultingly basically said, "We're
 7 giving people PPE so it's impossible for them to get it
 8 at their work", which I thought was a spurious way to
 9 respond to something.
 10 Then the guidance that came out from
 11 Scottish Government --- because through the Workforce
 12 Senior Leadership Group I raised this and said that
 13 Scottish Government should reinforce the guidance to
 14 employers, which they did, but there was a disconnect
 15 between the advice that they gave and the mechanism for
 16 testing.
 17 So the advice that they gave was that any nurses who
 18 they thought might have occupationally derived COVID or
 19 went off sick from work with COVID which might have been
 20 occupationally derived --- and they had a PCR test to
 21 demonstrate that it was --- should be reported via COVID.
 22 But by that time they'd moved into the mechanism where
 23 people were self-testing and it wasn't PCR tests that
 24 were being used. So in fact there were probably many,
 25 many more nurses who had contracted COVID possibly at

1 work but, because they didn't have a PCR test, their
 2 employer never recorded that or reported it to the
 3 Health and Safety Executive. Had the Health and Safety
 4 Executive got hundreds or thousands of more referrals
 5 for people that had been occupationally derived, they
 6 may, for example, have insisted on different control
 7 mechanisms being put into place, and that never
 8 happened.

9 Q. Is there — sorry, I don't want to press you on it if
 10 you may not know, but is there a database of how many
 11 times — so if a member of the Royal College contracts
 12 COVID, is there any database that shows how many times
 13 they've contracted it, occupationally contracted it?

14 A. Not that I'm aware of in terms of (inaudible) health.
 15 But I know that Public Health Scotland did some outbreak
 16 work with outbreaks in hospitals. So at the very
 17 beginning, if nurses went off sick, then it was assumed
 18 they had COVID. There was no testing. Then you get to
 19 the point where there is testing and people are still
 20 fairly restricted in terms of lockdown so they're
 21 technically at home or at their work and perhaps
 22 visiting the supermarket once a week. But then, towards
 23 the end of the pandemic, of course everything was open
 24 so it becomes more difficult to say, if a nurse got
 25 COVID, whether or not they got it at work.

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1 But bearing in mind that patients that had been
 2 admitted to hospital not as an emergency but in
 3 a planned way — those patients were tested prior to
 4 coming into hospital so you knew that patients, when
 5 they came into hospital, were COVID-free or
 6 COVID-positive. And what was known is that some of
 7 those patients that came in — they were COVID-free when
 8 they came into hospital — a few days later then tested
 9 positive. There was knowledge of the length of time of
 10 the incubation period for COVID, so it was likely then
 11 that those people got it in hospital, either from other
 12 patients, from nurses or indeed gave it to nurses, and
 13 I know that Public Health Scotland did do some outbreak
 14 testing using PCR but I don't have access to that data.

15 Q. Okay. I'll move on to a new topic, but PPE again. At
 16 paragraph 36 of your statement you identify that PPE was
 17 required in a variety of settings from ICU and hospitals
 18 to care homes. Are you aware of your members
 19 experiencing any difference in either the availability
 20 or the suitability of PPE, depending on where they
 21 worked?

22 A. Yes. So take aside the comment I made earlier about ICU
 23 having all the equipment and other wards which were
 24 feeding them having less equipment — yes, particularly
 25 in areas outwith acute district general hospitals, so in

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1 care homes and in the community, for example. Care
 2 homes are often small providers so they had their own
 3 method of purchasing PPE, and of course every health
 4 system in the world was trying to get great amounts of
 5 PPE at quite short notice at the beginning of the
 6 pandemic so for them it was particularly difficult to
 7 secure an increase in their supply chain. Through the
 8 Workforce Senior Leadership Group, we raised this and
 9 one of the things I would commend Scottish Government
 10 for was the setting up of hubs, which meant that those
 11 environments, like care homes, if they had difficulty
 12 securing their own PPE, could phone and they would be
 13 supplied PPE from hubs which was from the NHS stock.
 14 But certainly there appeared to be a hierarchy the
 15 further you got away from the very acute environments to
 16 both the availability and the type of PPE that was
 17 available.

18 Q. In terms of the hubs — I think we see later that you
 19 discuss community hubs. Is that the hubs that you're
 20 talking about?

21 A. Yes.

22 Q. In terms of the hierarchy, am I correct in understanding
 23 that the hierarchy is ICU, the gold standard, if you
 24 like, of PPE, and then is it filtered down — through
 25 different wards in the hospital, it wasn't that gold

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1 standard, and then, as it got further down to say
 2 primary care, GPs and care homes, it was of a lower
 3 standard again or am I misunderstanding you?

4 A. Yeah, I think that's fair, particularly at the
 5 beginning, when the big issue of course was about
 6 securing the amount of PPE that we required. So I know
 7 that in community there was certainly more frequent
 8 reuse of PPE and less of it. I also think there was
 9 a degree of hoarding happened when PPE came in and
 10 through National Shared Services and the Workforce
 11 Senior Leadership Group, within six months of the
 12 pandemic being in place, there was a fairly
 13 sophisticated system where, on a weekly basis, we were
 14 given information about exactly how much PPE was in
 15 stock for every item, where it was held, largely at
 16 a distribution centre in South Lanarkshire, and how much
 17 of it had been distributed to every single hospital in
 18 Scotland and how much they had in reserve. So the
 19 Scottish Government through the Workforce Senior
 20 Leadership Group did respond to that in a way to try to
 21 positively address that issue.

22 Q. Okay. I'll maybe come on to the National Shared
 23 Services shortly because I think you deal with that in
 24 paragraph 38 of your statement. But just to pick you up
 25 on one point there, you talked about the amount of PPE.

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1 Now, I think there's possibly two issues. There's the
 2 sufficient — essentially whether there's enough masks
 3 or gowns and so forth, gloves, and there's the issue of
 4 whether it's suitable for purpose. Were they both
 5 issues or was there enough but it wasn't suitable or was
 6 there a suitable one but it wasn't enough? Can you —
 7 A. They were both —
 8 Q. The issue was both?
 9 A. Yeah, at the very beginning it was about the volume of
 10 PPE that was required and then about the suitability.
 11 So at the very beginning, in terms of producing —
 12 people in the high areas like ICU would be given
 13 surgical gowns which were sealed at the wrist and you
 14 wore two sets of gloves and a visor, but the wards below
 15 that, it wasn't. It was a plastic apron and
 16 a fluid-resistant surgical mask, which there wasn't
 17 enough of and it wasn't of a high enough quality
 18 initially. Some of the aprons that were being
 19 purchased, for example, were in essence repurposed bin
 20 bags. Over time that supply got better, both in terms
 21 of the supply chain, which was internationally
 22 purchased, and indeed in Scotland. The
 23 Scottish Government set up some manufacture in Scotland
 24 itself to produce PPE.
 25 But right through the pandemic, although over time

1 the supply of it in terms of the amount was dealt with,
 2 the quality wasn't always dealt with. For example, and
 3 as I said in my statement, FFP3 masks come in a fairly
 4 standard size. Nursing is a largely female population
 5 and many nurses complained that the FFP3 masks didn't
 6 fit properly.
 7 Q. I was going to come on to that. We'll maybe just deal
 8 with that now. I read in a few papers that they talk
 9 about the masks not fitting properly. Can you help me,
 10 is that because you need masks of a different size or is
 11 that because they need fitted the same way you might fit
 12 a cycle helmet or an office chair, you might adjust it
 13 to the particular user? Is there one particular mask
 14 with adjustment or is there different sizes?
 15 A. I'm not aware of them being particularly manufactured in
 16 a range of sizes and some of them have better
 17 adjustability than others. The issue is that
 18 Scottish Government, through trial and error, tried to
 19 procure from different manufacturers to meet better, and
 20 everybody who was wearing an FFP3 mask was supposed to
 21 have it face-fitted, so that's somebody who was
 22 qualified to, one, fit that mask for you, show you how
 23 to adjust it and make sure that that was the supply of
 24 masks that you used going forward. Our members said
 25 that there was insufficient people trained to do that

1 face-fitting and that sometimes, when they couldn't get
 2 the mask that fitted best for them, they had to make do
 3 with what they had until such time as supplies
 4 increased.
 5 Q. Thank you. Obviously we don't deal with that, but
 6 there's obviously — is there a skill in it insofar
 7 as — with a cycle helmet — I just use a cycle helmet
 8 as something I'm familiar with — you turn it until it's
 9 tight and you pull the straps. Is it not as
 10 straightforward as that? It needs somebody to actually
 11 show you how to fit it?
 12 A. It's in essence as straightforward as that. They're
 13 usually adjusted at the back rather than at the mouth.
 14 The fact of the matter is that what somebody who is
 15 face-fitting is doing is making sure that the person
 16 understands that it's crucially important that the mask
 17 completely seals around the face whereas a surgical
 18 fluid-resistant mask is open at the side. So what
 19 they're doing is testing that, when you put it on,
 20 you're adjusting it and confident in adjusting it in
 21 such a way that that seal is made.
 22 Q. Am I correct in understanding that these masks, the
 23 non-surgical masks, the better-quality masks, if you
 24 like, were largely masks produced for larger male faces
 25 prior to the pandemic?

1 A. Yes.
 2 Q. Just dealing still with PPE, you identify at
 3 paragraphs 36 and 37 of your statement — you discuss
 4 the testing of PPE which had passed its expiry date.
 5 Did the Royal College have a view on essentially
 6 extending the expiry date through testing?
 7 A. We raised that. The amount of PPE that was required at
 8 pace very quickly meant that there was difficulty in the
 9 supply chain in terms of buying it in and there was
 10 a lot of PPE that was held in the storage areas that we
 11 have off-site for holding them that was out of date. We
 12 raised our concerns about that because people were very
 13 anxious about it. This was a novel virus that was
 14 killing people and they were saying, "Well, you're
 15 giving me PPE but the date on it says it's been out of
 16 date for 18 months. Is this safe to wear?". The
 17 National Shared Services did batch testing of that, so
 18 what they were doing was testing whether or not in fact
 19 it was still sterile, for example, or still was fit for
 20 purpose, and they reassured us that they were testing
 21 all of the PPE and were convinced that the out-of-date
 22 PPE was fit for use. In those circumstances, we would
 23 have approved that being used because it was better to
 24 have that than just discard it and say it's not working.
 25 Q. Thank you. At paragraph 38 you go on to discuss the

1 changes in the PPE procurement system by the NSS.
 2 I think you've mentioned that so I won't take you
 3 through that. You also mention in paragraph 39 that
 4 community hubs were set up for the supply of PPE.
 5 I think you briefly touched on those earlier. I just
 6 wondered, the community hubs, where were those located
 7 within a health ward or a local authority area and who
 8 was entitled to go and secure PPE from those community
 9 hubs?
 10 A. I can't tell you how many of them there were, but they
 11 were in all communities, all local authority areas. So
 12 any care home environment, for example, any community
 13 providers of care and in fact carers themselves could
 14 phone up and say, "I don't have any access to PPE", and
 15 they would be given a supply of them. That became
 16 a fairly responsive thing. People could phone on the
 17 day and it would be delivered to them on the same day.
 18 So it was Scottish Government's attempt to assert their
 19 ability to buy volume and make it available to places
 20 that couldn't secure supply chain in the way that a big
 21 organisation like the NHS in Scotland could, and that
 22 was, I would have said, quite successful.
 23 Q. Did I get you, you said that people who were carers ---
 24 would that include unpaid carers?
 25 A. Yes.

1 Q. Was there a fee for that, do you know?
 2 A. No.
 3 Q. You say at paragraph 40 of your statement that wearing
 4 PPE all day was uncomfortable and could be a barrier for
 5 communicating to patients. Whilst I'm sure that's
 6 correct, is there a solution to that?
 7 A. There were some engineered solutions, for example, masks
 8 provided that had a see-through panel because you have
 9 people who lip-read, for example. But there aren't any
 10 easy solutions to that, wearing PPE, particularly in
 11 places like care homes, where people might have
 12 cognitive impairment. Communicating with somebody when
 13 you have all of the PPE stuff on becomes much less
 14 personal. It was necessary for the protection of
 15 patients and staff but it certainly became a barrier to
 16 effective communication between nurses and patients at
 17 times and nurses found that very distressing.
 18 Q. At paragraphs 42 and 43, you discuss the airborne
 19 transmission of COVID and I think you've discussed that
 20 earlier in your evidence so I won't go through that. In
 21 terms of --- just before I move off from PPE, is it your
 22 evidence that if better testing --- sorry, I'll put the
 23 question in two parts.
 24 In your opinion, would those nurses that are now
 25 suffering from long COVID --- would they have been less

1 likely to have contracted long COVID if the PPE --- if
 2 there had been something different, if you like --- and
 3 I'll make it as wide as that --- about the supply and
 4 adequacy of PPE at an earlier stage?
 5 A. Yes, without question. And certainly the Public Health
 6 evidence --- Public Health Scotland evidence, when they
 7 did the outbreak in hospital, when it was known that
 8 people were coming in, they didn't have COVID --- I saw
 9 a presentation where they were able to state in numbers,
 10 although I don't recall those numbers particularly, the
 11 number of times where patients were contracting COVID
 12 from nurses or other healthcare staff, when patients
 13 were getting it from other patients or when nurses were
 14 getting it from patients. So it was sophisticated
 15 enough in the testing that it's quite clear, and in many
 16 of those areas it was areas where they had less PPE or
 17 less adequate PPE than others. So I have absolutely no
 18 doubt that there were nurses who contracted COVID at
 19 their work who would not have contracted COVID at their
 20 work or would have had certainly a significant less
 21 chance of contracting COVID at their work had they had
 22 higher levels of PPE.
 23 Q. I just ask you, at paragraph 45, we see that your
 24 Royal College raised concerns about the higher risks of
 25 COVID to ethnic minority population and that you say

1 that the Scottish Government acted upon this and
 2 developed a risk assessment tool which enabled those
 3 nurses to obtain additional PPE and also work in areas
 4 where the risk of contracting COVID was lower. Can you
 5 just tell us a little bit, what was that risk assessment
 6 tool?
 7 A. So initially there was international evidence that
 8 people from the BAME --- black and ethnic minority ---
 9 staff had less good outcomes if they got COVID and it
 10 wasn't known why. There was no understanding of why
 11 that was the case. But acknowledging that it was, we
 12 raised that with Scottish Government because there were
 13 various courses of action that they could take; for
 14 example, make sure that all staff that fell into that
 15 category were automatically given more PPE, the higher
 16 grade of PPE, if you like. They could have removed them
 17 to areas where it was known there were no patients with
 18 COVID, which would have reduced their risk.
 19 The risk assessment process largely, people who were
 20 older had less good outcomes, so having certain
 21 conditions or being from a black and ethnic minority
 22 background, the risk assessment added years to you. So
 23 if you were 30 years old and you were from an ethnic
 24 minority background, they would add X number of years
 25 and that would increase your chance of having a less

1 good outcome. So what it did in fact was it expanded
 2 people's risk by adding years to their biological age
 3 and said, "They would automatically be at more risk and
 4 therefore we will take these actions", ie give them
 5 additional PPE or remove them from working with COVID
 6 patients.

7 As it turns out, in the end, I believe the evidence
 8 showed that the reason that people from black and
 9 minority ethnic backgrounds had worse outcomes was
 10 largely because quite often they had more long-term
 11 conditions than others. It wasn't anything to do with
 12 (inaudible), it was the fact that they were predisposed
 13 because they had other physical reasons why they were
 14 more likely to be unwell.

15 Q. Thank you. You also speak positively about the
 16 Scottish Government acting quickly in relation to
 17 shielding at paragraph 46 of your statement and you say
 18 that the Scottish Government acted immediately and
 19 helpfully to assist nursing staff who were required to
 20 shield and ensure that they were not exposed to any
 21 financial detriment.

22 It appears to me --- and correct me if I'm wrong ---
 23 from reading your statement that there seems to be areas
 24 where the Scottish Government were acting swiftly and
 25 appropriately and then other areas, like PPE, which

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1 you've identified, that they weren't. Can you explain
 2 why they were listening to some of your concerns but not
 3 all of them? It might be that you can't.

4 A. No. What I would say is through the Workforce Senior
 5 Leadership Group --- if I was to be honest, I would make
 6 the comment that every single person that I came into
 7 contact with, either from a clinician, from a politician
 8 or from a civil servant, was trying to do the very best
 9 that they could, and the example that you give there
 10 about stuff through the Workforce Leadership Group, they
 11 did respond very quickly to things.

12 So the shielding --- for example, the health
 13 population is just like the general population. There
 14 are many people who work in health who have long-term
 15 conditions that fell into the exemption that was being
 16 done by GPs, who have said to people, "You shouldn't go
 17 to work". They were immediately removed from the
 18 workforce, advised to stay at home and were paid as if
 19 they were at work. So there was no financial detriment
 20 and therefore no pressure for them to continue to go to
 21 work, regardless of the fact that they were at a higher
 22 level. Those things were done very well. The one area,
 23 as I have already said, where I feel that we weren't
 24 listened to and with regret feel that we absolutely
 25 should have been listened to was about airborne virus.

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1 Q. I'm moving forward in your statement. We have starting
 2 at paragraph 54 the lessons to be learned. I don't
 3 think PPE or long COVID is specifically mentioned in
 4 those --- and again, with the benefit of hindsight but in
 5 terms of lessons to be learned, with PPE and long COVID,
 6 is there anything that you can assist the Inquiry with?

7 A. Yeah, without question. I think obviously learning from
 8 the pandemic and the purpose of this Inquiry, there is
 9 much that we did during the pandemic that had a positive
 10 impact without question and I think those things should
 11 just be adopted and rolled into a pandemic future plan.

12 Q. What are those things?

13 A. So things like securing supply of PPE quite quickly,
 14 identifying testing, categorising wards, so that you had
 15 green pathways with patients who are known not to have
 16 and red pathways that have, not swapping staff between
 17 clinical areas, certainly supplying everybody with the
 18 highest quality and quantity of PPE that you possibly
 19 can, are things that can certainly be learned from.
 20 Comments about patients that have been made in previous
 21 evidence about discharging people to care homes, for
 22 example. In hindsight I would think there is learning
 23 to be done there. Without question there will be people
 24 who were discharged from hospital who weren't tested who
 25 imported COVID into care homes, so I would suggest that

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1 not moving people to areas without knowing their
 2 infection status, there's learning from that that could
 3 be done as well.

4 Q. Thank you. Mr Provan, you've gone through my questions
 5 quicker than I'd anticipated, but before I thank you for
 6 your time today and obviously your comprehensive
 7 statement that you've provided to the Inquiry, is there
 8 anything else you would like to add that you think may
 9 be of assistance to the Inquiry and in particular his
 10 Lordship in the chair?

11 A. I think there is one area that we haven't touched on and
 12 that's in relation to workforce. In my statement, close
 13 to the beginning of it, I point out that the NHS has
 14 a whole-time equivalent staff that's supposed to be in
 15 place to provide services to people and, at the
 16 beginning of the pandemic, there were about 6,000 nurse
 17 vacancies in the NHS alone. So although the
 18 Scottish Government did what it could to try and
 19 encourage people to rejoin the workforce, at no time
 20 during the pandemic did the NHS have the number of
 21 nurses that would have been required if there was no
 22 pandemic on. So something that commits the
 23 Scottish Government to making sure that they do have the
 24 right numbers of people would be learning I think that
 25 would be crucially important.

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1 And also in terms of cross-sector. Places like care
 2 homes which don't have the infrastructure of the NHS
 3 were automatically at a disadvantage in the type of care
 4 that they were able to provide. So some collaboration
 5 between health boards in that sector would be good.
 6 And in terms of planning for the number of
 7 registered or regulated staff, doctors, nurses and AHPs,
 8 I think the Scottish Government should plan not just on
 9 the basis of the numbers of people who are required for
 10 the NHS, but in all the areas where care is provided,
 11 they should have a responsibility for making sure that
 12 we are training enough people.
 13 There have been things that have happened in the
 14 last couple of years that have had an impact on that so,
 15 for example, Brexit. We know that there used to be
 16 a healthy number of people that came from other European
 17 countries to work in the NHS in Scotland and other parts
 18 of the UK. From a nursing perspective, in the first
 19 year of Brexit, the number of European nurses attempting
 20 to join the UK register dropped by 95% and we have done
 21 nothing to domestically train more people to replace
 22 that. So I think workforce planning is an area that
 23 certainly requires to be looked at quite strongly.
 24 Q. Okay. You told us quite a lot there. Can I just pick
 25 up on one point? You said more collaboration between

1 care homes and hospitals. I wonder what you had in
 2 mind, what type of collaboration?
 3 A. Certainly issues in relation to education of nurses in
 4 care homes, infection control assistance. So when the
 5 pandemic happened, many of these nursing homes are
 6 stand-alone businesses with 40 employees, 50 employees
 7 maybe, they just don't have the infrastructure that the
 8 NHS has in terms of diagnostics, cleaning, infection
 9 control provision. So I think there could be better
 10 collaboration between health boards and the local
 11 authority in relation to the homes, care homes and
 12 nursing homes in their area, to import some of that
 13 expertise from the NHS into those environments.
 14 Q. That may be right. Would you accept though -- and
 15 I think we've heard evidence previously -- that there's
 16 a distinct difference between hospitals and care homes
 17 because a care home, that's the home of the resident,
 18 and there are differences insofar as there are photos of
 19 family up and certain things -- personal belongings,
 20 which perhaps make infection control easier in
 21 a hospital; is that a fair comment?
 22 A. Absolutely. Yes, hospitals are full of hard surfaces
 23 that are easy to clean; care homes are not. And
 24 I wouldn't suggest for a moment that we should change
 25 the environment of care homes or nursing homes to look

1 like hospitals because it is somebody's home, but they
 2 certainly don't have the same infection control
 3 expertise, for example, that a board will have. So
 4 there is no reason why boards couldn't come to
 5 arrangements to import some of that expertise into care
 6 homes. It just didn't have the capacity to get that at
 7 short notice when they were required in the pandemic.
 8 Q. Thank you. That's all very helpful and interesting.
 9 I will just take this opportunity to thank you for your
 10 time, your participation and the Royal College's
 11 participation as well and your own personal time
 12 commitment which you've given freely. Thank you.
 13 My Lord, I have no further questions for this
 14 witness.
 15 THE CHAIR: No. Thank you as well, Mr Provan. We're ahead
 16 of schedule because that was quicker than anticipated.
 17 No offence to Mr Dunlop and it's not your fault either,
 18 Mr Provan, obviously. I'm reasonably confident that the
 19 next witness is available because she's in court or in
 20 the tribunal hearing. I don't know if we can arrange --
 21 you're due to be heard at 1 o'clock -- no, 1.30.
 22 I imagine that, if you could be heard before then, it
 23 wouldn't inconvenience you and in fact might convenience
 24 you; is that a fair assumption on my part? Can I ask
 25 someone to check when we might hear you? You may have

1 to go and consult with Mr Gale because I understand
 2 Mr Gale is going to do the questioning.
 3 MR DUNLOP: Yes.
 4 THE CHAIR: I'll just wait here to see if we can get a time
 5 so that everyone knows what the situation is.
 6 Thank you, Mr Provan. There is no need for you to
 7 sit there.
 8 (Pause)
 9 12.30 then, ladies and gentlemen. Thank you all
 10 very much.
 11 (11.49 am)
 12 (The short adjournment)
 13 (12.30 pm)
 14 THE CHAIR: Good afternoon.
 15 Mr Gale.
 16 MR GALE: Thank you, my Lord. The next witness, my Lord,
 17 and final witness for today is Eileen McKenna. Her
 18 witness statement is SCI-WT0459-000001.
 19 MRS EILEEN MCKENNA (called)
 20 Questions by MR GALE
 21 MR GALE: Mrs McKenna, your full name, please?
 22 A. Eileen McKenna.
 23 Q. Your details are known to the Inquiry and you've
 24 provided us with a detailed statement and, together with
 25 the evidence that you will give orally today, you are

1 content that that be the evidence you provide to this
 2 Inquiry?
 3 A. I am.
 4 Q. I think you're also prepared that that evidence be
 5 recorded and transcribed?
 6 A. Yes.
 7 Q. Again, I'll make the point, Mrs McKenna, that there will
 8 be certain parts of your statement that I won't touch on
 9 in the course of this oral presentation this afternoon
 10 but please be assured, and your colleagues also, that
 11 all that will be taken into account.
 12 In your case there is actually — I'll give notice
 13 of it now — there is quite a large section dealing with
 14 education —
 15 A. Yes.
 16 Q. — and certification, which is something that falls
 17 within your ambit and we'll come to your role in
 18 a moment. If I can just tell you that, while it's
 19 a section which I and my team will have regard to in
 20 looking at impact, it is primarily an issue which falls
 21 within the ambit of the work being done by certain of my
 22 colleagues in the Inquiry and they will be dealing with
 23 education at all levels and they will be specifically
 24 considering the issues that you raise in the education
 25 section of your statement.

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1 A. Okay.
 2 Q. Now, you are the associate director for nursing policy
 3 and professional practice at the RCN; is that right?
 4 A. I am, yes.
 5 Q. And you tell us a bit about that post at paragraph 2 of
 6 your statement, which we can read, and you've been in
 7 that position since October 2018.
 8 A. I have, yes.
 9 Q. So it's a position you occupied during the whole of the
 10 pandemic?
 11 A. Yes.
 12 Q. You provided us also with details of your clinical
 13 experience at paragraphs 4 and 5 and, again, we can read
 14 what you say there and, at paragraph 6 and following,
 15 really, you talk about the role that you had as the
 16 representative of RCN Scotland from the early weeks of
 17 the pandemic.
 18 A. Yes.
 19 Q. Can you just explain that briefly, if you would?
 20 A. So mainly within the first weeks of the outbreak. So
 21 the RCN is a UK organisation but, because of the
 22 devolved nature of health, there are four countries, so
 23 Scotland, Northern Ireland, Wales and England. And at
 24 the outset of the pandemic senior staff from across the
 25 organisation came together and established

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1 a four-country senior group so we could look and address
 2 issues which members were encountering whilst working in
 3 hospitals, academic settings or social care settings.
 4 And our purpose was to monitor the emerging situation,
 5 the policies or the different policies across the UK and
 6 the guidelines that were being published and ensure that
 7 our members were provided with up-to-date evidence-based
 8 information.
 9 We also tracked and responded to issues that were
 10 raised by members through RCND and other means across
 11 the four countries, so we looked at trends and the
 12 themes that were coming out and sort of major issues
 13 that we needed to give support and advice to our members
 14 on.
 15 Q. Now, we've heard from Mr Poolman about some of those
 16 issues and you again have very helpfully listed them in
 17 paragraph 8 of your statement. Can I ask you about
 18 a couple of them, please?
 19 A. Yes.
 20 Q. Firstly, the section that is headed "Members at risk"
 21 and in particular those who are pregnant and had
 22 underlying health problems. Can you just give us
 23 a little more context to that, please?
 24 A. So at the outset of the pandemic it became clear that
 25 there were groups of the population that may be at

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1 a higher risk from COVID infections and the impact on
 2 their well-being, particularly pregnant mothers, so
 3 clearly, with nursing being a predominantly female
 4 population, there are many nurses who are pregnant and
 5 working during their pregnancy. So quite a number of
 6 our members were concerned about what was in the media
 7 around the impact on pregnant women. You know, the
 8 Government had said pregnant women should shield quite
 9 early on. So, in terms of the impact on them and their
 10 employment, I would say the majority of employers
 11 were — took cognisance of the risks and did allow
 12 pregnant members to shield, but some didn't and needed
 13 a bit of prompting to respond to the guidance. It was
 14 about, you know, if you are sick during a pregnancy, it
 15 can trigger early maternity leave and that can have
 16 financial implications, so it was making sure that they
 17 weren't financially disadvantaged as well as being
 18 protected by being allowed to shield.
 19 Q. And underlying health issues, I suppose that's
 20 self-explanatory?
 21 A. Yeah. You know, nurses who were diabetics or maybe had
 22 conditions that meant they were immunocompromised, so if
 23 they were on steroids for any underlying health
 24 condition, clearly that increased their risk of
 25 contracting COVID and having severe effects of COVID.

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1 Q. The second category of themes that I would like to ask
 2 you about are personal issues. This obviously is a bit
 3 of a catch—all, I suppose, isn't it?
 4 A. Yes. I mean, it is a catch—all, but, I mean,
 5 examples --- you know, travel issues, the guidance due to
 6 travel restrictions --- some members travelled a distance
 7 to get from home to work and because of the travel
 8 restrictions that meant that they potentially couldn't
 9 travel those distances. For example, staff working in
 10 the community would car-share to get to a patient's home
 11 and there was lots of issues about whether they should
 12 be car-sharing because they couldn't socially distance
 13 within a car. So there was lots of issues like that
 14 that we looked at and either lobbied the governments to
 15 clarify their guidance or give information to members.
 16 Q. So just to understand, RCN Direct was a platform where
 17 your members could express their concerns about various
 18 and possibly very specific issues ---
 19 A. Yes.
 20 Q. --- and obtain information?
 21 A. Yes. So RCN --- so we met daily at the outset of the
 22 pandemic, the senior group, and the senior member of
 23 staff from RCN Direct would come with a report on the
 24 previous day's calls. So we would compile themes and
 25 look at the types of issues that were being raised; were

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1 they particular to a certain geographical area or
 2 employer or were they generic themes across the UK or
 3 within the four countries of the UK individually. And
 4 then we would work to develop guidance or take action in
 5 terms of feeding back to our retrospective [sic]
 6 governments to get the guidance changed.
 7 Q. Would these have been matters upon which you, as
 8 a professional organisation, would offer advice to
 9 members or was it really a talking shop where you could
 10 take material to the persons who were responsible for
 11 formulating guidance and make representations to them?
 12 A. So it was both --- I wouldn't say we were a talking shop.
 13 It certainly didn't feel like that. So we would work to
 14 either --- like I brought the information back so ... We
 15 met from a UK perspective early in the morning, we
 16 reviewed the issues from the day before and then we
 17 would meet as a Scotland team and I would bring
 18 particular issues back that, say, my colleague,
 19 Norman Provan, would pick up from an employment
 20 relations perspective or I would pick up in terms of the
 21 guidance that staff were having to adhere to, and pick
 22 that up either through myself or through the then
 23 director of RCN Scotland at the time with
 24 Scottish Government or other stakeholders. But we did
 25 publish our own guidance as well. We would look at the

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1 evidence base and publish guidance for members.
 2 Q. Thank you. You were also a representative of the RCN on
 3 several Scottish Government groups which you list in
 4 paragraph 9.
 5 A. Hmm---hmm.
 6 Q. Can I ask you about CPAG, please?
 7 A. Yes.
 8 Q. Can you just tell us a little about that?
 9 A. So CPAG, the Clinical Professional Advisory Group, was
 10 a group that the Scottish Government established to
 11 respond to the many issues that were coming out from the
 12 care home sector. The group had wide representation
 13 from the care home sector and other stakeholders,
 14 including ourselves. It was a multi-professional group
 15 so it didn't just address nursing issues. There were
 16 medics on the group, AHPs and others.
 17 So it was to address many of the issues that were
 18 being raised by the care home sector, but I suppose the
 19 main function of it was to give that sector a voice and
 20 enable them to influence the Scottish Government around
 21 the guidance, et cetera, and the conditions within care
 22 homes, whether they were the conditions for residents.
 23 So there was lots of consideration around the guidance,
 24 around visiting, for example. It wasn't
 25 a decision-making body. It was a body that the

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1 stakeholders could give --- could have their input and
 2 influence some of the decisions that were being made.
 3 Q. You say it wasn't a decision-making body. What was its
 4 substantive function?
 5 A. Influencing, so influencing decisions.
 6 Q. Because I think one of the points you've made and your
 7 colleagues have also made is that while you, as
 8 a professional organisation, had a place on many of
 9 these committees and groups, you at no stage had a right
 10 of veto.
 11 A. No.
 12 Q. Is that right?
 13 A. No.
 14 Q. So to a certain extent, influencing was probably the
 15 heightened tool that you had available to you?
 16 A. Yes.
 17 Q. Can I move on to consider with you the impact on your
 18 members of the pandemic and particularly the pandemic
 19 planning carried out by the Scottish Government. In
 20 this context, you in your statement look specifically at
 21 staffing levels ---
 22 A. Yes.
 23 Q. --- at the outset of the pandemic. If one goes to
 24 paragraph 14, you say that those within the nursing
 25 profession have and continue to work "under sustained,

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1 heightened pressure" and:
 2 "This [has] a significant impact on the physical and
 3 mental health of nurses and [this has] a collateral
 4 effect on the quality of care being delivered ..."
 5 A. Absolutely, yes.
 6 Q. Can you explain that, please?
 7 A. So there I'm saying there has been concern for a number
 8 of years around the levels of nurse staffing, both
 9 within the NHS and within the care home sector. We --
 10 I have to say from the outset that Scotland is in
 11 a unique position in terms of the data that is publicly
 12 available through -- around the NHS workforce and we do
 13 use that data significantly to lobby and influence
 14 Scottish Government on workforce issues. However,
 15 I think the data highlighted pre-pandemic there were
 16 concerns around the number of vacancies, vacant posts --
 17 nursing vacant posts across Scotland, and prior to
 18 entering into the pandemic there was a growing crisis in
 19 the nursing workforce. If nurses cannot provide the
 20 care because of staffing levels, et cetera, that they
 21 feel or know that the patients require, that can have
 22 a detrimental impact on their own well-being in terms of
 23 that sort of moral injury, moral distress, because they
 24 know that they're not delivering care to the standard
 25 that is required.

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1 Q. And to the standard that they would wish to do?
 2 A. Absolutely, yes.
 3 Q. Yes. Perhaps you summarise it in the last two
 4 sentences, where you say, "Put shortly ...". Perhaps
 5 you could just read those two sentences, please,
 6 paragraph 14.
 7 A. "Put shortly, there are simply not enough nursing staff
 8 to provide the level of care that our population needs
 9 now, or indeed, before and during the pandemic. The
 10 impact this is having on our members is a situation that
 11 RCN Scotland has been gravely concerned about for some
 12 time -- and well before the pandemic hit."
 13 Q. So it's a pre-existing problem?
 14 A. Yes, not only -- I need to emphasise it's not only in
 15 the NHS. Prior to the pandemic, the RCN in Scotland was
 16 lobbying the Scottish Government and other stakeholders
 17 to value registered nurses within the care home sector.
 18 The number of registered nurses within the care home
 19 sector had been declining prior to the pandemic, and
 20 through work that we did in around about -- well, work
 21 we did in 2018 highlighted some concerning nurse to
 22 resident -- and I'm talking about registered nurse to
 23 resident -- ratios. Sometimes registered nurses could
 24 be the only nurse within a care home for -- I think the
 25 worst case I'd heard of was 120 residents.

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1 Q. Right. So this was an across-the-board problem?
 2 A. Absolutely, yes.
 3 Q. Now, you've provided us with information and very
 4 helpfully given us the various data sources for that
 5 information in paragraphs 15 and following of your
 6 statement and clearly this is something that we will be
 7 looking at. This has informed you, as I understand it,
 8 as to the adequacy of staffing both within the NHS and
 9 in the social care sector --
 10 A. Yes.
 11 Q. -- so could you just perhaps summarise your conclusions,
 12 having looked at this data?
 13 A. So this paragraph looks at data between December 2015
 14 and December 2019 which did show that, within the NHS,
 15 the nursing workforce did grow by 2.7%, so from circa
 16 41,000 to over 42,000 whole-time-equivalent staff.
 17 However, the upward trend was also reflected in the
 18 number of vacancies and the vacancy rate continued to
 19 rise steadily, including long-term vacancies, so posts
 20 that were not filled for three months or longer. And at
 21 that time the planned establishment, ie the number of
 22 staff required to meet the clinical activity across the
 23 NHS, was actually never achieved, with vacancies rising
 24 from 1,600 to 2,600 over that time period, and that was
 25 NHS data alone. The care home sector data, as I say,

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1 it's not as robust as the NHS data but it did
 2 demonstrate that over that period of time there were 380
 3 fewer registered nurses in care homes for adults.
 4 Q. Well, perhaps -- it obviously follows from what you've
 5 said that the pandemic did not serve to cause that
 6 deficiency in staff; is that right?
 7 A. No, but it's probably made it worse. But, yes, the
 8 deficiency was there.
 9 Q. Was there.
 10 A. Hmm--hmm.
 11 Q. Yes. Now at paragraph 17 you tell us about a survey
 12 that the RCN carried out.
 13 A. Yes.
 14 Q. And what were the results of that?
 15 A. So the RCN carries out a survey regularly, annually, and
 16 so November 2019 we published a report that highlighted
 17 that members across Scotland, whether they work in the
 18 NHS, GP practices or care homes, were feeling overworked
 19 and under-resourced and undervalued. So two-thirds
 20 reported they were too busy to provide the level of care
 21 that they considered necessary and they didn't feel that
 22 their contribution was valued by those in a position of
 23 power. I would say lack of being valued is a recurring
 24 theme from feedback from our members, and that's
 25 deteriorated during and after the pandemic.

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1 Q. When you say "not being valued" and you attribute that
2 to "those in positions of power", who is that directed
3 against?
4 A. So that was directed at the governments of the UK.
5 I think one of the key themes that comes out from
6 feedback from our members is that nursing as
7 a profession doesn't necessarily get the same
8 recognition of the critical safety nature that
9 registered nurses provide. There is international
10 evidence that registered nurses, if they're in the right
11 number with the right skills, impact significantly not
12 only on the quality of care but they reduce mortality
13 and morbidity, and if those numbers are insufficient,
14 that clearly has the opposite effect on not only quality
15 of care but mortality and morbidity.
16 Q. Right. Throughout this part of your statement you
17 punctuate what you have to say with quotations from
18 various sources. Can you tell me where they came from?
19 A. So some have come from our surveys in terms of the free
20 text that the nurses have chosen to enter into the
21 survey. The majority of the quotes within my statement
22 come from a system called "SenseMaker".
23 Q. Yes.
24 A. And we started collecting that data, so that captures
25 the lived experience of nurses over time, so both

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1 qualitative and quantitative data. So we started
2 at October 2020/November 2020.
3 Q. And are these quotes intended to demonstrate typical
4 responses from some of your members?
5 A. Yes. So I analysed the data from our Scottish members
6 and, in fact, up until last year, it was only
7 RCN Scotland and RCN Northern Ireland that were using
8 the system. So I would say I read every story that
9 nurses have entered into that system and I've taken
10 themes — the key themes and used individual stories to
11 illustrate the points.
12 Q. You tell us in paragraph 17 that almost two-thirds
13 reported that they were too busy to provide the level of
14 care that they considered necessary.
15 A. Prior to the pandemic, yes.
16 Q. Prior to the pandemic. How robust do you think that is
17 as a comment on the Health Service at that time?
18 A. I think it's fairly robust. In terms of — our
19 membership is significant. I think my colleague,
20 Mr Poolman, highlighted the size of our membership.
21 We're the biggest nursing-only organisation in Europe —
22 I'm looking to my colleagues to confirm that — so in
23 terms of the size of our responses to surveys, they're
24 significant and fairly representative of how nurses view
25 their working environment across the UK.

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1 Q. Would you read the quote at the bottom of paragraph 17,
2 please?
3 A. Yes, so:
4 "The most upsetting and stressful part of my job is
5 being unable to give good patient care due to poor
6 staffing levels ... and unfortunately it has become
7 'normal' to work under this constant stress. Never have
8 I felt pressure like this in my career and have never
9 felt so undervalued."
10 So that was from a band 5 nurse in a hospital in
11 Scotland pre-pandemic.
12 Q. Now, there's also, as you point out, a rise in
13 registered nurses as staff delayed retirement or
14 returned to work. I think you indicate that that, on
15 the one hand, had a positive aspect to it in that they
16 felt that they were, as you put it, doing their bit, but
17 also a downside, where they felt that their skills were
18 not being appreciated.
19 A. Yes.
20 Q. Can you explain that latter, the downside, rather than
21 the upside?
22 A. So as an organisation we set up — when the call went
23 out for nurses to consider coming back to work, they did
24 respond across the UK in their thousands, so we knew
25 from our members that there was varied experiences. So

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1 we set up a network to engage with nurses returning and,
2 as I say, the feedback was mixed. But in many cases,
3 you know, nurses returned to maybe clinical areas that
4 they had recently left, and I think the example I give
5 in my statement is a nurse, who was a band 6 or a charge
6 nurse level, had recently retired from a clinical area
7 and volunteered to return weeks after leaving for her
8 retirement and was interviewed for the post and then
9 placed on the bottom of the band 5 salary, but clearly
10 was coming back to work with the skills that they'd had
11 prior to retirement and was expected to work at the same
12 level as they did prior to retiring.
13 Q. Obviously the need of staff to self-isolate exacerbated
14 the problem, as you point out.
15 A. Yes.
16 Q. One of the points that both you and your colleague
17 Mr Poolman made is the question of situations where
18 staff were redeployed into roles that perhaps were not
19 familiar to them.
20 A. Yes.
21 Q. Do you have a comment on that?
22 A. So I think, in terms of planning for the impact of COVID
23 on hospitals, the acute hospitals primarily, staff were
24 not only redeployed. So a number of staff — there was
25 a need to increase the intensive care capacity and, in

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1 order to increase intensive care capacity, you need to
 2 increase the number of staff that clearly work in
 3 intensive care settings. So, for example, intensive
 4 care — so my own — I am an intensive care nurse by
 5 background and did an additional year's training and
 6 education to work within that environment and it's
 7 different knowledge and skills that are required from,
 8 say, an acute medical or an acute surgical ward. It's
 9 a completely different set of skills that are required.
 10 And to move people quickly into that environment ... and
 11 I'd have to say, even the staff who worked in intensive
 12 care — you know, I worked there for well over ten
 13 years — I never experienced anything like the staff who
 14 worked in ICU during the pandemic. This was a new
 15 illness and it had, you know, a significant mortality
 16 rate at the outset of the pandemic so the conditions
 17 that they were working in were extremely stressful. And
 18 for staff to move into that environment, not having the
 19 benefit of years of experience of working within
 20 intensive care, was clearly very, very stressful.
 21 So normally nurses in ICU would look after one
 22 patient and they would have a senior nurse and medical
 23 staff supporting them with that one patient, so
 24 somebody — a nurse at a much more senior level with
 25 advanced skills would be there to support them. We knew

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1 that, during the pandemic, one ICU nurse could have
 2 responsibility for four patients and to supervise
 3 non-ICU nurses or even other healthcare professionals,
 4 like some medics were redeployed to ICU to work in
 5 a nursing capacity or AHPs were redeployed. So the
 6 pressure on the ICU nurses was immense as well as those
 7 that had been redeployed into that area.
 8 But for nurses in other areas, wards were changed
 9 from, say, medicine for the elderly to COVID wards, and
 10 that's a completely different set of skills. Surgical
 11 wards were changed into medical wards. There was
 12 a complete redesign of services, and not just in acute
 13 hospitals. Even nurses who cared for, as I say,
 14 patients with learning disabilities in an outpatient
 15 setting, that had to change. They had to meet the needs
 16 of those patients in a different way because of —
 17 clearly those with learning disabilities were shielding,
 18 so they had to deliver services in a completely
 19 different way than was the norm.
 20 Q. I suppose one might say that in some, if not all, of
 21 those situations it was a case of needs must?
 22 A. Yes. Yes.
 23 Q. But while needs must, was there, you say, a detrimental
 24 effect on the well-being of the nurses who were having
 25 to do that?

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1 A. Yes.
 2 Q. But also was there, in your view, any detrimental effect
 3 on patient care?
 4 A. I think undoubtedly, yes, in terms of you need a level
 5 of expertise, and staff were maybe not working within
 6 their own level — their own expertise. They were being
 7 redeployed or working with a different client group than
 8 would be their norm.
 9 Q. One of the points you make — and I think it's possibly
 10 one that is perhaps or has been perhaps slightly
 11 underplayed — is the level of aggression and violence
 12 that was demonstrated towards nurses. Is that fair to
 13 say? Is it something that's been underplayed —
 14 A. Yes, it was something that nurses reported increasingly
 15 as the pandemic went on in terms of the level of
 16 violence and aggression that was — that they were
 17 experiencing. I think, you know, we need to recognise
 18 that people were frustrated, anxious, if they had
 19 a family member within a hospital that they weren't
 20 allowed to visit or within a care home that they weren't
 21 allowed to visit, but nurses didn't make that guidance,
 22 they didn't make those decisions, but were often at the
 23 receiving end of those frustrations.
 24 Q. I think you've given two quotations from nurses —
 25 A. Yes.

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1 Q. — in relation to that. We can read those.
 2 Would you go to paragraph 29, please, of your
 3 statement, which I think is effectively a conclusion in
 4 this part of your statement. Would you just read it
 5 out?
 6 A. So — sorry, is it the quotation or ...?
 7 Q. No, just the text from figure 29 onwards.
 8 A. "The impact of the Government's pandemic planning on
 9 RCN Scotland's members cannot be understated. The above
 10 illustrates the demands felt on RCN members throughout
 11 the pandemic which were exacerbated by a depleted and
 12 overworked workforce. It is imperative that the
 13 Scottish Government considers a structured approach to
 14 workforce planning that ensures we have the right number
 15 of registered nurses and nursing support staff with the
 16 right knowledge, skills and experience in the right
 17 place at the right time should we ever be faced with
 18 a future pandemic."
 19 Q. That's obviously your considered view from your
 20 perspective and on behalf of the RCN?
 21 A. Yes.
 22 Q. Do you have any reason to depart from that?
 23 A. None whatsoever.
 24 Q. Thank you. Can I now ask you to go to paragraphs 35
 25 and 36 of your statement, please, in relation to PPE?

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1 You set out the guidance on PPE that was issued by the
2 Scottish Government in March 2020, and what you indicate
3 is that this is guidance that the RCN strongly disagreed
4 with. Can you take us through that disagreement and the
5 eventual resolution, if there was one, of it?

6 A. So at the beginning of March 2020, the guidance for PPE
7 was that in any setting where there was a suspected or
8 confirmed case of COVID-19, that the PPE that should be
9 worn by staff was an FFP3 mask, long-sleeved
10 fluid-resistant disposable surgical gown, two pairs of
11 sterile gloves and eye and face protection. That
12 changed in the middle of March 2020 to a table that set
13 out different PPE requirements for different settings.

14 So, for example, ICU areas, it was the full PPE as
15 described, but in non-critical hotspot areas the PPE was
16 a fluid-resistant surgical mask, disposable plastic
17 apron and disposable gloves, required when working in
18 a room or a cohort area with suspected or confirmed
19 cases of COVID-19. If not in direct contact, ie within
20 2 metres of a confirmed or suspected case, then no PPE
21 was required.

22 So there was the situation where you could have
23 a bay of six patients and there was yellow tape put at
24 the end of the bay, and the nurses on one side of that
25 tape did not have to wear any PPE and on the other side

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1 of that type were required to wear a fluid-resistant
2 surgical mask, plastic apron, and they only wore the
3 face visors if there was a risk of splashing from bodily
4 fluids.

5 Our contention at the time of that change was that
6 was insufficient protection for the staff working within
7 clinical environments. The guidance was changed
8 frequently and it did eventually change, you know,
9 within a hospital or care setting or for community staff
10 going out to people's homes, that they needed to wear
11 a fluid-resistant surgical mask at all times.

12 Our contention was that the guidance was based on
13 the belief that COVID-19 was droplet -- transmitted by
14 droplets, where the RCN has always considered that the
15 science around that was not proven to begin with and
16 therefore, in terms of the balance of risk, it should be
17 considered airborne and, as you heard this morning, the
18 RCN was part of an alliance, a coalition, that looked at
19 the international evidence and our contention that
20 COVID-19 is aerosol -- airborne --

21 Q. Airborne.

22 A. -- was -- has been proved correct.

23 We also -- there was lots of research studies coming
24 out from countries across the world, even prior to
25 pandemic hitting the UK, and if you look at comparisons,

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1 the actual infection rate for hospital workers was
2 reduced in countries that took a more precautionary
3 approach to PPE and respiratory protective equipment, ie
4 FFP3 masks, than, say, the infection rate within the UK.

5 If you look at the comparison between -- even in the
6 UK, those that were working in critical care areas had
7 no higher than the general population's incidence of
8 COVID-19 but those who worked in other clinical areas
9 had a higher incidence than the general population of
10 COVID-19 infections.

11 Q. You say that there was a disagreement between you and
12 the Scottish Government and the Scottish Government
13 persisted for some time in basing its PPE guidance on
14 the contention that COVID was droplet-transmitted.

15 A. Yes, droplet.

16 Q. Was that an area of particular frustration to the RCN?

17 A. Yes. So not only was there the reliance on the
18 assumption it was droplet transmission but also the
19 hierarchy of infection control, so the five different
20 levels. So that you could reduce risk by ventilation,
21 social distancing. Social distancing doesn't work for
22 nursing staff. They cannot socially distance from their
23 patients or residents. And we also contested the
24 efficacy or efficiency of ventilation systems in many of
25 the institutions that nurses had to work in. You know,

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1 people's homes, for example, you can't rely on the air
2 exchanges being adequate, and in many of the hospital
3 and care home settings clearly that was still an issue.

4 Q. Did you ascertain any particular reason why
5 Scottish Government was wedded to the idea of droplet
6 transmission?

7 A. They said from their own literature reviews and their
8 reviews of the evidence that it was droplet
9 transmission. As my colleague said this morning, the
10 RCN carried out its own literature reviews and engaged
11 with experts, not only in the UK but across the world,
12 and reviewed literature, et cetera, and contested that
13 view almost from the onset.

14 Q. When you were arguing for, I suppose, a basis for PPE
15 based on airborne transmission in discussion with
16 Scottish Government and in the various groups in which
17 you were engaged, were you a lone voice on that?

18 A. No. No.

19 Q. Can you indicate, without naming anybody, who else was
20 of a similar view?

21 A. The other royal colleges -- the medical royal colleges,
22 the BMA, for example. There were other scientists who
23 contested that view. So, yeah -- and we contested the
24 view around carrying out CPR, for example, and we
25 contested their definition of "aerosol-generating

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1 procedures", which was another trigger for higher levels
2 of PPE if you were carrying out an aerosol-generating
3 procedure. Ourselves and other organisations wrote to
4 Scottish Government to say that, in terms of carrying
5 out CPR, we considered that an aerosol-generating
6 procedure and staff should be given full PPE.

7 Staff were expected to carry out CPR with surgical
8 masks on up until the point of intubation. Intubation
9 is considered by the Scottish Government as an
10 aerosol-generating procedure, therefore they would need
11 to wear FFP3 masks and full PPE for that. But, you
12 know, you can carry out CPR for a length of time before
13 the anaesthetist arrives to intubate and, if you're
14 carrying out chest compressions, you're pretty close to
15 somebody's face.

16 Q. Could you understand the basis of having full PPE at the
17 point of intubation but not at the point of carrying out
18 cardiac pulmonary resuscitation?

19 A. No.

20 Q. You also make reference in paragraph 36 to the RCN
21 developing its own COVID-19 risk assessment resource.

22 A. Yes.

23 Q. What was that?

24 A. So the RCN worked with other stakeholders and we
25 developed our own risk assessment. It's online, so it

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1 was to enable our members to be able to access what we
2 considered the evidence base and their rights in terms
3 of health and safety legislation, et cetera, in asking
4 their organisations to complete risk assessments in
5 terms of the level of PPE that was required, and that
6 included things like ventilation changes. We did get
7 a commitment from the Scottish Government that they
8 would instruct employers to carry out risk assessments
9 and make them freely available to staff within the
10 clinical areas and to date I've not heard one nurse say
11 that those risk assessments were made available to them.

12 Q. What's your view on that?

13 A. I think if you're making an assumption that ventilation
14 is adequate and that reduces the risk, if you're using
15 ventilation within your hierarchy of controls and saying
16 that PPE is at the bottom of that hierarchy of control,
17 that other methods are more effective, you have a duty
18 to ensure those other methods were actually functioning
19 and effective.

20 Q. You move on to consider the situation of transfer of
21 residents or patients into or from care homes. You look
22 at this at paragraphs 39 and following. Mr Poolman has
23 already said that the RCN wasn't involved in the
24 decisions on that, in the sense of the strategic
25 decisions taken; not, obviously, the individual clinical

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1 decisions taken. The one thing that you do say at
2 paragraph 39 is that you recognise the detrimental
3 effect that restrictions on visiting had on residents
4 and their families, particularly when they were
5 suffering from dementia. That is obviously an area that
6 this Inquiry has heard so far a considerable amount of
7 evidence about. Was that something that would have been
8 obvious to you at the outset of the pandemic?

9 A. I think anybody who's worked clinically with individuals
10 and their families, you know, individuals with dementia
11 or learning disabilities, recognised the need for those
12 connections in terms of their well-being and in terms of
13 their human rights, I suppose, and if that wasn't able
14 to happen, that it was going to have a detrimental
15 effect.

16 Elderly people can deteriorate quite quickly in
17 terms of their physical and mental well-being, and
18 I think, for the residents in care homes, not having
19 that contact was clearly detrimental. But equally, for
20 elderly people who were then shielding at home as well,
21 in terms of their physical and mental well-being, the
22 fact that their connections were severed would have
23 a detrimental impact in terms of the level of frailty,
24 et cetera.

25 Q. Do you see a way round that problem, possibly through

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1 enhanced infection control procedures?

2 A. I think there was learning throughout the pandemic and
3 one of the main functions of CPAG that we touched on
4 earlier was getting that feedback from staff who had
5 expertise and experience of working within care homes,
6 who — I have to say my experience on CPAG is those
7 staff really advocated for their residents and their
8 families in terms of trying to influence the guidance
9 and take a more — a different approach to visiting. It
10 took some time for visiting restrictions to be lifted or
11 eased and different approaches were put in place by care
12 homes, like, you know, in the summer months, trying to
13 enable visiting outside, socially distanced, et cetera.
14 So they did try and address that.

15 It was balancing risk really, the risk of being
16 socially isolated, not being able to see your relatives
17 and maintain those connections to the risk of
18 introducing an infection. As I say, CPAG was not
19 decision-making but it was there to influence the
20 guidance and the cases were well made from the sector.

21 Q. Can I ask you for a personal opinion? Did you find that
22 influence or what was being said at that stage
23 compelling?

24 A. Yes. I don't think you can shy away from there were
25 difficult decisions to make and — absolutely difficult

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1 decisions .
 2 Q. I suppose one of the elements that one has to factor
 3 into that decision is that, if you have family members
 4 who are anxious to see their relative who may have
 5 dementia or may be at end of life and if you want to be
 6 able to get that person into a close environment with
 7 the resident or the patient, I suppose you have to have
 8 a degree of trust in the willingness of that relative or
 9 friend, whoever it may be, to do what is necessary to
 10 achieve that.
 11 A. Yes.
 12 Q. Do you think that would be a reasonable request to make
 13 of somebody in that situation?
 14 A. Yes. Yeah, I think everybody made decisions and looked
 15 to see how they could minimise the impact on, say, their
 16 elderly relatives, so I would say it would be no
 17 different for those whose relatives were within care
 18 homes. You would do your best to protect them.
 19 Q. Can I take you to paragraph 42, please, of your
 20 statement? Could you just read that out, please, and
 21 then expand on it a little, if you could.
 22 A. Yes, so:
 23 "The problems care homes have faced during the
 24 crisis have, in many respects, been symptoms of how the
 25 sector and the people that live and work in it have been

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1 undervalued by society for far too long."
 2 So I said earlier that the RCN had campaigned for
 3 a long time prior to the pandemic to highlight the
 4 issues within the care home sector in terms of funding,
 5 staffing, skill mix. So there are two types of care
 6 homes. There are care homes with nursing and care homes
 7 without nursing. So social carers would provide the
 8 care within care homes without nursing; care homes with
 9 nursing have to provide at least one registered nurse
 10 and the reason they're a care home with nursing is that
 11 the residents have higher clinical need.
 12 Our premise was that that clinical need was
 13 increasing over time, but in terms of the value that
 14 registered nurses could bring to that sector, were
 15 undervalued for whatever reason. I think there is
 16 a systemic undervaluing of nursing knowledge and
 17 expertise, but particularly within that sector in terms
 18 of the clinical nursing expertise that is required.
 19 Q. Has the pandemic done anything to increase that regard
 20 that may be had for that sector?
 21 A. I don't think so. I think the sector is still facing
 22 the same issues. The number of registered nurses within
 23 the sector continues to decrease and the feedback from
 24 our members who work in that sector continues to be that
 25 they work under significant pressure.

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1 Q. Now, you give voice to a care manager — a nurse manager
 2 in a care home at the bottom of page 43. It seems to me
 3 that that is quite a significant quotation. I'm sorry,
 4 it's a slight long one, but I wonder if you'd read it
 5 out for us please.
 6 A. Yeah, so:
 7 "My last week of nursing has been really challenging
 8 for me. I feel that as a clinical lead and deputy
 9 manager that I have the skills and experience to carry
 10 out my job well. However, the last week threw me
 11 a curve ball and even though I did everything I could
 12 possibly do to rectify the situation, it was unresolved
 13 and left me feeling rather hopeless and frustrated. It
 14 is very clear to me that there is still a blame culture
 15 towards care homes and this needs to change. It made
 16 [me] question myself and why I actually do this job.
 17 It's thankless! The reality is I make a difference in
 18 people's lives every day, sometimes I have to dig deep
 19 to remind myself of that. My background is A&E, high
 20 dependency, acute medicine and cardiac arrest team lead
 21 and it's through this experience that I am able to do my
 22 role now. I use my clinical decision skills on a daily
 23 basis, I don't have a full ward of doctors to ask or
 24 5 other nurses or nurse practitioners. I am expected to
 25 know everything about 55 residents and manage their

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1 conditions as well as holistic care for not only
 2 residents but relatives. Yet I am treated as if I am
 3 'just a care home nurse', 'can you manage a catheter?',
 4 'will you manage to take a cannula out?'. I am the
 5 equivalent of a band 7 in a hospital setting but often
 6 treated as a student nurse."
 7 Q. Right. As I indicated, the section on education and
 8 certification we're going to take as read and some of my
 9 colleagues will look at that separately, but, with that,
 10 could we go to your lessons to be learned? Again, these
 11 probably reflect much of what you've already said to us,
 12 but perhaps if you could just take us through what you
 13 think are the lessons that, from your perspective, need
 14 to be learned.
 15 A. So I think one of the lessons to be learned is to
 16 recognise and value the contribution that nurses make to
 17 the outcomes within health and social care and not
 18 undervalue nursing knowledge and expertise and, as
 19 I say, you know, the impact — the safety critical
 20 nature of nurses and registered nurses and not dilute
 21 skill mix to a detrimental level.
 22 We need a structured approach to workforce planning
 23 that ensures that we have the right number of registered
 24 nurses and support staff, who do contribute
 25 significantly but do not replace registered nurses. It

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1 would be a failure if we don't learn the difficult
 2 lessons of the pandemic and tackle head-on the issues
 3 which have been in place for many years and probably in
 4 the "Too hard to do" box. I think staffing decisions
 5 need to be driven by need and outcomes rather than
 6 finance. I suppose that's a purely controversial thing
 7 to say, but I think often staffing levels are driven by
 8 finance and not actually clinical need.
 9 Q. Right. You say perhaps -- I'm not sure whether you
 10 quoted it, but in paragraph 62 you say -- and it's in
 11 block:
 12 "However, it is clear that in order for Scotland to
 13 be ready for the next pandemic, and for [the]
 14 detrimental impacts to be minimised the greatest lesson
 15 to be learned is to ensure that there is a suitable
 16 health and social care workforce in place."
 17 A. Absolutely.
 18 Q. That's in terms of numbers and skills?
 19 A. In terms of numbers and skills.
 20 Q. Yes. Right. Mrs McKenna, that's all I wish to ask you.
 21 I offer you the opportunity, if there's anything you
 22 would like to add to what you've said, please do so.
 23 A. I would just like to reiterate my colleagues'
 24 expressions of condolences to the families of those that
 25 were bereaved and impacted on by COVID-19, in terms of

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1 the families and for the nursing and other healthcare
 2 staff who were negatively impacted.
 3 Q. Yes. That includes nurses and healthcare staff who
 4 died?
 5 A. Absolutely, yes.
 6 MR GALE: Thank you very much, Mrs McKenna.
 7 Thank you, my Lord.
 8 THE CHAIR: Yes, thank you very much, Mrs McKenna. I can
 9 infer from what is said we may see you again. I'm sorry
 10 if we do have to!
 11 A. (Inaudible).
 12 MR GALE: I think you may.
 13 A. Thank you.
 14 THE CHAIR: Thank you all. That's all for today. I'm very
 15 grateful to everyone for allowing us to go as quickly as
 16 we did. 9.45 tomorrow morning, I think. Very good.
 17 (1.32 pm)
 18 (The hearing adjourned until
 19 Thursday, 21 March 2024 at 9.45 am)
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