OPUS 2

Scottish Covid-19 Inquiry

Day 27

March 20, 2024

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(9.44 am)

THE CHAIR: Good morning, Mr Poolman. Good morning, Mr Gale.

MR GALE: Good morning, my Lord.

THE CHAIR: One minute, please, I haven't been provided with my notebook. (Pause)

That's a most unusual mistake, I'm sorry.

(Pause)

Thank you very much indeed. My apologies to you both.

MR GALE: My Lord, we have three witnesses today. They are all office-holders of the Royal College of Nursing. The first of the witnesses is James Colin Poolman, whose witness statement is SCI-WT0497-000001.

MR JAMES COLIN POOLMAN (called)

Questions by MR GALE

MR GALE: Mr Poolman, your full name is James Colin Poolman, I think.

A. That's correct.

Q. And your details are known to the Inquiry. You provided a statement with the reference I've just given and you are content that that statement, as amplified by the evidence you're about to give today, will constitute the material you wish to place before the Inquiry?

A. I am.

Q. You provide this evidence as the director of the RCN Scotland?

A. I do.

Q. I'll use the abbreviation "RCN". I think we all use it. I'm sure you do.

A. Yes.

Q. Before we go into any detail, there's something that you have provided me with prior notice of. I think there is something you would like to publicly say before you give your evidence to the Inquiry.

A. I would and I thank you for the opportunity in doing so. I think it's important for myself personally and on behalf of the Royal College of Nursing Scotland to offer our condolences and our heartfelt thoughts to everyone who has lost loved ones during the pandemic. Of course we will never forget the sacrifice of front-line workers, including those in nursing, across health and social care who passed away as a result of the pandemic, selfless individuals who, in our view, were just trying to do their best for their patients and paid the ultimate sacrifice. We also have many others who contracted COVID in their workplaces who have gone on to suffer long COVID and continue to experience debilitating effects of illness, and we must ensure we

support them as we go forward.

Of course the Inquiry will do its job and you'll learn from the pandemic, but we all in society owe a debt of gratitude and must never forget the dedication shown by thousands of health and social care workers to their patients and their professions and the impact that the experience has had on them.

Thank you for giving me that opportunity.

Q. Thank you. Now, just a few preliminaries, Mr Poolman. Firstly, your statement is relatively brief, but within it it's quite detailed, and I do want to make the point that, if there are parts of your statement that we don't touch on in the course of your oral evidence today, that does not mean that those parts of the statement are ignored. The whole of your statement will be considered and taken account of by the Inquiry team, analysed and utilised, so please be assured of that.

Secondly, we do have a general restriction order in place which prevents the naming of other people. So I don't think there's a great deal of difficulty, having looked at your statement, because the only other people you name are in fact the two other witnesses who will be giving evidence today, and that's fine. You can name them. I think also you may have named some politicians. So, beyond that, please don't name other people you may

have had conversations with or something like that. If you do, it doesn't make a great deal of difference. We'll just have to stop proceedings. But if you can just be mindful of that.

Now, you're authorised, I understand, to give this evidence about the RCN's views on the impacts of the strategic decisions made by Scottish Government in respect of health and social care; is that right?

A. That's correct.

Q. And your colleagues, Norman Provan and Eileen McKenna, will expand on certain areas. We will hear from them later today. But there will inevitably be certain overlap between some of the things that you'll be talking about and things that they may be talking about but in greater detail.

A. Indeed.

Q. Some personal information first of all if, we may. You provide your career history in paragraphs 4 and 5, from which we can see that you took up the post of director of the RCN in Scotland in September 2021. You took it up initially on an interim basis?

A. That's correct.

Q. And your appointment was made permanent in September 2022?

A. That's correct.

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

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

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

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

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

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

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

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

being redeployed, presumably at short notice, to situations that were not within their usual area of expertise or comfort?

A. To set into context, prior to the pandemic there was significant issues with the nursing workforce —— across health and social care, there was significant vacancies. That in itself contributed to the requirement, as the pandemic developed —— the requirement for staff to work in specific areas, for example, ICU, and that required many staff to be redeployed because of the need, because of how things were developing, but of course they required a period of time of adjustment because not all individuals that were moved obviously had the recent experience of working in these areas, and that in itself was difficult for the staff. Although they were given support and education to allow them to go into these areas, it was extremely difficult because they were being asked to move in areas that, to be quite frankly, wouldn't have been their area of choice to work in, but they were moved from all types of areas. Part of that was because we didn't have a sufficient workforce.

Q. That's something that your colleague Mrs McKenna will deal with in a little bit more detail ——

A. She will.

Q. —— about the deficiencies in the numbers of the nursing

workforce which was pre—existing the pandemic.

Could I just take you a little further on that, if I may. The idea of a nurse with a specialised training being —— or possibly not having a specialised training, and being deployed into an area which one would normally expect there to be specialised training, does the RCN —— I suppose put it this way —— accept that as a necessity or do you disapprove of it?

A. Well, I think the issue is that people shouldn't be put in places they don't have the competence to work in, and of course nurses have a general level of education for qualifying and then their experience is built on that, but, as you move in to areas, there is additional training that requires to be given and people need time to acclimatise and get used to working in these areas and to build up the knowledge and expertise to be proficient, and of course we would always suggest that people should be given the time and induction and the support to do that when they move to a new area. But because of the necessity, as you say, of the pandemic, that had to happen really quickly and many staff were not —— there wasn't a lot of choice. The issue was they were —— well, they were asked to be moved in the most positive way, but then they were moved to areas they weren't used to working in.

Q. I'm not going to ask you what effect that might have had on patient safety but I am going to ask you what view your members took as to whether they felt fully equipped to deal with patient safety in those situations.

A. I think many members have expressed that they didn't feel that they had adequate time or they did get support but wasn't it adequate enough because it was done at such rapid pace and that had a significant impact on individuals when they would have been asked to be moved. And, as I say, they were asked to move, but to all intents and purposes people were redeployed because that was what the system needed at the time.

Q. They were told to move?

A. Basically.

Q. You also mention professional dilemmas and you give the example of whether or not to treat patients without wearing PPE. Can you just expand on that a little?

A. I think, as you'll definitely hear from my colleague in relation to PPE and infection control guidance, the guidance changed on a repeated basis throughout the pandemic and that led people to not —— you know, to have some concerns around about, you know, what PPE they should use. That didn't —— let's not go into the issue about the availability of it, but that dilemma about what PPE should be used, how you should care for

somebody, of course that brought dilemmas in relation to it.

It also brought dilemma in relation to individuals in relation to their attendance at work; for example, if they were experiencing symptoms themselves. And especially in the very early stages of the pandemic when there wasn't testing, that of course led people to the professional dilemma about being at work if they suspected they had one symptom, if you like, of the virus itself. So that did leave people with dilemmas around about attending work, how they conducted themselves at work, because there was a crisis building and of course there was a lack of workforce.

Q. Yes. I think one of the issues that your colleague, Mrs McKenna, touches upon is —— and quotes from some of your members, making the point that they felt that they were unable to give of their best in certain situations. Was that something that was a repeated concern for your membership?

A. Yeah, that definitely came through in one—to—one contact but also in our surveys in relation to members, one, didn't feel prepared but they also didn't feel that they had, for example, the right guidance. And PPE was a significant issue because there wasn't the provision that we believe there should have been.

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

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

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

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

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

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

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

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

a similar type as the COVID-19 pandemic" -- let's assume it's going to be the same type -- if you're going to plan for that, what sort of involvement would your organisation wish to see having in that exercise?

A. Well, we would want to be involved in all the discussions around about the development of the protocols, procedures, the guidance in relation to what the workforce and the public should be given. We'd want to be involved in that because I think -- of course hindsight does come into it in respect of what we've learned, so we think we would play quite a key role in the support and expertise that both our organisation and our membership could bring to that aspect of planning, but also to plan for the more practical elements in respect of both the support, development and preparation of the workforce to be able to react to a future pandemic if it does come that we need to deal with that.

One of the things that we need to do is also think around about the workforce that you would require to be able to fight a pandemic and the flexibility of that. We clearly already had vacancies and the pandemic increased the requirement and need for especially healthcare staff to look after people. So being involved in how you do that and being involved in thinking around about how we were to react we think

would be a key role for a stakeholder like ourselves.

THE CHAIR: Can I interject, Mr Gale?

MR GALE: Certainly, my Lord.

THE CHAIR: Mr Poolman, this may sound a harsh question. It's not intended to be a harsh question, but it's perfectly obvious from what you just said in response to the questions by Mr Gale that you were not involved and I understand what you say about that. But the RCN is a large organisation, obviously, and, as you have just said, you would have a desire to be involved in any future planning and I can understand that desire. Did you, as an organisation -- I suspect I know the answer -- but did you as an organisation do any internal pre-planning for pandemics of any sort prior to the one we've just experienced?

A. Not in the detail, I would suggest. If you look at it, some of our guidance that we produced to members, could it be used in the pandemic? Absolutely. But we didn't have, if you like, an exercise to plan for a pandemic, so, no, we didn't.

THE CHAIR: Thank you. Sorry, Mr Gale.

MR GALE: Not at all, my Lord.

Another -- or an area of dispute with the Scottish Government was the question of whether COVID was an airborne virus rather than one spread by

droplets. I think you make reference to this in particular at paragraph 40 of your statement. Can you just explain how that disagreement manifested itself?

A. Partly due to the guidance that was published in Scotland but across the UK in relation to PPE and the provision of what PPE should be used and when it should be used. Very early on, as in our view the evidence started to show that the transmission -- and especially as the variants developed, we believe the evidence supported that the virus was airborne in its transmission, and that in itself would mean that you need to look at other aspects -- well, you need to look at the aspect of PPE. But also an important aspect, which was the ventilation within healthcare environments where people were being looked after because of the transition route and then of course with individuals being exposed to the virus.

So that became evident to us quite early on. We started to raise it both in a regular contact through the various groups, both informally and formally, with Scottish Government, but they, to be fair, didn't respond to that and didn't accept the position we were taking.

Q. I think you put it fairly bluntly at paragraph 46 of your statement. You say:

"Ultimately, RCN Scotland considers that there was a serious lack of engagement by the Scottish government to consider the growing international scientific evidence of airborne transmission of Covid-19 but this was ultimately dismissed in favour of droplet transmission despite no evidence supporting this and the impact of these decisions require to be critically examined by this Inquiry."

Can you just give us a little flavour of how Scottish Government set its face against what you were arguing for and what you were saying had a growing international scientific evidence base for?

A. Very early on there was a rapid review of literature in relation to the transmission of the virus and the Government preferred that, over the period late 2020 into 2021, we ourselves actually commissioned an independent review of that process that actually came out and agreed with our position. And there was developing scientific evidence. Numerous papers were being published about the transmission of the virus and, as I say, as the variants changed, it became much more clearer that, for us, it was airborne transmitted.

I have to say, the Government, they refused to really take that on board and change their guidance or evidence to reflect that, and that, I have to say, was

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

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

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

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

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

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

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

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

adequate number of medical, clinical and healthcare workers with the right mix of skills and who are able to deliver the appropriate standard of ... care to meet the demand of the country at the present time in the absence of a pandemic, then there is no chance at all that the demand created by any future pandemic will [be] close to being met."

Q. Right. Thank you very much, Mr Poolman. As is the norm, I will ask you, is there anything that you would like to add to the material you've placed before the Inquiry in your statement and amplified in the discussion that we've had this morning?

A. I think I would just like to amplify that absolutely having the benefit of attending and giving evidence to the Inquiry, the RCN wishes to participate and learn like everybody else in relation to the lessons that we need to learn as —— across health and social care but also as a society of how we can, if we ever have to, react and deal with a pandemic in the future and my colleagues will add to my evidence as you take that from them this morning.

MR GALE: Thank you very much, Mr Poolman. Thank you, my Lord.

THE CHAIR: Thank you, Mr Poolman. 11 o'clock, Mr Gale.

MR GALE: Yes, it's Mr Dunlop who is taking the next

witness.

THE CHAIR: Very good.

(10.47 am)

(A short break)

(11.04 am)

MR NORMAN PROVAN (called)

MR DUNLOP: Good morning, my Lord. This morning I have one witness, Mr Norman Provan.

THE CHAIR: Good morning, Mr Provan.

MR DUNLOP: For the benefit of, I suppose, the transcript and your own notes, my Lord, the reference number of his witness statement is SCI—WT0491—000001.

Thank you, my Lord. Unless there are any preliminary matters?

THE CHAIR: Please start.

MR DUNLOP: Thank you.

Questions by MR DUNLOP

MR DUNLOP: Can you provide the Inquiry with your full name, please?

A. Norman Provan.

Q. Mr Provan, I think you wanted to say something before I got into the body of the questioning this morning.

A. Yes. In Mr Poolman's evidence, he gave an organisational statement giving the RCN's condolences to those who lost loved ones during the pandemic and those

who continue to be affected by it. I won't go through the statement again but I would just reiterate that personally.

Q. Thank you. Can you provide us with your position within the Royal College of Nursing please?

A. I'm the associate director of the Royal College of Nursing in Scotland and my particular responsibilities are for the employment relations functions.

Q. You've provided a statement to the Inquiry which contains a lot of detail and I don't propose to go through all of that in the hour or so that we have this morning. You identify your qualifications and employment history at paragraphs 3 and 4 and thereafter you move on and you tell us at paragraph 6 of the statement that you're part of a strategic group established by the Scottish Government in response to the pandemic and you say that that group's role was to manage the workforce's response to the pandemic. Can you tell me, who was the chair of that group?

A. It was a senior civil servant in Scottish Government who chaired the group. When it was initially put together, it was the first group that was to get together in relation to pandemic response and then many of the other groups in my statement and indeed Mrs McKenna came from that because we were able to hive the work off to other

groups to do a piece of work rather than the strategic group. So, for example, initially, when that group met —— when it was first put together, we met twice a day seven days a week at the very beginning, and over time that lessened off and other groups were established to take on particular issues so that the group didn't have to consider anything, but it was really was about the workforce response.

Q. We may hear from Scottish Government witnesses later in the Inquiry process. You said it was a senior civil servant. Do you remember his or her name?

A. I think the chair of it changed and I can't recall, but it might come to me.

Q. Don't worry if you can't remember.

A. I think it was Gillian ...

Q. I'm not going to ask you to guess.

A. Russell —— Gillian Russell.

Q. Thank you. What kind of topics were discussed in the early stages of the pandemic? I'm really thinking kind of late March/early April at this group.

A. It was a multi—agency group —— I think that's important to note —— so it wasn't just the NHS. So there was stakeholder involvement from primary care, secondary care and indeed the care home sector. Initially, very initially, it was largely about the workforce, having

sufficient workforce, how we would deploy them, and particular issues in relation to the supply and distribution of PPE.

Q. You've maybe answered my next question but I'll just ask you anyway. What kind of decisions were made? Was it just discussions in principle or decisions made about "what we're going to do about workforce" or "what we're going to do about PPE".

A. It was about both. Some decisions we made on the day and they would be applied across the whole of the health and social care system, sometimes from the very next day. Other things we would decide would take longer to put in place, so, for example, in terms of the procurement of PPE gowns, for example, which are reusable, washable gowns, we were making decisions about stepping up the laundry facilities so that all of it could be bagged, sent to laundry and returned back into the system quite quickly. That didn't happen quickly, but the deployment of staff, some of those decisions were made immediately and were implemented, as I say, in some cases almost from the next day.

Q. Thank you. We see in paragraph 8 of your statement there's a list of other groups that you're also a member of. I don't propose to go through those, but we see there's the National PPE Oversight Group. Those groups,

did any of those —— and it may have been too early in the pandemic to have been involved in it, but did any of those groups deal with long COVID?

A. No, not at that point in time.

Q. In paragraph 11 of your statement you identify that there were issues where the Scottish Government didn't act in relation to concerns raised by the Royal College. Could you give me a couple of examples and tell me when those concerns were raised?

A. Sure. Most predominantly it was the issue about the supply of certain types of PPE. The Royal College of Nursing and other stakeholders raised their concerns about the use of, for example, fluid surgical resistant masks, which are open at the side, where we felt it would have been more useful for all staff to have access to FFP3 masks, which form a seal and are therefore better and —— including issues such as aprons and visors. And that's the one thing out of all of the engagement that we had with the Scottish Government that I regret, that the Scottish Government did not act more fully on the concerns that we had.

Within the first year of the pandemic, particularly as there was new variants appearing which were more virulent, they spread more easily and more quickly —— we wrote in the January of 2021, almost a year into the

pandemic, to say that there was emerging evidence about this not being a droplet—passed infection but an airborne one and urged them to change their guidance, and they didn't and to this day never have.

Q. And did they explain why they didn't?

A. They constantly said that, "We're convinced by the work of ARHAI", which was a Scottish group that was providing guidance for the whole of the UK in relation to the modality of the infection spread. We —— in pure logic terms, there were some things —— so if I could illustrate with an example.

Fairly early in the pandemic, hospitals were being filled with people who had COVID so wards that did surgical interventions were being transferred into medical wards because that's what the need was. Many people would come into the hospital, would deteriorate and some of them ended up in ICU. So if you went into ICU, people had all of the gowns and the masks and the visors and the FFP3 masks.

And I remember having a discussion very early at the Workforce Senior Leadership Group, and we raised an issue in relation to the Victoria Hospital in Kirkcaldy in Fife, where we pointed out that in the ICU, the department where they had all of the PPE, there was one member of staff off sick with COVID, and a medical ward

that fed the ICU, for want of a better word, there were 17 members of staff off sick with COVID, with different PPE. Simple logic tells you that actually the issue here is if they had better PPE ...

So bear in mind that we weren't being listened to, the RCN then commissioned a report where we had experts look at the guidance and they were fairly critical of the conclusions that were reached by ARHAI in terms of the guidance that they produced and indeed the evidence base that they had used to make those guidance. So we had commissioned a specialist report which we furnished the Scottish Government with in February 2021, and again they didn't respond adequately to that. They insisted that their guidance was sufficient.

Q. Correct me if I'm wrong, but I think you said that to date they still do not accept it was —— is that correct? Did I pick you up correctly?

A. I think now the pandemic is seen as being over, they accept the WHO's statement now that it's an airborne infection, but certainly during the whole of the pandemic and every iteration of the guidance that they put out maintained that it was a droplet infection and not an airborne infection.

Q. Thank you. At paragraph 12 of your statement, you discuss pre—pandemic planning and you tell us that the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

changes in the PPE procurement system by the NSS. I think you've mentioned that so I won't take you through that. You also mention in paragraph 39 that community hubs were set up for the supply of PPE. I think you briefly touched on those earlier. I just wondered, the community hubs, where were those located within a health ward or a local authority area and who was entitled to go and secure PPE from those community hubs?

A. I can't tell you how many of them there were, but they were in all communities, all local authority areas. So any care home environment, for example, any community providers of care and in fact carers themselves could phone up and say, "I don't have any access to PPE", and they would be given a supply of them. That became a fairly responsive thing. People could phone on the day and it would be delivered to them on the same day. So it was Scottish Government's attempt to assert their ability to buy volume and make it available to places that couldn't secure supply chain in the way that a big organisation like the NHS in Scotland could, and that was, I would have said, quite successful.

Q. Did I get you, you said that people who were carers -- would that include unpaid carers?

A. Yes.

Q. Was there a fee for that, do you know?

A. No.

Q. You say at paragraph 40 of your statement that wearing PPE all day was uncomfortable and could be a barrier for communicating to patients. Whilst I'm sure that's correct, is there a solution to that?

A. There were some engineered solutions, for example, masks provided that had a see-through panel because you have people who lip-read, for example. But there aren't any easy solutions to that, wearing PPE, particularly in places like care homes, where people might have cognitive impairment. Communicating with somebody when you have all of the PPE stuff on becomes much less personal. It was necessary for the protection of patients and staff but it certainly became a barrier to effective communication between nurses and patients at times and nurses found that very distressing.

Q. At paragraphs 42 and 43, you discuss the airborne transmission of COVID and I think you've discussed that earlier in your evidence so I won't go through that. In terms of -- just before I move off from PPE, is it your evidence that if better testing -- sorry, I'll put the question in two parts.

In your opinion, would those nurses that are now suffering from long COVID -- would they have been less

likely to have contracted long COVID if the PPE -- if there had been something different, if you like -- and I'll make it as wide as that -- about the supply and adequacy of PPE at an earlier stage?

A. Yes, without question. And certainly the Public Health evidence -- Public Health Scotland evidence, when they did the outbreak in hospital, when it was known that people were coming in, they didn't have COVID -- I saw a presentation where they were able to state in numbers, although I don't recall those numbers particularly, the number of times where patients were contracting COVID from nurses or other healthcare staff, when patients were getting it from other patients or when nurses were getting it from patients. So it was sophisticated enough in the testing that it's quite clear, and in many of those areas it was areas where they had less PPE or less adequate PPE than others. So I have absolutely no doubt that there were nurses who contracted COVID at their work who would not have contracted COVID at their work or would have had certainly a significant less chance of contracting COVID at their work had they had higher levels of PPE.

Q. I just ask you, at paragraph 45, we see that your Royal College raised concerns about the higher risks of COVID to ethnic minority population and that you say

that the Scottish Government acted upon this and developed a risk assessment tool which enabled those nurses to obtain additional PPE and also work in areas where the risk of contracting COVID was lower. Can you just tell us a little bit, what was that risk assessment tool?

A. So initially there was international evidence that people from the BAME -- black and ethnic minority -- staff had less good outcomes if they got COVID and it wasn't known why. There was no understanding of why that was the case. But acknowledging that it was, we raised that with Scottish Government because there were various courses of action that they could take; for example, make sure that all staff that fell into that category were automatically given more PPE, the higher grade of PPE, if you like. They could have removed them to areas where it was known there were no patients with COVID, which would have reduced their risk.

The risk assessment process largely, people who were older had less good outcomes, so having certain conditions or being from a black and ethnic minority background, the risk assessment added years to you. So if you were 30 years old and you were from an ethnic minority background, they would add X number of years and that would increase your chance of having a less

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

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

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

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

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

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

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

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

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

Q. What are those things?

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

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

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

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

And also in terms of cross-sector. Places like care homes which don't have the infrastructure of the NHS were automatically at a disadvantage in the type of care that they were able to provide. So some collaboration between health boards in that sector would be good.

And in terms of planning for the number of registered or regulated staff, doctors, nurses and AHPs, I think the Scottish Government should plan not just on the basis of the numbers of people who are required for the NHS, but in all the areas where care is provided, they should have a responsibility for making sure that we are training enough people.

There have been things that have happened in the last couple of years that have had an impact on that so, for example, Brexit. We know that there used to be a healthy number of people that came from other European countries to work in the NHS in Scotland and other parts of the UK. From a nursing perspective, in the first year of Brexit, the number of European nurses attempting to join the UK register dropped by 95% and we have done nothing to domestically train more people to replace that. So I think workforce planning is an area that certainly requires to be looked at quite strongly.

Q. Okay. You told us quite a lot there. Can I just pick up on one point? You said more collaboration between

care homes and hospitals. I wonder what you had in mind, what type of collaboration?

A. Certainly issues in relation to education of nurses in care homes, infection control assistance. So when the pandemic happened, many of these nursing homes are stand-alone businesses with 40 employees, 50 employees maybe, they just don't have the infrastructure that the NHS has in terms of diagnostics, cleaning, infection control provision. So I think there could be better collaboration between health boards and the local authority in relation to the homes, care homes and nursing homes in their area, to import some of that expertise from the NHS into those environments.

Q. That may be right. Would you accept though -- and I think we've heard evidence previously -- that there's a distinct difference between hospitals and care homes because a care home, that's the home of the resident, and there are differences insofar as there are photos of family up and certain things -- personal belongings, which perhaps make infection control easier in a hospital; is that a fair comment?

A. Absolutely. Yes, hospitals are full of hard surfaces that are easy to clean; care homes are not. And I wouldn't suggest for a moment that we should change the environment of care homes or nursing homes to look

like hospitals because it is somebody's home, but they certainly don't have the same infection control expertise, for example, that a board will have. So there is no reason why boards couldn't come to arrangements to import some of that expertise into care homes. It just didn't have the capacity to get that at short notice when they were required in the pandemic.

Q. Thank you. That's all very helpful and interesting. I will just take this opportunity to thank you for your time, your participation and the Royal College's participation as well and your own personal time commitment which you've given freely. Thank you.

My Lord, I have no further questions for this witness.

THE CHAIR: No. Thank you as well, Mr Provan. We're ahead of schedule because that was quicker than anticipated. No offence to Mr Dunlop and it's not your fault either, Mr Provan, obviously. I'm reasonably confident that the next witness is available because she's in court or in the tribunal hearing. I don't know if we can arrange -- you're due to be heard at 1 o'clock -- no, 1.30. I imagine that, if you could be heard before then, it wouldn't inconvenience you and in fact might convenience you; is that a fair assumption on my part? Can I ask someone to check when we might hear you? You may have

to go and consult with Mr Gale because I understand Mr Gale is going to do the questioning.

MR DUNLOP: Yes.

THE CHAIR: I'll just wait here to see if we can get a time so that everyone knows what the situation is.

Thank you, Mr Provan. There is no need for you to sit there.

(Pause)

12.30 then, ladies and gentlemen. Thank you all very much.

(11.49 am)

(The short adjournment)

(12.30 pm)

THE CHAIR: Good afternoon.

Mr Gale.

MR GALE: Thank you, my Lord. The next witness, my Lord, and final witness for today is Eileen McKenna. Her witness statement is SCI-WT0459-000001.

MRS EILEEN MCKENNA (called)

Questions by MR GALE

MR GALE: Mrs McKenna, your full name, please?

A. Eileen McKenna.

Q. Your details are known to the Inquiry and you've provided us with a detailed statement and, together with the evidence that you will give orally today, you are

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

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

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

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

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

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

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

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

heightened pressure" and:

"This [has] a significant impact on the physical and mental health of nurses and [this has] a collateral effect on the quality of care being delivered ... "

A. Absolutely, yes.

Q. Can you explain that, please?

A. So there I'm saying there has been concern for a number of years around the levels of nurse staffing, both within the NHS and within the care home sector. We -- I have to say from the outset that Scotland is in a unique position in terms of the data that is publicly available through -- around the NHS workforce and we do use that data significantly to lobby and influence Scottish Government on workforce issues. However, I think the data highlighted pre-pandemic there were concerns around the number of vacancies, vacant posts -- nursing vacant posts across Scotland, and prior to entering into the pandemic there was a growing crisis in the nursing workforce. If nurses cannot provide the care because of staffing levels, et cetera, that they feel or know that the patients require, that can have a detrimental impact on their own well-being in terms of that sort of moral injury, moral distress, because they know that they're not delivering care to the standard that is required.

Q. And to the standard that they would wish to do?

A. Absolutely, yes.

Q. Yes. Perhaps you summarise it in the last two sentences, where you say, "Put shortly ... ". Perhaps you could just read those two sentences, please, paragraph 14.

A. "Put shortly, there are simply not enough nursing staff to provide the level of care that our population needs now, or indeed, before and during the pandemic. The impact this is having on our members is a situation that RCN Scotland has been gravely concerned about for some time -- and well before the pandemic hit."

Q. So it's a pre-existing problem?

A. Yes, not only -- I need to emphasise it's not only in the NHS. Prior to the pandemic, the RCN in Scotland was lobbying the Scottish Government and other stakeholders to value registered nurses within the care home sector. The number of registered nurses within the care home sector had been declining prior to the pandemic, and through work that we did in around about -- well, work we did in 2018 highlighted some concerning nurse to resident -- and I'm talking about registered nurse to resident -- ratios. Sometimes registered nurses could be the only nurse within a care home for -- I think the worst case I'd heard of was 120 residents.

Q. Right. So this was an across-the-board problem?

A. Absolutely, yes.

Q. Now, you've provided us with information and very helpfully given us the various data sources for that information in paragraphs 15 and following of your statement and clearly this is something that we will be looking at. This has informed you, as I understand it, as to the adequacy of staffing both within the NHS and in the social care sector --

A. Yes.

Q. -- so could you just perhaps summarise your conclusions, having looked at this data?

A. So this paragraph looks at data between December 2015 and December 2019 which did show that, within the NHS, the nursing workforce did grow by 2.7%, so from circa 41,000 to over 42,000 whole-time-equivalent staff. However, the upward trend was also reflected in the number of vacancies and the vacancy rate continued to rise steadily, including long-term vacancies, so posts that were not filled for three months or longer. And at that time the planned establishment, ie the number of staff required to meet the clinical activity across the NHS, was actually never achieved, with vacancies rising from 1,600 to 2,600 over that time period, and that was NHS data alone. The care home sector data, as I say,

it's not as robust as the NHS data but it did demonstrate that over that period of time there were 380 fewer registered nurses in care homes for adults.

Q. Well, perhaps -- it obviously follows from what you've said that the pandemic did not serve to cause that deficiency in staff; is that right?

A. No, but it's probably made it worse. But, yes, the deficiency was there.

Q. Was there.

A. Hmm-hmm.

Q. Yes. Now at paragraph 17 you tell us about a survey that the RCN carried out.

A. Yes.

Q. And what were the results of that?

A. So the RCN carries out a survey regularly, annually, and so November 2019 we published a report that highlighted that members across Scotland, whether they work in the NHS, GP practices or care homes, were feeling overworked and under-resourced and undervalued. So two-thirds reported they were too busy to provide the level of care that they considered necessary and they didn't feel that their contribution was valued by those in a position of power. I would say lack of being valued is a recurring theme from feedback from our members, and that's deteriorated during and after the pandemic.

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

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

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

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

order to increase intensive care capacity, you need to increase the number of staff that clearly work in intensive care settings. So, for example, intensive care -- so my own -- I am an intensive care nurse by background and did an additional year's training and education to work within that environment and it's different knowledge and skills that are required from, say, an acute medical or an acute surgical ward. It's a completely different set of skills that are required. And to move people quickly into that environment ... and I'd have to say, even the staff who worked in intensive care -- you know, I worked there for well over ten years -- I never experienced anything like the staff who worked in ICU during the pandemic. This was a new illness and it had, you know, a significant mortality rate at the outset of the pandemic so the conditions that they were working in were extremely stressful. And for staff to move into that environment, not having the benefit of years of experience of working within intensive care, was clearly very, very stressful.

So normally nurses in ICU would look after one patient and they would have a senior nurse and medical staff supporting them with that one patient, so somebody -- a nurse at a much more senior level with advanced skills would be there to support them. We knew

that, during the pandemic, one ICU nurse could have responsibility for four patients and to supervise non-ICU nurses or even other healthcare professionals, like some medics were redeployed to ICU to work in a nursing capacity or AHPs were redeployed. So the pressure on the ICU nurses was immense as well as those that had been redeployed into that area.

But for nurses in other areas, wards were changed from, say, medicine for the elderly to COVID wards, and that's a completely different set of skills. Surgical wards were changed into medical wards. There was a complete redesign of services, and not just in acute hospitals. Even nurses who cared for, as I say, patients with learning disabilities in an outpatient setting, that had to change. They had to meet the needs of those patients in a different way because of -- clearly those with learning disabilities were shielding, so they had to deliver services in a completely different way than was the norm.

Q. I suppose one might say that in some, if not all, of those situations it was a case of needs must?

A. Yes. Yes.

Q. But while needs must, was there, you say, a detrimental effect on the well-being of the nurses who were having to do that?

A. Yes.

Q. But also was there, in your view, any detrimental effect on patient care?

A. I think undoubtedly, yes, in terms of you need a level of expertise, and staff were maybe not working within their own level -- their own expertise. They were being redeployed or working with a different client group than would be their norm.

Q. One of the points you make -- and I think it's possibly one that is perhaps or has been perhaps slightly underplayed -- is the level of aggression and violence that was demonstrated towards nurses. Is that fair to say? Is it something that's been underplayed --

A. Yes, it was something that nurses reported increasingly as the pandemic went on in terms of the level of violence and aggression that was -- that they were experiencing. I think, you know, we need to recognise that people were frustrated, anxious, if they had a family member within a hospital that they weren't allowed to visit or within a care home that they weren't allowed to visit, but nurses didn't make that guidance, they didn't make those decisions, but were often at the receiving end of those frustrations.

Q. I think you've given two quotations from nurses --

A. Yes.

Q. -- in relation to that. We can read those.

Would you go to paragraph 29, please, of your statement, which I think is effectively a conclusion in this part of your statement. Would you just read it out?

A. So -- sorry, is it the quotation or ...?

Q. No, just the text from figure 29 onwards.

A. "The impact of the Government's pandemic planning on RCN Scotland's members cannot be understated. The above illustrates the demands felt on RCN members throughout the pandemic which were exacerbated by a depleted and overworked workforce. It is imperative that the Scottish Government considers a structured approach to workforce planning that ensures we have the right number of registered nurses and nursing support staff with the right knowledge, skills and experience in the right place at the right time should we ever be faced with a future pandemic."

Q. That's obviously your considered view from your perspective and on behalf of the RCN?

A. Yes.

Q. Do you have any reason to depart from that?

A. None whatsoever.

Q. Thank you. Can I now ask you to go to paragraphs 35 and 36 of your statement, please, in relation to PPE?

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

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

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

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

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

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

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

Q. Airborne.

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

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

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

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

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

A. Yes, droplet.

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

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

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

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

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

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

A. No. No.

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

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

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

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

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

A. No.

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

A. Yes.

Q. What was that?

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

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

Q. What's your view on that?

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

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

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

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

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

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

enhanced infection control procedures?

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

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

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

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

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

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

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

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

would be a failure if we don't learn the difficult lessons of the pandemic and tackle head—on the issues which have been in place for many years and probably in the "Too hard to do" box. I think staffing decisions need to be driven by need and outcomes rather than finance. I suppose that's a purely controversial thing to say, but I think often staffing levels are driven by finance and not actually clinical need.

Q. Right. You say perhaps —— I'm not sure whether you quoted it, but in paragraph 62 you say —— and it's in block:

"However, it is clear that in order for Scotland to be ready for the next pandemic, and for [the] detrimental impacts to be minimised the greatest lesson to be learned is to ensure that there is a suitable health and social care workforce in place."

A. Absolutely.

Q. That's in terms of numbers and skills?

A. In terms of numbers and skills.

Q. Yes. Right. Mrs McKenna, that's all I wish to ask you. I offer you the opportunity, if there's anything you would like to add to what you've said, please do so.

A. I would just like to reiterate my colleagues' expressions of condolences to the families of those that were bereaved and impacted on by COVID—19, in terms of

the families and for the nursing and other healthcare staff who were negatively impacted.

Q. Yes. That includes nurses and healthcare staff who died?

A. Absolutely, yes.

MR GALE: Thank you very much, Mrs McKenna.

Thank you, my Lord.

THE CHAIR: Yes, thank you very much, Mrs McKenna. I can infer from what is said we may see you again. I'm sorry if we do have to!

A. (Inaudible).

MR GALE: I think you may.

A. Thank you.

THE CHAIR: Thank you all. That's all for today. I'm very grateful to everyone for allowing us to go as quickly as we did. 9.45 tomorrow morning, I think. Very good.

(1.32 pm)

(The hearing adjourned until Thursday, 21 March 2024 at 9.45 am)

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