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Scottish Covid-19 Inquiry

Day 39

April 25, 2024

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Thursday, 25 April 2024
(9.30 am)
THE CHAIR: Good morning, Mr Dunlop.
MR DUNLOP: Good morning, my Lord. The first witness this morning is Mrs Holliday and, for the benefit of the recording, the witness reference number is SCI-WT0534-00001.

MRS ANNETTE HOLLIDAY (called)

THE CHAIR: Thank you. Good morning, Mrs Holliday.
A. Good morning, my Lord.
THE CHAIR: When you're ready, Mr Dunlop.
MR DUNLOP: Thank you, my Lord.

Questions by MR DUNLOP

MR DUNLOP: Good morning, Mrs Holliday.
A. Good morning.
Q. If I could firstly remind you when you're giving your evidence not to name any individuals.
A. Okay.
Q. You've provided a statement to the Inquiry and we have that in front of us and we see your full name and position within the Greater Glasgow and Clyde Health Board in paragraph 1. We also see in the first four paragraphs of the introduction that you're a registered nurse and a health visitor; is that correct?
A. Yes.

Q. We also see that you've held various positions within Unite the Union since 2018. I think that's correct, is it?
A. Yes.
Q. Under the paragraphs headed "Overview" -- we find those at 5 to 13 -- you explain that health visitors are responsible for children from birth until school age and that you provide support in relation to child development and health. Am I correct that your particular specialism is newborn children up to the age of 2?
A. Yes, in Family Nurse Partnership it's from pregnancy until the child is 2.
Q. When you say "family", I appreciate you changed jobs in late 2021.
A. Yes.
Q. Prior to that, when you were in the post -- at the outset of the pandemic up to you changing your position in late 2021, was it children of a particular age that you were dealing with?
A. I was a health visitor team lead then, so that was children from birth until age 5 or entry to school.
Q. Thank you. You explain at paragraph 9 of your statement that, before the pandemic, health visitor services were done in person and mainly with the child at the family

home in order to assess the child in their own environment. Just to give us an idea of how many different homes a health visitor might be in in a particular week or month, can you give me -- I know there's no such thing as an average day and there's no such thing as an average child, but how many children would a full-time health visitor see on an average day?
A. They may see three, four, five families in a day. It would depend on what was happening and the caseload. Caseloads can obviously sort of peak and trough at different times and obviously there's a significant amount of record-keeping that goes along with each visit. But the average used to be about 250 families for a full-time health visitor, but with the --
Q. In a year? Sorry.
A. 250 on a caseload -- sorry -- in a full caseload to manage, but that's variable now with the uplift in health visitors over a few years. So it can vary from maybe round about 100/120 on a caseload if you're in a very disadvantaged area to maybe up to 350 in a more affluent area.
Q. Just to get an idea of -- you're not obviously going to see the same families every day.
A. No.
Q. How on average -- and again I appreciate there will be

more vulnerable children and you might need to see more of them.
A. Yes.
Q. There might be some that are developing that you don't need to see. But on average would you see a child once a year or ...?
A. No. The universal pathway for health visiting has 11 contacts between birth and pre-school for every child as a minimum and most of them, about eight of them, occur in the first year of the child's life.
Q. So during some years could a health visitor be in 100 different homes over the space --
A. I'm not sure, but I would imagine it might not be dissimilar to that.
Q. You tell us at paragraph 17 of your statement that, since the pandemic, the number of healthcare visitors is reducing. I'm just wondering if that's related to COVID in any way. Can you explain why the numbers are reducing?
A. I don't think it's -- I think the statement should say "health visitors" rather than "healthcare visitors" --
Q. I'm sure it does.
A. My apologies for that.

I don't think it's particularly to do with the pandemic. I think it's to do with budget decisions. We

1 had an uplift in health visitors a few years ago in
2 order to be able to support families to the level that
3 we were talking about, that 11 minimum mandatory
4 contacts, and, as a result of these sort of changes,
5 health visitors were given an upgrade in their banding.
6 They went from a band 6 to a band 7.
7 Scottish Government, my understanding, is still funding
8 us at band 6 and therefore HSCPs are staffing to that
9 level and not to the level of the need that's required.
10 Q. At the outbreak of the pandemic -- I understand from
11 reading your statement that -- you say most visits, as
12 you've said, were in a child's home. What happened
13 immediately at the beginning of the pandemic? Did that
14 continue or was it done remotely? Can you tell us what
15 was ...?
16 A. At the very beginning there was a "business as usual"
17 message that went out that caused staff a bit of stress
18 and anxiety because, although these visits and the
19 assessments that come with them are useful, you wouldn't
20 necessarily say that they were a life and death thing in
21 a pandemic. So staff wanted, I think, to naturally
22 reduce down to sort of essential visits only, and that
23 did happen but it took a number of weeks for that
24 guidance to sort of be produced. So I think staff felt
25 that they were taking what would have been a common

1 sense or logical approach and then we were told for
2 a few weeks it was, "Business as usual, business as
3 usual", and that was causing staff some stress.
4 Q. So for a number of weeks -- I don't want to pin you
5 down -- but can you remember how many weeks or how many
6 months?
7 A. It would be weeks rather than months. I don't think
8 I could say how long, but it would have been the first
9 few weeks rather than months.
10 Q. So during that period health visitors were still going
11 to family homes?
12 A. They were still going to family homes. I mean,
13 certainly throughout the pandemic we would certainly
14 have wanted to see the children that we considered to
15 be -- you know, needed to be seen essentially. So
16 things like brand-new babies would have to be seen,
17 children who had high levels of vulnerability or were
18 through child protection procedures would be wanted to
19 be seen. Other contacts, you know, we felt could be
20 either paused or done remotely, depending on the needs
21 and the circumstances for the family and the child.
22 Q. When we talk of newborn babies, I presume most newborn
23 babies are born in hospitals?
24 A. Yes.
25 Q. Does that mean that the health visitors were going into

1 homes where essentially the parents had just essentially
2 come out of hospital?
3 A. The health visitor takes over from the midwife from
4 day 10.
5 Q. From day 10 then --
6 A. Yes.
7 Q. If I look at day 10 --
8 A. From day 10 to 14 the newborn visits should be carried
9 out.
10 Q. During that initial period at the outset of the pandemic
11 when it was -- I think the phrase was "business as
12 usual" -- was there -- I appreciate -- we know from your
13 statement that I think you managed a team of 18 health
14 visitors.
15 A. Yes.
16 Q. In terms of -- did sickness absence increase during that
17 period?
18 A. No, certainly not in the team I was managing -- at the
19 time it didn't. We were pretty well staffed. We had
20 some staff that had to either shield or it was -- you
21 know, they were then getting assessed about whether they
22 could carry on doing face-to-face visits and of course
23 that was one team in a range of services, but I don't
24 overly remember a high level of sickness absence at that
25 time. It might have been that we had some staff

1 shielding and we might have had some pregnant staff and
2 they were advised at a certain point in pregnancy to go
3 and work at home, but we didn't really get high levels
4 of sickness absence, I would say, until 2021. That year
5 was when we started to get chronic sickness absence.
6 Q. Since we're just talking about it -- we'll come back to
7 2020 -- I notice that you said "at that time", when we
8 were talking about the beginning of the pandemic, so
9 what happened in 2021?
10 A. I'm not entirely sure what happened. Some people
11 I think took the opportunity, once that immediate part
12 of the pandemic was over, to potentially retire -- you
13 know, some staff retired and other staff, you know,
14 sometimes reduced their hours or people went off.
15 I think people were finding work-related stress quite
16 significant. It feels like the pace of the work has
17 really escalated, the complexity of families has
18 escalated since the pandemic and there's not really been
19 the re-investment back into health visiting that allows
20 you to support that -- the work that you would want to
21 do.
22 Q. We are particularly interested in, I suppose,
23 COVID-related -- not necessarily illnesses, but
24 COVID-related absences which could be mental health or
25 could be COVID or long COVID. Was there an increase in

1 any COVID-related absences during that period in 2021?
2 A. There would have been some people -- I can't speak for
3 my team. There wasn't anybody in the team I managed
4 that had that. But there was people off with -- on
5 COVID special leave I think throughout the pandemic.
6 We certainly had people that would contract COVID
7 and would maybe have ten days' isolation and their
8 workload would have to be managed and we had other
9 people that were off for other sort of related -- you
10 know, other illnesses. So I don't remember a lot of
11 COVID-related, long COVID-related absence --
12 Q. Not necessarily long COVID. I was just really
13 interested in whether it was COVID-related absences.
14 A. We certainly had -- you know, I think most people in the
15 team eventually had COVID so that would have required
16 ten days minimum of isolation at the time, as the
17 guidance.
18 Q. You say "most of them", and I appreciate it's difficult
19 to know, when we're in the supermarket, on buses and so
20 forth, but do you know if they were occupationally --
21 A. I don't know.
22 Q. You don't know. Okay.
23 If we could look at your statement again and I want
24 to look at the challenges faced by health visitors in
25 2020 caused by the pandemic. Now, you mention at

1 paragraph 25 of your statement that there was a lot of
2 confusion around the use of the term "essential workers"
3 and whether that would apply to health visitors given
4 that -- and I think you identify that the service is
5 provided during normal working hours and is not an
6 emergency service. Was anything that you're aware of
7 done by either your employers or perhaps the union to
8 clarify whether health visitors were essential workers?
9 A. I'm not sure what happened at higher levels of the
10 union. We certainly got guidance -- initially there was
11 talk that health visitors might be redeployed or a good
12 percentage of the staff would be redeployed into other
13 nursing roles. However, we did get guidance after a few
14 weeks that we were to continue to try and see these
15 children and that these children would be, you know --
16 or visits to those children would be a level -- there
17 was a level of being essential for that, so there wasn't
18 the sort of high-level redeployment that was first
19 anticipated.
20 Q. In terms of just the term "essential workers", given
21 that I think you identify there was a confusion over
22 whether or not you fell under the category of essential
23 workers, did that cause any particular difficulties in
24 itself?
25 A. I think there was -- so there was certainly some stress

1 and difficulties about what that would mean for the
2 staff because health visitors --
3 Q. In what respect? Sorry.
4 A. So health visitors have obviously a unique skill set but
5 they're not necessarily -- they felt anxious maybe about
6 going back into a ward environment where -- you know,
7 that nursing skill has been sort of removed over many
8 years working in community, in a service that's about
9 promoting health and well-being. So there was a bit of
10 worry about what would we be expected to do. But also
11 there was the stress of feeling that some visits to
12 families were not -- you know, were not an absolute
13 essential as part of -- in the middle of a pandemic and
14 the organisation sort of giving a message of "business
15 as usual" also was causing -- people were worried they
16 would take COVID into families, they were worried about
17 bringing COVID back into their own family -- all the
18 kind of things that people were worried about at the
19 beginning of that year.
20 Q. Dealing with that point -- and we'll come on to PPE that
21 the health visitors had in due course, but I'm just
22 interested in the families at the moment that were being
23 visited -- were they -- when a health visitor went into
24 the house, were the family wearing masks or gloves?
25 A. No, I don't think so, although I think there was a mixed

1 response. Some families didn't want the health visitor
2 to come, so the visit could be offered and they would
3 decline the visit, and I know health visitors sometimes
4 saw children through the window of the house or they
5 handed the scales in in the garden and then, as the
6 weather was quite nice that year, some of the visits
7 were done outside in the gardens. There was also some
8 families that of course were pleased to have contact
9 from the health visitor because their normal social
10 supports had reduced. So it was very mixed. Some
11 families were quite set against and some families were
12 very welcoming and there would be a personal choice
13 about whether they would want to wear a mask in the
14 house or not.
15 Q. Was that in itself of concern to health visitors?
16 Obviously the health board can impose rules upon health
17 visitors, "You're required to wear masks and so forth",
18 but am I correct that you couldn't impose that upon
19 families?
20 A. Yes. I think what worried people more was when there
21 wasn't the ability to sort of manage who was in the
22 visit. So we tried to encourage only to have one parent
23 there so that we could socially distance in the houses
24 and, if families then had a number of people visiting,
25 that certainly caused the health visitors a bit of

1 personal sort of stress.
2 When we didn't have PPE, the visits -- going into
3 visits certainly was more -- you know, they found that
4 more stressful. I think they got some reassurance when
5 we did get some PPE. And then we did also -- as time
6 went on, we were able to ask about COVID and if anybody
7 had COVID we could postpone the visit, and that helped
8 when those kind of -- that guidance came.
9 Latterly people sort of said -- you know, if they
10 needed to see the child, they went in with a mask, even
11 if COVID was in the house, but generally people
12 postponed the visits and rearranged them for, you know,
13 the ten days after. So we had those abilities to be
14 able to, if you like, sort of remove ourselves a little
15 from anybody who was acutely unwell, but staff would be
16 anxious if they had asked and people said, no, they were
17 fine, and then during the visit said, "Oh, we've all had
18 COVID" or "They're off because we've got COVID".
19 Q. If staff were anxious, what could they do about it?
20 A. There was a bit of guidance around trying to shorten
21 your visit, you know, not necessarily weighing the baby
22 if you didn't need to weigh the baby. But generally
23 that postponing the visit or if there wasn't a level
24 of -- high levels of risk or vulnerability, then moving
25 the visit to telephone or remote through

1 Attend Anywhere.
2 Q. When you say "moving the visit to remote or telephone",
3 you identify in paragraph 28 of your statement that
4 face-to-face visits were postponed, I think you say, for
5 a very short period of time. When was that period of
6 time that face-to-face visits were postponed?
7 A. So I suppose the key thing is nobody -- there was never
8 a time when we didn't visit face to face. We always
9 visited those ones that I talked about that would be
10 essential, so a brand-new baby would always have had
11 a face-to-face contact; any children that were under
12 child protection procedures would have had face-to-face
13 contact. We reduced down the number of routine visits
14 that we would offer and that's where some of them were
15 postponed. So we stopped doing some of the other
16 pathway visits that weren't necessarily as critical.
17 Q. "Postponed" to me suggests they didn't take place.
18 A. Yes.
19 Q. Were they postponed or were they done remotely?
20 A. A mixture of both. Some people who were working at home
21 carried on supporting families through telephone or
22 Attend Anywhere contacts. Sometimes they would agreed
23 with colleagues they would do a lot of that bit and then
24 the colleague would go out with the scales and weigh the
25 baby, measure the baby and finish off the assessment

1 that way.
2 Q. If you're normally, in an ideal world, carrying out the
3 health visit in person, that suggests there's a benefit
4 to doing it in person. What particular disadvantages
5 are there, when you're assessing a child's development
6 or health, doing it remotely?
7 A. It's not the same. You don't get the same sense of
8 what's going on for the child as you do when you're in
9 their own home. When you're in their own home, that
10 assessment is a very -- I suppose "organic" might be the
11 word I would use. You can see it happening in
12 real-time, the child is comfortable in their home
13 environment. You're also able to kind of explore
14 sensitive topics knowing that you're having
15 a conversation with one person. So there would have
16 been things that health visitors would routinely
17 explore, things like gender-based violence, that they
18 wouldn't have been able to be comfortable exploring that
19 remotely when you don't know who else is in the room or
20 part of that visit.
21 I should say, Mr Dunlop, when I said that we were --
22 I did say in my statement we were back to kind of
23 virtually all pathway visits again by the summer of 2020
24 and that was ahead -- in Glasgow that was ahead of the
25 guidance that was issued from Scottish Government. They

1 were still suggesting that some of the visits could be
2 remote.
3 Q. And when you say "pathway visits", just for the benefit
4 of us, what do you mean by "pathway"?
5 A. The universal pathway for health visiting. It's
6 a standard that -- that's the 11 contacts that are
7 a minimum for every family.
8 Q. Thank you. Moving on to paragraph 30 of your statement,
9 you say at the outset of the pandemic that there was
10 a lack of guidance from the Scottish Government and the
11 health boards were waiting on that guidance. What type
12 of guidance was it? What information in that guidance
13 was being awaited?
14 A. So I suppose the initial sense was why are we not able
15 to go work at home for our administration purposes --
16 not for obviously all our contacts -- but for our
17 documentation and our written assessment work and our
18 administration processes -- we had remote technology --
19 why were we not able to do that. And then, later on,
20 some guidance about, you know, who was going to be
21 expected to be seen in terms of essential visits and who
22 wasn't.
23 If I could go back to my earlier point about -- your
24 point about the impact when there's a lack of
25 continuity, and the remote working did that, but the

1 absence rate since the pandemic has had a huge impact on
2 the ability to build a relationship with one health
3 visitor to a family because of the absence.
4 Q. And when you say "the absence", the absence of the
5 health visitor carrying out an in-person visit?
6 A. Yeah, the health visitors -- the level of absence means
7 that your caseload is having to be covered by other
8 staff and they're dropping into visits but they've not
9 got the longevity of that continuous relationship.
10 Q. Sorry, so that's other people having to step into the
11 shoes of other people's caseloads, if you like?
12 A. Yes, yes. So the guidance was initially about being
13 able to go work at home and then also about who -- there
14 was also guidance about who were the staff who were to
15 continue to work in the office or work face to face and
16 who were the staff that were to perhaps shield or be --
17 if they weren't shielding, they were certainly advised,
18 because of their conditions, to work at home -- and also
19 who was to be seen and what visits were to be done and
20 what visits were not to be done or could not be done --
21 didn't need to be done in person.
22 Q. I suppose two questions just in terms of this guidance
23 that you had to wait for. How long did you have to wait
24 for it, I suppose, first?
25 A. Well, there was different -- those different elements

1 came at different times. The working at home didn't
2 probably come until the UK Government gave the guidance
3 for people to work at home and so we already -- we were
4 trying to socially distance in offices ahead of that.
5 And then the guidance around staff who were able to
6 continue their work and other staff who were perhaps to
7 work at home or advised to work at home, again that took
8 a number of weeks as well. And then the guidance about
9 the visits was probably -- from memory was maybe our
10 latest bit. So all of it was probably delivered in
11 a matter of weeks but the staff wanted answers
12 immediately.
13 Q. In that period where the guidance hadn't been delivered,
14 as you identify, a matter of weeks, did that -- I know
15 that you've told us earlier it was business as usual.
16 Essentially, in the absence of the guidance, were health
17 visitors just doing what they'd done pre-pandemic?
18 A. They were expected to, but people were very anxious
19 about that and people started to feel very stressed
20 around what they were perhaps walking into, what they
21 might -- you know, people were very worried about
22 contracting COVID and they were very worried about --
23 you know, I remember being, "Why am I sitting in this
24 office? Why am I being made to come into work this
25 morning when I could do this same paperwork at home?",

1 you know. And then people asking about, "I have
2 X condition, does that mean I can work at home more?"
3 or -- you know, so people got very anxious. They got
4 anxious about taking COVID into families and infecting
5 families and new babies and they were worried about
6 bringing COVID back to their own families.
7 Q. Staying on the guidance point, at paragraph 36 you talk
8 about when guidance was issued. I think you say it
9 was -- it went to a senior management meeting almost on
10 a daily basis to discuss the updates and that the
11 guidance would essentially cascade down through the
12 various layers of management. Am I correct in my
13 understanding of your statement that the guidance was
14 regularly changing?
15 A. I don't think it was regularly changing. There was some
16 other iterations, as far as I remember, so we might have
17 had two or three versions over time. I suppose I would
18 probably say it was more -- it got more developed.
19 Q. I suppose my question -- if I put it I suppose quite
20 bluntly: was the guidance clear? I'm asking you a kind
21 of binary question, I suppose.
22 A. Yeah.
23 Q. Was some of the guidance unclear and some of it clear?
24 A. I would say there's a potential for that, yes, I think.
25 Q. Moving on in your statement, you talk of the impact of

1 the delivery of services as a result of the COVID-19
2 pandemic and we've already discussed working at home.
3 You identify that you worked in a geographic area --
4 this is at paragraph 38 -- where the parents were
5 professionals and therefore you had less concerns about
6 digital poverty. Is the contrary true, that if you were
7 working in a poor area, would you have concerns about
8 digital poverty?
9 A. Yes, I think that was already known and then there was
10 a scheme to offer technology for families that needed
11 it. So my understanding is we know that children who
12 were the ones that probably needed to be in school the
13 most were the children who were not present in school
14 and weren't present online and we did start to
15 deliver -- health visitors were out delivering iPads and
16 SIM cards in order for children to be able to access --
17 or families to be able to access these kind of
18 educational materials.
19 Q. Was that -- do you know where the funding for that --
20 was that a Scottish Government initiative, was it the
21 health board?
22 A. I think it was a Scottish Government initiative that was
23 then -- it came via a different team and they were
24 co-ordinating it, but the health visitors, as visitors
25 to home anyway, were out -- were delivering. They would

1 identify the families who would need it and then
2 distribute them.
3 Q. At paragraph 39 of your statement you discuss the infant
4 feeding service. Can you tell me what is that service?
5 A. The infant feeding service, there's a variety of things,
6 but we know that breast-feeding rates across Scotland
7 are pretty poor and often there's a lack of real support
8 in order to establish and maintain breast-feeding. So
9 there's a range of services -- the health visitor of
10 course provides a universal provision around that and
11 supports infant feeding and there is also then sort of
12 a specialist service if there's -- what we call
13 a "problem-solving clinic", and there's also then
14 usually community groups that would offer sort of peer
15 support for breast-feeding that health visitors may or
16 may not sort of have attended as well as charitable
17 third sector sort of organisations.
18 Q. The infant feeding service -- am I correct? -- is it
19 simply breast-feeding or is it other types of feeding?
20 A. It can be other issues with feeding but a lot of the
21 problem-solving things come around breast-feeding.
22 Q. Now, you say in your statement that the service has
23 really struggled to come back post pandemic. Can you
24 explain what is it about the pandemic that has caused
25 that to struggle to come back?

1 A. Well, I think again post pandemic people looked at what
2 they were doing in terms of services and how they would
3 deliver them in a different way. The problem-solving
4 clinic I think had some success in doing remote contact
5 with families and still were able to support but there
6 were other things that perhaps didn't come back in the
7 same way. We used to support -- health visitors used to
8 support at what we called "weaning fairs", where there
9 was information about progressing on to solid foods and
10 there would be a number of speakers at those events for
11 parents. That took a long time for those to come back.
12 They're only sort of coming back in the last maybe year
13 or so.
14 The infant feeding groups, again, similarly in the
15 community they've taken a long time to sort of come back
16 to face to face, and -- sorry, there was something else
17 I was going to say about the infant feeding team but
18 I can't --
19 Q. Don't worry about it.
20 A. Sorry.
21 Q. No, no. That's quite all right.
22 In paragraph 43 you mention that health visitors
23 were not able to put their children into childcare hubs.
24 Was that anything that was ever raised at -- I don't
25 know -- either a senior management level or higher?

1 A. Certainly any issues I was having with the team, I would
2 certainly raise with my service manager and I assume
3 that she was taking that back to the senior team. It
4 was generally children that, if they were under the age
5 of sort of nursery or school age, where they had perhaps
6 informal childcare at the time before the pandemic,
7 like, you know, their own parents, grandparents,
8 watching their children, and they didn't then qualify
9 for that provision that -- those childcare hubs. And at
10 the very beginning of the pandemic there was -- no
11 childcare bubbles had been created, so health visitors,
12 although they could work at home doing their
13 documentation, you know, if they had young children they
14 were telling me that they didn't know what their
15 priorities were. They were looking at a screen all day
16 and their own children, they felt, were not necessarily
17 getting the same level of supervision that they should
18 have had.
19 Q. But if I understand you correctly, it wasn't just
20 looking at a screen all day. There was this "business
21 as usual" period where health visitors were expected to
22 go out but nonetheless no longer had the childcare that
23 they could rely upon. Did that -- I mean, were health
24 visitors essentially phoning in saying, you know, "What
25 do I do?"?

1 A. Yes, there was some of that and we again had to try and
2 do a bit of local support around that, sort of
3 individual support, where perhaps they would maybe have
4 a particular day where they did have, for example,
5 a partner at home that was able to watch them and they
6 would do, you know, as many visits as they could on that
7 one day and then try -- so we tried to be very open and
8 flexible about ways of working and --
9 Q. They presumably couldn't take children to the health
10 visits?
11 A. No.
12 Q. Moving on to the "Impact of the COVID-19 pandemic on
13 children" section of your statement, which starts at
14 paragraph 49, you tell us at paragraph 50 that
15 children -- they weren't going to nursery during the
16 pandemic, which meant that they didn't get used to,
17 firstly, socialising with other children and, secondly,
18 getting used to being away from parents. I'm just
19 interested in how that affects the development of young
20 children. Does that delay development or is that
21 a permanent loss that will stay with them throughout
22 their life?
23 A. I think it's difficult to say it would be permanent
24 because we know so much about brain development and the
25 plasticity of the brain and the ability to develop those

1 skills later that you've maybe not learned earlier.
2 I suppose the question about did that delay their
3 development would have been around the -- it would
4 depend on their experiences at home outwith nursery. So
5 if you were in a very, you know, rich environment at
6 home, then you would benefit from that, but if you are
7 a child whose parents are, you know, working and focused
8 on that, then there's a likelihood that, you know,
9 you've not had the same sort of stimulation and support
10 as a young child that you would normally have got if
11 you're in nursery.
12 Q. And this isn't in your statement, but have you noticed
13 a difference where children had siblings as opposed
14 to -- someone else to play with, for want of a better
15 term?
16 A. So it's difficult for me because I'm now in
17 Family Nurse Partnership and we deal with the oldest
18 child to 2, so some of the developmental things you
19 might see are probably -- I'm probably not seeing that
20 because I'm not in that age range now.
21 Q. That's quite candid of you and a fair answer.
22 Moving on to the child -- still the child's health,
23 you discuss the Childsmile service and oral health
24 support at paragraph 51 and you're of the opinion that
25 you think we'll see an increase in young children with

1 tooth decay. I'm just wondering again, is that
2 something that is going to be temporary or is that
3 something that will have long-lasting effects?
4 A. It can have long-lasting effects. There is, you know,
5 definite issues with losing your teeth. Your teeth are
6 responsible for you making sounds and your correct
7 speech.
8 Q. Are these not baby teeth we're talking about? I'm just
9 wondering -- are they? I'm just wondering whether --
10 sorry, I'll put my question a different way. I suppose
11 I'm wondering if a lack of instilling a sense of oral
12 health into a child has lasting consequences. I suppose
13 that's -- I don't want to lead you --
14 A. Yes.
15 Q. I suppose that's the question that I had my mind at.
16 I've got young children and I know how difficult -- and
17 you have to buy toothbrushes with firemen or animals and
18 so forth on it to encourage them and suchlike. I'm just
19 wondering if in some way the lack of those services
20 somehow had an effect.
21 A. Yes, and my apologies for laughing. I suppose what
22 I was thinking about was the reasons why Childsmile came
23 in was because we had a culture of "baby teeth didn't
24 matter because they fell out anyway" and we took a long
25 time over Childsmile to change that opinion, that

1 actually your baby teeth are important for the alignment
2 of your adult teeth coming in, for your ability to make
3 sounds and communicate effectively, for your confidence
4 with a smile. So there are loads of reasons -- lots of
5 reasons why that oral health is important.
6 And, I mean, my understanding is one of the highest
7 reasons for general anaesthetic in the under-5s is for
8 dental decay and clearance of those teeth. The pain
9 that comes with that decay as well -- and potentially we
10 set up -- what happened years ago, we set up adults who
11 are frightened of the dentist because the only time they
12 go is when they're in pain. So we create more fear of
13 the dentist and less provision and less prevention of --
14 preventing those things happening in generation upon
15 generation upon generation.
16 THE CHAIR: I suppose -- and I'm in dangerous territory
17 here, I've got to admit -- but I suppose that, if there
18 is an impairment of a child's ability to speak properly
19 or speak at the appropriate level caused by dental
20 problems at that earlier age, that effect can be
21 longstanding because damage done to a child's ability to
22 speak in its earliest years could be carried forward.
23 Is that a fair comment?
24 A. I think that is a fair comment, my Lord. Again, the
25 ability to make friendships as a young child in nursery

1 when you're able to communicate effectively, when you're
2 confident in those abilities to make friends and sustain
3 friends -- so there is probably wider effects than the
4 issue alone of dental decay.
5 THE CHAIR: I see that. Yes, thanks.
6 MR DUNLOP: Thank you, my Lord.
7 Moving on to -- you deal with PPE, starting at
8 paragraph 53, and you tell us that in the early stages
9 of the pandemic health visitors were told they didn't
10 need to wear any PPE. Where was that advice coming
11 from?
12 A. I think that must have been coming -- as I said, the
13 senior management -- my understanding was the senior
14 management team were meeting on a very regular basis,
15 perhaps even daily, and they had links in -- or people
16 within that senior management team had links into
17 Government and, I take it, Public Health Scotland, and
18 this is where our information was coming from in terms
19 of guidance about PPE. So initially we were told that
20 as long as we maintained a 2-metre distance and then
21 later -- I think again there was a bit of information
22 later about the length of time that you were in a house,
23 that if you were in, you know, less than an hour -- was
24 it? -- or something like that and maintained a 2-metre
25 distance, you would be okay. Again, people obviously

1 had some ideas about how they thought COVID was
2 spreading and this was information they had and this was
3 information they were sharing and we were then to
4 cascade that down into how that worked into practice.
5 Q. In terms of -- so that's at the early stages, that the
6 guidance was that you didn't require to wear a mask.
7 You tell us at paragraph 58 about that and I think --
8 quotes -- "Eventually guidance came in", stating that
9 health visitors needed to wear a mask, gloves and an
10 apron. Just to kind of put our -- I suppose to try and
11 put it into -- I appreciate I'm asking you to think back
12 a few years -- but by "eventually", again, was that
13 a matter of weeks, was it a matter of months?
14 A. It would be a matter of weeks, again, I think.
15 Q. When that guidance was issued, that you were required to
16 wear a mask, gloves and an apron, can you remember what
17 type of mask you were advised to wear?
18 A. We were asked to wear -- or we were told that
19 a fluid-resistant surgical mask would be all that was
20 required. Again our guidance I don't think was specific
21 to health visitors. From memory the guidance was about
22 community staff and therefore there was a sort of level
23 of, "This is kind of the level of PPE that is required".
24 So there was face masks, gloves and aprons and then
25 there was an option of a face shield, a visor, if people

1 felt that that's what they also wanted.
2 Q. In terms of PPE, you identify in your statement that --
3 I think you say the gloves ripped and the apron ties
4 were breaking and you've identified what type of masks.
5 Do you have a view on whether or not the PPE that was
6 being supplied was adequate?
7 A. I think it depended on what came in the order, so
8 sometimes we ordered and nothing -- you know, we didn't
9 get because there wasn't any.
10 Q. I'm just thinking when you did get -- so if you got
11 a mask, was it -- if I say "FFP3 masks", do you know the
12 kind of respiratory-type masks, did you ever get
13 provided with those type of masks?
14 A. No, no.
15 Q. So it was always the kind of -- I'll call it the blue --
16 A. Yes, surgical masks.
17 Q. I was going to say a lot of people refer to them as
18 "surgical masks".
19 A. Yes.
20 Q. In terms of when PPE did arrive, were you satisfied,
21 "This is fit for purpose, this is adequate", or did you
22 have concerns?
23 A. I think certainly there was the concerns of the gloves
24 were ripping, and again it was variable. Some rolls of
25 aprons, for example, were perfectly adequate, you know,

1 they had the loop for your head and tied round your
2 waist. I've given in my statement about the roll I had
3 and clearly they were manufactured faulty and there was
4 no -- there was I think two tie-ers. One was where the
5 neck loop should be and one was where the waist one
6 would be, and I was trying to tie them sort of together
7 on a very windy day outside somebody's house, so it was
8 variable.
9 I think staff felt that, you know, "What makes the
10 difference between me having a gown -- an apron on at
11 the front but sitting on somebody's couch without
12 anything covering me at the back?", and the gloves
13 I think were variable. Some gloves we got, staff were
14 happy with, others they felt that they were -- you know,
15 they were easily ripped or they just didn't do the job
16 that they needed them to do.
17 Q. Can I pick you up on a point? You said when it did
18 arrive.
19 A. Yes.
20 Q. Are you suggesting that sometimes there wasn't any PPE,
21 that the stocks had run out?
22 A. Yes, or certainly perhaps they went to places that were
23 deemed to be more priority. As I said, we did have some
24 ability -- depending on the kind of visit we were doing,
25 we had the ability to postpone that visit, so we were

1 not -- and we also could screen and, if there was COVID
2 in the house, we could say, "I'll not come today, I'll
3 make it next week".
4 So we did have that ability, so I don't know whether
5 sometimes PPE went to other services that were in
6 greater need of it. But sometimes -- you know, the
7 ordering was done and sometimes, when the order came the
8 following week, sometimes you had everything that you
9 asked for and other times not everything was there.
10 Q. Okay, so there could be shortages?
11 A. Yes.
12 Q. Moving on in your paragraph to -- you talk about
13 volunteering at the staff hub -- and that's at
14 paragraphs 66 to 71 of your statement -- and you say
15 that you're a volunteer in the staff well-being hub at
16 Inverclyde Hospital. Can you firstly tell us, what is
17 a staff well-being hub?
18 A. I suppose, if I was being very blunt, I would say it was
19 the kind of things that used to perhaps be round and
20 about in place before budgets got cut and everything got
21 stopped. It may resemble, if you like, a doctors' mess
22 or a decent staff room.
23 Q. If we don't -- and I don't -- if we didn't know it
24 existed before then, could you give us a concrete
25 example of what we would expect if we went into

1 a well—being hub?
2 A. The well—being hubs were put in place to support staff
3 in the hospital settings and they provided a place for
4 the staff to go and, in effect, be able to debrief, but
5 they also provided —— a lot of them provided a bed, for
6 example, where staff, if they were working a long shift,
7 could go and have a lie—down during some breaks.
8 There was —— some of the local businesses supplied
9 sort of meals and they also —— you know, we were able to
10 supply tea and coffee and, you know, biscuits and
11 snacks. As I said, there was also often —— they often
12 were created in places that were wards that were maybe
13 not in use and so there was beds to be able to have
14 a lie—down, there was a shower facility. There was just
15 things that take care of staff that we've seen eroded
16 over, you know, the last decade or so.
17 Q. And were those types of hubs in all the hospitals or ——
18 do you know?
19 A. I'm not entirely sure. Certainly I think they tried to
20 put them in the main ones and certainly I did —— the
21 training day around that was I think the Easter Monday
22 of 2020, so that was the April—time or kind of towards
23 the end of April I think that year maybe. And then they
24 started —— it started up a few —— a couple of weeks
25 later, which is why in my statement I've said that some

1 of the staff that came down said, "Actually we needed
2 this a few weeks ago".
3 Q. I noted that in your statement you seem to be very
4 supportive of these hubs and you say that the hubs came
5 too late and should have been earlier. Could they have
6 been commenced earlier?
7 A. Well, I think you could say the same about all sorts of
8 things, and I know the pandemic was obviously a bit of
9 a moving feast, but if you've got a level of planning
10 around these things, then I suppose that might be
11 something that you would —— if there was pre—planning,
12 you would think that these things could be part of that
13 and therefore maybe the implementation wouldn't take as
14 long as what we seem to have found during this pandemic.
15 I think, if we're learning lessons, it's about
16 pre—planning and thinking about what things were put in
17 place during COVID that would have been supportive and
18 helpful and actually have those ready so that, if we got
19 into a pandemic again, we know what will support staff
20 to be able to do their jobs well.
21 Q. Which would include well—being hubs, I think; is that
22 what you're saying?
23 A. It could very possibly. It would be lovely to think
24 that —— especially because people are feeling that the
25 work is so pressured and so difficult, that it would be

1 good if these kind of things were put in place and kept
2 in place, but, as I said, these are the types of things
3 that have been eroded over time.
4 Q. You talk about the delivery of training in your
5 statement at paragraphs 72 to 75 and you explain the
6 impact of the pandemic on training health visitors and
7 you identify there's been a lack of in—person training
8 and working remotely rather than alongside an
9 experienced health visitor. Is there something that
10 could have been done differently if this was to happen
11 again in the future?
12 A. I would think that's difficult to know because you'd
13 have to balance up the benefits of that learning and the
14 need to learn alongside someone with individual staff's
15 fears and worries about what that —— what the spread of
16 a virus would do if you were working alongside. It's
17 a difficult balance I think to try and get right.
18 Q. Maybe it's a question, I suppose, that I've asked
19 previously, but the impact on the training, is that
20 something that trainee health visitors —— I'm sorry if
21 that's not the term ——
22 A. That is the term.
23 Q. That is the term —— is that something that they will
24 eventually develop and they'll get back to the level
25 they would have been or is this going to be a permanent

1 drag on the profession?
2 A. I would hope it's not going to be a permanent drag.
3 We're back now, we would be offering —— well, we're not
4 back in the offices in the same way that we used to be.
5 However, I think if we've got —— I think we recognise
6 now, if you have somebody in training, that you do need
7 to spend more time with them than perhaps was possible
8 during the pandemic.
9 We obviously have things like the bases are open and
10 available now whereas at the height of the pandemic
11 bases were shut and people were maybe only allowed to go
12 in on a rota basis or, you know, at very sort of fixed
13 points. So I think there is recognition about the need.
14 I think for the individual health visitors what we seem
15 to be seeing is concerns about their competency as they
16 become qualified health visitors, and I think it's that
17 ability —— it's the difficulty of quantifying tacit
18 learning, the things you learn when you're sitting
19 alongside somebody, and the difficulty is these staff
20 are now facing, if you like, punitive policies in the
21 workplace perhaps because of their experiences during
22 the pandemic.
23 Q. Sorry —— and I don't want to dwell on it —— but when you
24 say "punitive policies"?
25 A. Capability, disciplinary, those kind of things. The

1 notion that actually your competency is considered to be
2 compromised, and it may well be it's because of the
3 limitations of the learning that they had.
4 THE CHAIR: Mr Dunlop, you're into your last ten minutes.
5 MR DUNLOP: Yes, yes, my Lord. I'm literally just on
6 lessons to be learned so I shall only be five minutes.
7 Thank you, my Lord.
8 I was simply going to say that that may be something
9 that applies to more than simply the health visitor
10 profession.
11 A. Absolutely.
12 Q. In terms of -- we go into the lessons to be learned at
13 paragraphs 76 to 78 and you identify that that includes
14 better pandemic planning and you quite fairly refer to
15 the visiting of care homes, albeit that that's probably
16 not directly within the health visitor's role.
17 A. No.
18 Q. We have your statement in front of you. Before thanking
19 you for your time, is there anything else that you think
20 would be relevant for the Inquiry that we haven't either
21 discussed today, isn't within your statement or has
22 cropped up in your mind perhaps in the days running up
23 to giving evidence?
24 A. I think I would probably say, and it does go back to the
25 point, Mr Dunlop, that we made about that continuity,

1 and health visiting is -- they would say it's
2 a therapeutic role rather than a clinical role. And
3 I would say a therapeutic relationship is about -- it's
4 not just about the continuity but it is about the
5 ability to be emotionally available and provide
6 emotional support and practical assistance to families
7 when they need it.
8 And what we found, during the pandemic that was
9 disrupted and since the pandemic it seems to be
10 almost -- it feels impossible to deliver and some of
11 that is because we're not funding health visitors the
12 way we need to. We have an aspiration in Scotland that
13 Scotland will be the best place to grow up and we've
14 not -- I'm not seeing the evidence of that happening.
15 I'm seeing a decline in those things happening. We
16 see -- we hear about cost of living crisis, we hear
17 about fuel poverty and food poverty, and health visitors
18 are one of the first people around these families and
19 are able to provide some support, but we can only do
20 that if we've got the resource to be able to do that.
21 And ultimately we have, in order to be able to
22 support children, to support their early experiences and
23 to provide rich experiences for them as parents, you've
24 got to feel emotionally present and available to your
25 child. And if you're not feeling that, then it's very

1 difficult to provide your children with these optimum
2 experiences. Health visitors should try to do that for
3 parents, and health visitors also need to feel that.
4 When we're sitting, as we currently are, with the
5 staffing pressures that we've got and have had since
6 2021, people are exhausted, they're tired and they're
7 not able to emotionally contain and support other
8 people.
9 MR DUNLOP: Thank you. Thank you for your time and also the
10 time that you've obviously put into preparing your
11 comprehensive statement, which is very helpful.
12 A. Thank you, Mr Dunlop.
13 MR DUNLOP: My Lord, I have no further questions.
14 THE CHAIR: Very good. Thank you, Mr Dunlop.
15 Thank you, Mrs Holliday. I appreciate that.
16 A. Thank you, my Lord.
17 THE CHAIR: We'll come back at 20 to 11 for the next
18 witness.
19 MR DUNLOP: I'm obliged, my Lord.
20 (10.22 am)
21 (A short break)
22 (10.40 am)
23 THE CHAIR: Good morning, Ms Bahrami.
24 MS BAHRAMI: Good morning, my Lord. Our next witness is
25 Claire Elizabeth Ronald of the Chartered Society of

1 Physiotherapists and her witness statement reference for
2 the record is SCI-WT0184-000001.
3 MS CLAIRE RONALD (called)
4 THE CHAIR: Thank you. Good morning, Ms Ronald.
5 A. Good morning.
6 THE CHAIR: Are you ready, Ms Bahrami?
7 MS BAHRAMI: Yes, my Lord. Thank you.
8 THE CHAIR: On you go.
9 MS BAHRAMI: Thank you.
10 Questions by MS BAHRAMI
11 MS BAHRAMI: Good morning, Ms Ronald. Please could you
12 start off by telling us about your role within the
13 Chartered Society of Physiotherapists and also a brief
14 background about the society?
15 A. Thanks. It's the "Chartered Society of Physiotherapy"
16 rather than "Physiotherapists".
17 Q. Oh, sorry.
18 A. It's slightly pedantic but ... so the Chartered Society
19 of Physiotherapy is the professional body and trade
20 union for physiotherapists and physiotherapy support
21 workers. We also cover students and retired members and
22 have some overseas members as well in sort of different
23 categories.
24 My role is working for the trade union part of the
25 CSP and I cover Scotland along with someone else and

1 I also cover Northern Ireland as the other half of my
2 job.
3 Q. Thank you. You're a senior negotiating officer within
4 the organisation?
5 A. Yeah, that's the job title , yeah.
6 Q. But your background is that you are a qualified
7 physiotherapist?
8 A. I was. I'm no longer on the HCPC register so I can't
9 technically call myself a physiotherapist anymore, but,
10 yeah, I was a physiotherapist ——
11 Q. You're experienced in that field ?
12 A. Yeah.
13 Q. Thank you. Could you tell us a bit about the areas in
14 which physiotherapists work?
15 A. Physiotherapists can be found in so many areas. So
16 within the Health Service, physios will be on most
17 wards, so we'll be on surgical wards, orthopaedic wards,
18 medical wards. We work with people from birth right
19 through, so we're in neonatal units, we're dealing
20 antenatally, post—natally with mums. You'll have
21 physios in independent hospitals, physios in the private
22 sector, in charities , dealing with hospice care as well,
23 right through to your kind of elite sports clubs and
24 elite sports people, so it 's a whole breadth of areas
25 that physiotherapy works within.

1 Q. Thank you. One area I think that was of particular
2 significance during the pandemic was respiratory care.
3 A. Yeah.
4 Q. Could you tell us what the significance of
5 physiotherapists' involvement in respiratory care was
6 for ensuring that patients survive the impacts of COVID?
7 A. Yeah, physio is part of the multi—disciplinary team in
8 both intensive care units and kind of acute medical
9 wards, so dealing with patients with respiratory
10 problems, trying to increase their air flow, clearing of
11 secretions when they're there, so using manual therapy
12 techniques, breathing techniques. And during COVID, in
13 the kind of early stages, what became quite apparent was
14 putting patients into a prone position, so lying on
15 their front, improved their ventilation because it
16 opened up more of their kind of lung space at the back.
17 So they were involved in kind of proning teams as well
18 as on the ICU and on the acute medical wards.
19 Q. And presumably that then requires the physiotherapists
20 to work very closely, physically closely, with patients,
21 and if they are putting patients into a prone position,
22 then especially for adults they wouldn't be able to do
23 that alone often?
24 A. No, that involved kind of —— so the proning involved
25 working as teams, so being able to co—ordinate, getting

1 the patient into position in a safe way both for the
2 patient and for the staff involved —— so yeah, it was
3 close working with other staff and with patients who
4 were COVID—positive.
5 Q. And when the lockdown restrictions were announced, what
6 was the initial impact on your members, especially given
7 that their work necessarily involves being so close to
8 others?
9 A. So when lockdown initially impacted within the NHS, some
10 of our clients would have been classed as extremely
11 vulnerable and so shielding, so services were held ——
12 services were pulled back from those areas and only
13 going in within emergency sort of situations. So a lot
14 of our staff in the hospital were redeployed still
15 within physiotherapy but more into the acute side, so
16 into where patients still were, so your acute medical
17 ward, your ICU, your high dependency units, so pulled
18 into those areas.
19 For our members in education there was a big impact
20 and then for our members in the private sector and in
21 independent hospitals, again, a really big impact on
22 what they were allowed to see and what was defined as an
23 emergency, so if you were running your own clinic as
24 a private physiotherapist, what were you allowed to see
25 within those lockdown restrictions. So a lot of clinics

1 were essentially closed but not technically closed at
2 that time.
3 Q. And was there a fear of potentially taking the virus
4 home?
5 A. I think physiotherapists, along with anyone who was
6 working in the acute hospital, had that real fear. This
7 was a virus that we didn't know an awful lot about. The
8 guidance seemed to be constantly changing and evolving.
9 If you're working really closely, like in physical
10 contact with patients who are COVID—positive, there's
11 a natural fear and anxiety, and especially if you've
12 come from an area where you previously were out in the
13 community, possibly working with children or people with
14 learning disabilities , mental health, and then moved
15 into working with acute respiratory conditions, there
16 was a greater level of anxiety.
17 Q. Where staff were redeployed to other physiotherapy roles
18 but in a different setting, in ICU or acute wards, how
19 did they adjust to that change in the daily requirements
20 of their job and what was the effect on staff morale?
21 A. How staff adjusted is probably as unique as each staff
22 member, so there was —— in most areas you would have
23 been looking at the skill set people had and moving them
24 within their skill set, so taking our more respiratory
25 experienced people and moving them and then backfilling

1 some of those roles with other physiotherapists. It
2 was -- anxieties were high, even the staff who were
3 managing the teams. A lot of teams were then adjusting
4 their hours to cover longer periods in the hospital.
5 You also have the problem that you're working in the
6 hospital but, if you have children, who is then looking
7 at your children at that point in time. We have quite
8 a high female population in physiotherapy and, again,
9 caring still tends to fall to the women in the
10 household. So there's that anxiety of where are you
11 leaving your children and then what are you bringing
12 back to children. So I think, like other health
13 professionals, lots of the same stories at the outset of
14 virtually stripping off outside the house, the fear of
15 are you washing your uniform in with your other clothes
16 and not knowing exactly how the virus was spread at the
17 outset.
18 Q. Thank you. I think some physiotherapists were
19 redeployed to roles outwith physiotherapy; is that
20 correct?
21 A. Yes. So some of them would have been redeployed into
22 vaccination services or into supporting other parts of
23 the hospital, but it was less so for physio. More of
24 them were redeployed at -- I think in one of the
25 meetings we had with members, about 80% had been

1 redeployed within physiotherapy rather than outside of
2 physiotherapy.
3 Q. For those who were redeployed outside, were they
4 provided with training and did they feel adequately
5 supported to be taking on those new roles?
6 A. In most cases, yeah, training was provided. You
7 wouldn't just dump somebody into a vaccination clinic.
8 So there was training and there was upskilling to put
9 people into those roles. How comfortable and how
10 confident -- again, if you ask ten different people,
11 you're going to get ten different answers, even with the
12 same sort of level of training, because everyone has
13 their own background concerns and their own skill set
14 that they're bringing into it.
15 Q. Do you know whether there was a difference in morale
16 between those who were redeployed within physiotherapy
17 roles and those outwith physiotherapy roles or is that
18 not something that's been looked into?
19 A. I can double-check whether we covered that in any of our
20 surveys, but I don't have that information to hand.
21 Q. Thank you. Now, those that were redeployed to ICU and
22 acute wards, presumably there would have been an
23 increase in workload but also an increase in the number
24 of patients with terminal conditions or who did pass
25 away during the pandemic. What was the impact of that

1 on your staff because it's not a profession that one
2 would usually associate with high numbers of deaths.
3 A. Yeah.
4 Q. How did staff find that?
5 A. I think we're still seeing the knock-on effects of that
6 as people are still recovering from what happened during
7 COVID, from the redeployment. I think, when you're in
8 it at the time, you just kind of buckle down and deal
9 with what's there. The Health Service has been really
10 good at putting in a variety of supports and health and
11 well-being initiatives. What's not always so clear is
12 how well they're being audited on uptake; is that uptake
13 equal across the professions; is it easy for different
14 professions to access. I think as well, when you had
15 social distancing in place, where you would normally
16 bounce ideas off another therapist or offload on to
17 a colleague, when you're not seeing your colleagues in
18 the same way, then that has an impact on your mental
19 health and well-being.
20 Even at the time, if you were going off on maternity
21 leave, you didn't have your usual chance to say
22 "Goodbye" or talk to people before you were going off.
23 Staff who retired or who changed jobs in that time just
24 kind of -- you might have had an outdoor gathering if
25 the weather -- which in Scotland isn't always ideal --

1 allowed for it. So you lost some of that connection
2 that staff might have had and I think that's still
3 having an impact.
4 Q. Thank you. Where therapists had been redeployed,
5 obviously there were patients who were then no longer
6 receiving physiotherapy treatment or physiotherapy,
7 do you or do your members think that much thought had
8 been given to those patients whose health necessitated
9 physiotherapy but whose therapists were redeployed?
10 A. I think where -- a lot of the patients would have been
11 in the shielding category and so naturally you were
12 trying to restrict the amount of people that went in,
13 and I think the decisions that were made were made with
14 the best of intentions at that time, but I think it's
15 how we learn from them going forward into what does
16 constitute -- what would constitute "essential" for
17 somebody who is in a shielding category. And I know
18 from conversations with some staff in those areas that,
19 when they've gone back to their service post COVID,
20 they're seeing patients who will not regain where they
21 were -- where their potential was pre-COVID and there's
22 a lot of guilt associated with that for staff, that have
23 they in some way let their clients down; that they know
24 they're not going to get to quite where they should have
25 been. I think we need to consider, if there is any

1 future pandemic, how we look after shielded patients but
2 also consider their rehabilitation needs and maintaining
3 that rehabilitation, their mobility, their function,
4 their posture. All of those elements do require some
5 input.
6 Q. Do you think then that, despite having the best of
7 intentions, perhaps those responsible for formulating
8 the policy haven't had a full appreciation of how vital
9 physiotherapy is to some patients and their ability to
10 function generally? As you've told us, physiotherapists
11 can help with breathing, for example, and there are
12 people living in the community who do have respiratory
13 issues or movement issues and so therapy plays a role in
14 enhancing their everyday life for them to do basic
15 things. So do you think perhaps there was a lack of
16 that fundamental appreciation of the role of
17 physiotherapy?
18 A. Yeah, I think there was a lack of understanding of the
19 impact of withdrawing that service and I think it's
20 understanding that, while some patients are vulnerable
21 and might need to shield from the virus, you still have
22 to encourage their mobility, improve their function, if
23 you want to maintain that quality of life. And even for
24 patients coming out of hospital post COVID, again, there
25 is that need to continue that rehabilitation to maximise

1 their function and their ability so that they can
2 maintain as active a part in life as possible.
3 Q. Yes. And now that things have largely gone back to
4 normal or by the end of 2022, which is the time period
5 we were looking at, were any extra resources put in
6 place to help those patients try to get to a similar
7 level that they would have been even if they couldn't
8 fully catch up?
9 A. In terms of workforce planning, I don't think we've seen
10 an increase in the resource for those areas. We've seen
11 the staff who were redeployed back within those areas
12 but not necessarily an extra resource put in. And
13 I think for the staff there's an anxiety that: are they
14 seen as non-essential services, so is there a risk of
15 them being pulled again? What happens if we're
16 short-staffed, short-funded? Which areas are going to
17 be pulled and which areas are going to suffer? And
18 is it always the acute hospitals that are seen as the
19 mainstay instead of looking at how we facilitate
20 patients' journeys on a rehabilitation pathway? So it's
21 how we can think about it differently.
22 Q. Is that then continuing to have an impact on staff
23 morale and mental health?
24 A. Yes, I think that's something we're still seeing and
25 I think I mentioned in the report that we're anecdotally

1 hearing of more staff retiring sooner than they might
2 have pre COVID. In the old pension scheme
3 physiotherapists had a right to retire at 55 without
4 actuarial kind of reductions as a special class status,
5 and I think we're seeing more people who are approaching
6 that threshold taking that up where they might have
7 worked a little bit longer in the past.
8 Q. Do you think that's largely down to morale or do you
9 think there are other issues that affect that?
10 A. I think, again, there's many issues that affect it.
11 I think COVID caused many of us to re-evaluate the
12 decisions we make in life, to re-evaluate your work/life
13 balance, to look at things. But morale and mental
14 health and well-being certainly contributes into that
15 picture as well.
16 Q. Thank you. You mention in your -- sorry. Actually
17 I want to move on to PPE. Could you tell us about the
18 issues that your members had with PPE?
19 A. One of the issues that was probably more unique to
20 physio with PPE was around about how you defined an
21 aerosol-generating procedure. As I say, physio works
22 quite closely with respiratory care, so you're
23 encouraging patients to take deep breaths, you're
24 encouraging them to cough and you're often quite close
25 to them at that point of view. You know, if you've got

1 your hands on somebody's chest and encouraging that sort
2 of chest expansion, you can't do that from really far
3 away. So physios are aware that, when patients cough,
4 it generates aerosols that quite often land on you.
5 But there was a big debate about whether chest
6 physiotherapy was classed as an aerosol-generating
7 procedure and therefore should get a higher level of PPE
8 than just kind of surgical masks or more your FFP3 type
9 masks or your fit-tested masks, and that caused a lot of
10 concern at the beginning for us, and the lack of ability
11 for our professional body to be involved in the IPC, the
12 infection prevention and control cell discussions around
13 about that. So we were advising members that they
14 needed to risk-assess but that then could put them in
15 conflict with other staff or you had staff going, "Why
16 are physios wearing a mask in with that patient and we
17 are not allowed to wear a mask?".
18 Then you have the common issues lots of other areas
19 have. PPE predominantly is designed around a male body
20 even though our workforce in the NHS is not
21 predominantly male, so you had the issues of the fit
22 test and how well the masks fitted when you have
23 a smaller face than what the mask has been designed for.
24 So you had staff who might only have one or two brands
25 of masks that they passed the fit test on and they were

1 in short supply, so that had an impact. And then the
2 sort of common issues just around, again, length of
3 apron, are the gloves in the right size for the type of
4 staff that are in, so do you have more large gloves but
5 more staff who need small gloves for the work they're
6 doing.
7 Q. Yes, thank you. I think there were also issues around
8 the disposal of PPE for those based in the community; is
9 that right?
10 A. Yeah. So it was trying to get clarity and understanding
11 on how you disposed of it. Did it get disposed of in
12 the person's household waste? Did it sit outside their
13 house for so many days and then get put into their
14 household waste? Did you bring it back to the centre.
15 And if people were using their own car, there's that
16 question of, "Do I really want used PPE sitting in the
17 back of the car where my kids are going to be sitting or
18 where I'm transporting our shopping back home?"; "Do you
19 want to put your shopping bags next to where you've just
20 been carrying contaminated PPE back?".
21 And especially with the Scottish weather, staff were
22 being encouraged to put PPE on before they got into the
23 house, so you were often putting it on in your car,
24 which is not right outside people's houses -- it's very
25 rare that you can park right outside somebody's house.

1 So you're often then having to run through the rain, run
2 through the snow, and you've got to be bare to the
3 elbows. So you're wearing just a uniform and an apron
4 and having to kind of run into houses and then again
5 coming out and having to change outside and run back to
6 the car. That all has an impact on general health and
7 well-being if you're getting soaked on your way to
8 a client.
9 Q. Yes. Did the rules require physiotherapists to be bare
10 below the elbows?
11 A. It's kind of -- for hand-washing it tends to be bare
12 below the elbows, so you couldn't put a fleece on and
13 comply with infection control guidance.
14 Q. Did you try to contact anyone to get clarity around the
15 issue of PPE disposal?
16 A. The society -- not me personally but within the CSP,
17 yeah, and again it's trying to figure out -- the unique
18 situation here is: is it UK guidance that applies in
19 Scotland or do we have different guidance in Scotland?
20 So you're often kind of re-jigging and re-looking at
21 where that guidance is and where it comes from.
22 Within the hospitals, for shortages of PPE, they did
23 quite quickly set up a PPE helpline, which was really
24 useful because we could then direct staff to that. So
25 we weren't having to act as an intermediary and try and

1 interpret what their concerns were. They were able to
2 go direct with their concerns.
3 Q. With the national infection prevention and control, you
4 said that the society wasn't included within those
5 conversations and the consultation. Did you try to --
6 did you approach them with a view to being involved and,
7 if you did or the society did, what was the response?
8 A. That was done at a UK level and I can double-check for
9 you the communication, but I do know that there was
10 certainly requests to be involved on the IPC
11 discussions, especially around about aerosol-generating
12 procedures, and there was quite a lot of communication
13 back and forwards about that and I can share that with
14 you.
15 Q. Yes. You mention in your statement that you felt more
16 involved with what was going on in Northern Ireland.
17 Why was that the case, that they were willing to include
18 the society?
19 A. I think within Northern Ireland I hold a seat for five
20 unions on our joint negotiating forum, so when we were
21 having fortnightly meetings I was naturally included and
22 then cascading the information back out, where in
23 Scotland we discovered about groups that were happening
24 but that we weren't aware of until quite a while
25 afterwards, that weren't our usual structures. And they

1 were put in place because decisions needed to be made at
2 pace, but it's really hard when you're seeing the
3 outcome of the decisions but not knowing where they're
4 made, and you're working at pace as well but then having
5 to go, "Wait a minute, what's this group that I haven't
6 heard about it? How do I find out about it? How do
7 I know where it's meeting, what the minutes of the group
8 are?". So it took a while to understand where the gap
9 was to then know where to approach.
10 Q. Yes, and once you approached them, were you able to join
11 those groups?
12 A. So the group in Scotland, the Senior Leadership
13 Workforce Group, I think it was called, we weren't able
14 to join it, but my staff side colleagues who were on it
15 were able to share the minutes from the meeting with you
16 so you at least had some understanding of what was
17 happening, but it wasn't quite the same as being engaged
18 and involved.
19 Q. Yes. I mean, this will be an obvious question, but
20 presumably you would have found it more beneficial to be
21 included and be able to input into the decisions that
22 were made?
23 A. Even to be able to understand what was leading to the
24 decisions, you know, so to know the conversation that's
25 then led to that being the decision instead of kind of

1 going, "I see the decision but I don't know how we
2 arrived at that". So, yeah, an earlier involvement
3 would have been ideal and I think that would be one of
4 the key learnings for us from this.
5 Q. Thank you. Going back to the issue of early retirement,
6 is this having a knock-on consequence on current
7 workforce levels and recruitment or are you finding that
8 graduates are filling the vacancies at a good pace?
9 A. Within Scotland, the CSP has a campaign around about
10 Scotland needs more physiotherapists. Our undergraduate
11 training places haven't increased for a considerable
12 period of time so we don't think that we're going to be
13 producing enough physiotherapists to meet the demand
14 that is out there. Even within the existing gaps within
15 the workforce, we think there's going to be problems.
16 Q. Thank you. I want to come on to students and training
17 in a moment, but just before we move on to that, you
18 mention in your statement at paragraphs 40 and 41 that
19 there has been a loss of rehabilitation space, that
20 spaces such as gyms and hydrotherapy pools were
21 repurposed and have not returned.
22 A. No.
23 Q. For what purposes are they being used?
24 A. So physiotherapy gyms are normally quite big spaces and
25 at the start of lockdown we weren't bringing patients

1 in. There was a large move to doing some of our MSK
2 outpatient services through Near Me appointments, so
3 using video conferencing. So at that time it made sense
4 for some of those spaces to be repurposed, sometimes for
5 storage, sometimes for a variety of reasons.
6 On a number of acute wards, so on medical wards or
7 on stroke wards, we might have had a base outside as
8 a rehab space and some of them have been repurposed.
9 Beds have been put in them. That then limits how easily
10 physiotherapy can do rehabilitation for stroke patients
11 and for other sort of neurological conditions and
12 orthopaedic conditions. If you don't have space, you're
13 then trying to do rehab at a bed space, which is not
14 always easy to fit a number of therapists in and
15 a patient and to maintain dignity, and if you need to
16 bring equipment in, that makes it even more awkward.
17 You can't always take patients down to the main
18 physio gym because simply transporting them isn't always
19 easy and for some patients it can be too loud, too
20 noisy, too distracting, and you need somewhere quieter
21 to allow you to do that one-to-one rehab. So it is
22 having a knock-on effect and it's something that
23 we're -- we're still trying to encourage
24 physiotherapists to challenge getting those spaces back
25 but it's not always easy. And not all of our

1 hydrotherapy pools have re-opened, so again that's an
2 area of rehabilitation that's not open to all patients
3 in all areas of Scotland.
4 Q. Why have the hydrotherapy pools remained closed?
5 Presumably there aren't many other purposes that those
6 spaces can serve.
7 A. No. Part of the problem is that, once you've emptied
8 a hydrotherapy pool and if it remains empty for a while,
9 there can be structural issues. So there's some issues
10 around about that and some issues around about -- from
11 my understanding, some of it is a reluctance of the
12 cost. These are heated pools so there is a cost
13 associated with that. You have to have them at or close
14 to body temperature for the rehabilitation, so there's
15 a reluctance to invest in that cost. But that also has
16 a cost in that you're then not able to use that as
17 a tool for patients and you're having to find
18 alternative ways to do therapy where hydrotherapy might
19 have been the easier approach.
20 Q. And is that having -- both the lack of hydrotherapy
21 pools and the lack of physiotherapy gyms, wards with
22 physiotherapy spaces, is that having a significant
23 impact on patient well-being and perhaps even the time
24 spent in acute wards?
25 A. We would say "Yes". It's really hard to get it

1 quantifiable as the data, but if you want to improve
2 patient flow through a hospital, you need to look at how
3 you're rehabilitating them and you need to have that
4 investment in rehabilitation and have it meaningful.
5 You're not going to get patients out of hospital unless
6 you improve their mobility, improve their function, and
7 returning as much of that mobility and function as
8 possible. That's where physiotherapy is key and it's
9 where our rehab spaces are also key. There's no point
10 in having amazingly skilled physiotherapists who are
11 trying to do a job at a bedside or trying to
12 rehabilitate someone's balance on an air flow mattress
13 that you're having to kneel behind them on, so, as
14 a therapist, you're not on a stable surface and you're
15 trying to work with your patients instead of being able
16 to take them to a gym and have a plinth that's
17 adjustable, that's easy to use and that works best for
18 the patient and therapist.
19 Q. So part of the reasoning, you think, is down to funding,
20 saving money, but actually it might be costing just as
21 much or more to keep these patients in hospital --
22 A. Yeah.
23 Q. -- for longer and it's also at the expense of quality of
24 life for the patients?
25 A. Yeah.

1 Q. Thank you. I want to move on to students and training
2 now, and this starts at paragraph 45 of your statement.
3 Firstly, could you tell us at what stage of their
4 training do physiotherapy students engage in
5 placement-based learning?
6 A. In most universities you do your first placements within
7 the first year, so you are out on placements from very
8 early on, and it's in supervision with your
9 physiotherapists, with your qualified staff.
10 Q. How long are placements generally for? Presumably it
11 won't be a full year at a time. Is it a few weeks,
12 a few months? Are they at university and in hospitals
13 or the community?
14 A. Yeah, so a lot of the universities will have a split, so
15 half the students out and half the students in, so you
16 might have students in at lectures and other students
17 out on placements. Placements tend to be between
18 a six-week and a 12-week duration so you're normally --
19 depending on the specialty -- so you're normally in the
20 hospital working with the therapists for that kind of
21 six-week period of the placement.
22 Q. Do students express a preference for certain settings or
23 is it a requirement that every student experiences
24 particular settings?
25 A. From knowledge, the students don't get to kind of --

1 there is key areas they should be covering and a key
2 number of hours they have to cover clinically to get
3 their qualification. So as well as their exams, their
4 kind of practical placement experience also counts.
5 Q. Yes. And what is the purpose, the primary purpose, of
6 placement-based learning?
7 A. There's a limit to what you can do either on other
8 students who don't have that condition -- so if you want
9 to learn how to handle a stroke patient, how to
10 rehabilitate somebody with Parkinson's, how to work with
11 paediatric patients, you can't replicate that on
12 a healthy student. You really need to be seeing what
13 therapy is. It's a very -- physiotherapy is and should
14 be a very hands-on profession, so you do need to be on
15 placement to learn how to do that. If you're wanting to
16 deal with patients with COPD or chronic obstructive
17 pulmonary disease, again it's really hard to learn those
18 techniques on healthy people. You need to be in
19 treating your patients and learning on the job.
20 Q. Yes, thank you. You mention in your statement that,
21 apart from students who were in their final year, all
22 other placements were cancelled. What was the impact of
23 that on the training of first- to third-year students?
24 A. The impact of that was huge. So we also had the fact
25 that their classes went online, so where you would have

1 been in person before, when we brought back in-person it
2 was a much smaller group, there was social distancing,
3 which becomes really hard with a hands-on profession to
4 maintain social distancing.
5 The focus correctly was on getting final year
6 students to meet their requirement of clinical hours,
7 knowing that with the earlier students there would be
8 the time to kind of gain that back. Some of them were
9 then doing placements virtually, so where we were doing
10 Near Me consultations, the students could be in on them,
11 not always in the same room as the physiotherapist, and
12 then chatting to the physio afterwards about the
13 consultation.
14 I think again this is something we're still seeing
15 the impact of. Students had a very altered experience
16 during COVID and that I think is still having an impact
17 on their confidence as they come out, on their skills,
18 and we are hearing anecdotally about slightly more time
19 needing to be taken with newer graduates who were
20 students during this time, that it's just -- it's almost
21 making up for some of what they couldn't get during that
22 pandemic period.
23 Q. For those students -- you mentioned that those earlier
24 in their university career, it was thought that they
25 could catch up. For those who were in the first or

1 second year in 2020, by the time they got to their final
2 year, do you think that they were able to catch up or
3 do you think there was a noticeable difference between
4 that cohort and those who had had four years or three
5 years of placement-based learning before that point?
6 A. In order to qualify, you have to do a set number of
7 clinical hours, so they had all done the same amount of
8 clinical hours so they had to make those clinical hours
9 up. The quality I think we're still monitoring and
10 seeing. I couldn't say for definite. I would probably
11 need to speak to some of my HEI colleagues to get more
12 information on how they've perceived it at this point in
13 time as well.
14 Q. What impact has that had on their ability to qualify
15 into the profession? Do they -- you've mentioned that
16 things are taking a bit more time. Do they have to
17 carry on training once they graduate and start
18 a position or at the point of starting a position
19 are they able to just start without any other training?
20 A. I mean, when you qualify as a physiotherapist, you're an
21 autonomous professional, but what I would say is your
22 university degree gives you your baseline and you are
23 constantly learning. So even in your first job, it's
24 almost a developmental post that you're still learning
25 within that first post and I think that's where we're

1 still seeing some of the impacts. And then you have the
2 knock-on effects of we're seeing retirements, we're
3 seeing an impact on our workforce, that there's less
4 staff to supervise, so there's more stress generally all
5 round, which is really where we need to look at that
6 workforce planning in a more holistic way.
7 Q. So are there then issues with retaining practical
8 knowledge and skills?
9 A. I would -- again, I would probably need to check that
10 with some of my colleagues on our professional side on
11 what they're hearing about that and we can come back to
12 you on that one.
13 Q. Sure, thank you. Moving on to paragraphs 46 and 47,
14 I understand that you state the guidance was confusing
15 and we've heard that from others too and that this had
16 to do with the Four Nations approach or lack of it. On
17 the basis that Scottish students or students in Scotland
18 were presumably on placements in Scotland, could you
19 tell us a bit more about why the Four Nations' approach
20 affected that, you know, why it perhaps wouldn't have
21 seemed the case that only Scottish guidance would apply?
22 In what ways were the Four Nations' guidance interacting
23 that led to confusion?
24 A. So this was more around guidance for -- there was
25 a point where we were trying to bring those who were

1 close to concluding their training onto the HCPC
2 register and into the workforce sooner and also looking
3 at, when students had their summer gap, how could they
4 help out within the Health Service. So there was
5 guidance around about how we could bring students from
6 various years into the workforce.
7 The four chief allied health professions officers,
8 as I understand it, were in close communication with
9 each other in the same way as the Chief Medical Officer
10 and Chief Nursing Officer were, but then any guidance
11 they produced had to be specific to the country. So
12 there was a lot of confusion because we were seeing some
13 forms of guidance -- in Northern Ireland I was hearing
14 about it being done one way. In Scotland it was then,
15 again, "Where was the guidance? Was it coming out too
16 late for what we were seeing within the workforce? Did
17 we need that same amount of students coming into the
18 workforce?". So it was joining up the guidance with the
19 workforce planning, with what the service actually
20 required, with whether it was meeting the students'
21 needs and the service needs. And, again, not always
22 clear communication channels for us as a professional
23 body at that point in time.
24 Q. Thank you. You mention that the CSP wasn't involved in
25 decision-making with the Scottish Government. Did you

1 ever -- did the society ever get a chance to make
2 representations before decisions were made or did that
3 position carry on throughout?
4 A. So that was sort of specifically this Senior Workforce
5 Leadership Group -- I think I've got the title correct.
6 So there were partnership groups that existed pre COVID
7 and kind of were in place during COVID but not meeting
8 to make the decisions, so the Scottish Terms and
9 Conditions Committee, it was more the secretariat that
10 were making decisions and sharing that with the rest of
11 us. The Scottish Workforce & Staff Governance wasn't
12 really meeting and the Scottish Partnership Forum wasn't
13 really meeting.
14 So the Senior Leadership Workforce Group was
15 bringing -- to my understanding, it was bringing some of
16 health and social care together because social care is
17 not as involved in those other groups, and it was the
18 one that was making decisions at pace and that we found
19 out about at a much later stage. So we were never part
20 of that group but we did eventually manage to see the
21 minutes from the group so were able to see the kind of
22 scope of decision-making and try and understand some of
23 the decisions that were being made.
24 Q. Then presumably following on from that the society
25 didn't have a chance to make the impacts of decisions

1 known to the Scottish Government, so, for example, the
2 impact of not allowing placement-based learning and the
3 like. Were you able to make any representations about
4 that?
5 A. So we were using the routes that were open to us. So to
6 try and engage with the Chief Allied Health Professions
7 Officer, it tended to be through a group called the
8 Allied Health Professions Federation Scotland, so that's
9 where the professional bodies for the 14 allied health
10 professions come together. So it was through that to
11 make representation, through any direct communication
12 routes we had. So we weren't sitting silent. We were
13 trying to make our voice heard as much as possible.
14 Q. What sort of response were you able to get?
15 A. Sometimes it felt like you were shouting into a void,
16 that there wasn't always a clear response back and you
17 weren't hearing, "Right, we've heard from you on that so
18 we'll now include or involve". It didn't always open
19 the communication channels that you would have hoped for
20 from it so you did then have to, again, use multiple
21 means of trying to raise questions to try and figure out
22 who was dealing with the decisions and how to get the
23 answers.
24 Q. So in terms of education, that was limited and you
25 weren't really -- you didn't feel that you were being

1 listened to. Overall, as an organisation with the
2 multiple different areas that you cover, how well do you
3 think you were listened to by those making decisions?
4 You mention in paragraph 59, for example, that you had
5 fortnightly meetings with certain organisations and with
6 civil servants. Do you think your concerns were
7 listened to by the civil servants? Do you feel you were
8 overall listened to?
9 A. The fortnightly meetings were in Northern Ireland --
10 Q. Ah, okay.
11 A. -- so that was kind of the contrast for me, was that as
12 trade unions we were meeting regularly with our
13 HR directors. Northern Ireland is smaller, we've got
14 five trusts as opposed to 14 -- 14 health boards -- but
15 it felt, from my point of view, that there was more
16 desire to meet with us and talk. In Scotland the
17 problem was not really understanding where the decisions
18 were being made, so not knowing who to speak to, so you
19 were trying multiple routes to try and understand where
20 decisions were being made and to try and have the
21 concerns that our members were raising with us then
22 heard at the appropriate levels.
23 Q. But within Scotland that unfortunately doesn't seem to
24 have happened?
25 A. No. For me, it felt much more disconnected and, for me,

1 it was having that comparison of -- and often in
2 Northern Ireland I was hearing about where we were
3 getting guidance from the Chief Medical Officer and it
4 was like, "Oh, right, so now I can find that in Scotland
5 because I know what I'm looking for". But if you're not
6 involved in the groups, you're kind of having to hunt
7 various places to try and find where the most relevant
8 guidance is and, as I say, understanding is it UK-wide
9 guidance, in which case that's fine, I can leave some of
10 my other colleagues to find that, or do I need to find
11 something that's specific within Scotland? And if it is
12 UK, are we applying it in Scotland or are we tweaking it
13 and changing it slightly for the needs within Scotland?
14 So you were always kind of on a slight hunt whenever you
15 found anything to then search it back and check you were
16 giving the right information to members.
17 Q. And did that have quite an impact on the morale and
18 mental health of your members as well?
19 A. I would hope that the members didn't see that as much.
20 I think it probably had more of an impact on us as
21 a professional body and for the team of staff who were
22 engaged with that. I would genuinely hope that our
23 members didn't see that as much as we were experiencing
24 it.
25 Q. So for the society itself, a key issue is that, if there

1 was to be another pandemic in the future, that the
2 society is involved in these decision-making processes
3 so as to avoid these long-term consequences that you've
4 spoken about?
5 A. Yeah, and I think because we're both a professional body
6 and a trade union, there's scope to involve us in
7 multiple ways. So the trade union channels should have
8 been open to us and, again, as a professional body, we
9 should have routes in as well for those. So where we're
10 talking about terms and conditions and how things are
11 applying and then when we're talking about professional
12 issues around about aerosol-generating procedures and
13 PPE, it's having the right routes for that joint
14 communication from us and to feel that the voices of our
15 members are then heard within those decisions.
16 Q. Yes, thank you.
17 Now, is there anything that we haven't discussed
18 today that you would like to mention at this point or
19 raise?
20 A. I think -- and I mention at point 61 in the statement
21 about lessons to be learned and it comes back to that
22 rehabilitation, that I think each health board needs to
23 have somebody whose focus is on rehabilitation and have
24 that rehabilitation lead and a clear rehabilitation
25 pathway established in each health board. I think that

1 would then help with that communication, because if that
2 rehabilitation lead is picking up on the relevant people
3 in that rehabilitation journey, which isn't just
4 physiotherapy but does involve a lot of our other allied
5 health professions, I think that would make
6 a significant difference.
7 Our voice is often further down the chain within
8 health boards because of where the allied health
9 professions as a group sit and then it's our voice
10 within that grouping. So you're often labelled as
11 allied health professions who sit under the chief nurse,
12 so you're further and further away from that
13 decision-making. So I think it's looking at whose
14 voices are heard within health boards and how that
15 impacts on the patient journey.
16 MS BAHRAMI: Okay. Thank you very much.
17 THE CHAIR: Yes, thank you, Ms Ronald.
18 A. Thank you.
19 THE CHAIR: Right. Those are all the witnesses I think for
20 today, Ms Bahrami, and we're sitting again tomorrow
21 morning at 9.30.
22 MS BAHRAMI: Thank you, my Lord.
23 THE CHAIR: Thank you. That's all.
24 (11.30 am)
25 (The hearing adjourned until

1 Friday, 26 April 2024 at 9.30 am)
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