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Scottish Covid-19 Inquiry

Day 40

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(9.30 am)

THE CHAIR: Good morning, Mr Gale.

MR GALE: Good morning, my Lord. There are two witnesses today. The first is Mrs Elizabeth Martin.

MRS ELIZABETH MARTIN (called)

THE CHAIR: Good morning, Mrs Martin.

A. Morning.

Questions by MR GALE

MR GALE: Mrs Martin, good morning. Your full name, please?

A. Elizabeth Martin.

Q. You've provided us with a statement, Mrs Martin, and you're agreeable that that statement should be published. You're also agreeable that your evidence today should be broadcast and recorded?

A. Yeah.

Q. Can I remind you that we have in place a general restriction order so that please don't name other people as you're giving your evidence, please, otherwise we'll have to briefly stop our proceedings to remove reference to that, but if it happens, it happens. Don't worry about it, but if you can avoid that, please.

Your statement, for the record, is SCI-WT0418-000001. You are employed as a private care branch secretary and representative of private care for

the GMB union?

A. Yes.

Q. And you've been in that position for six years, I think; is that right?

A. Yes.

Q. You first joined the union as a workplace representative in 2007?

A. Yes.

Q. And your background is that you qualified and registered as a nurse in 1979?

A. Yes.

Q. Your work was initially in the NHS and after your second child arrived you continued to work but in a care home setting; is that right?

A. Yes.

Q. I think you've recently retired from a career working in care homes, the care home setting, and you'd been doing that for about 38 years.

A. I definitely wanted a break from nursing really.

Q. Right. Were you working in a care home during the pandemic?

A. Yes.

Q. Now, Mr Arkison has told us about the GMB so we can take what you've said about the background and overview of the GMB as read. But, as you say in paragraph 19 of

your statement, your role in the union and therefore the role that you're going to tell us about today focuses on those workers who were employed in private care homes --

A. Yes.

Q. -- like yourself.

Now, if we go to paragraph 23 of your statement and indeed following, you tell us that during the pandemic -- it was really from the outset of the pandemic -- the issues apparently being raised by members that they were consulting you about were largely having regard to the guidance that was being produced and how it affected them in their own roles within care homes; is that correct?

A. Yeah. Guidance, it was very difficult because it was changing constantly. Staff were working on shifts, they went on shift in the morning and by the afternoon the guidance had changed again. It was confusing for everyone.

Q. I think you can rest assured that we've heard that from a number of people, Mrs Martin. From your point of view, in your union role, I think you describe this experience as somewhat frustrating.

A. Pardon?

Q. You describe this experience as somewhat frustrating for you as a union representative?

A. Yeah, it was frustrating. As well as the guidance changing constantly, the guidance wasn't very clear at times. Some of the guidance, from a care home point of view, you were looking at it and thinking, "That's an impossibility within a care home setting". Managers were interpreting the guidance different from staff and it just -- it was extremely confusing. Staff were having to deal with horrendous stuff as it was and then the guidance just being unclear and constantly changing had a massive effect on them.

Q. From your own perspective, did you find it difficult to keep up with the guidance?

A. Yes.

Q. Did you find it difficult on occasions to interpret the guidance?

A. Both as working in a care home and as a rep, because I was trying to keep up with the guidance to just sort of try and help the members within private care. They were phoning in because they were getting confused with the guidance. I don't suppose I was a great deal of help at times because I couldn't understand the guidance and where it was coming from, you know, and the best I could say to the members was, "Look, I appreciate it's frustrating, I appreciate youse are angry, I will try and get some clarification in that", but that was the

sort of best I could do. It was difficult .
Q. And also one of the issues you had was that —— I get the impression from having read your statement and having met you that, prior to this, you were somebody who, if you wanted to settle or resolve an issue, you went to the workplace and did so. You were now having to do this all on Teams or Zoom or some remote means of communicating with your members?
A. Yes. That was just another sort of difficulty . As I say, prior to that, if there were difficulties , we could arrange to visit the home, speak to staff, speak to managers, try and resolve issues, but then we couldn't. We had to learn how to use Zoom and Teams, which was all at that time very new, and it's no ideal trying to reassure people over a screen. It's difficult .
Q. Yes. Can I ask you to go to I think paragraph 25 of your statement? One of the issues that you mentioned members were seeking clarity about was the self—assessment that members were having to make regarding the use of face masks. Can you just tell us a little about that, please?
A. Again, that's —— it just kind of goes back to the guidance a wee bit and how sort of we needed clarity —— at one time the guidance came out —— and I can't

remember the exact date because there was loads of them —— but there was one particular one that said that staff were to self—assess whether they needed to use a face mask or not, which ——
Q. Did that rather beg a question ——
A. It was just a bit confusing. You either need a face mask or you don't. You know, and asking carers that werenae used to working in that kind of environment to self—assess just didnae make a great deal of sense, to be honest.
Q. This is not meant as any criticism of carers in that situation but was that something about which carers in care home settings had a great deal of experience of using face masks?
A. No, I would say the only staff within a care home setting that maybe had some sort of experience of face masks, et cetera, was possibly trained nurses who had done their training in a general setting. A lot of the care staff had just —— hadnae worked in a National Health Service setting, a hospital setting, so the use of face masks just was very rare.
Q. So what you presumably would have been looking for would have been guidance as to the circumstances in which a face mask should have been worn rather than leaving it to the discretion of care workers as to when they might

choose to wear it?
A. Yeah, you either wear a mask or you don't wear a mask. To self—assess just didnae make sense.
Q. It probably arises out of that type of situation —— and indeed it's something you mentioned just a short while ago —— but you go on at paragraph 27 of your statement to observe that guidance was, as you put it, seen to be written by people who did not know or understand how a care home works. Again, this is something we've heard from a number of people. Was this your impression, that there was a degree of —— or a lack of appreciation of the particular circumstances in which care home workers had to operate when guidance was being written?
A. Yeah, it did. I think they didnae appreciate the environment of a care home setting. They didnae appreciate sort of what's involved in a care home; sort of an example of that being, you know, the guidance saying to keep people —— people in their own rooms, which —— that's fine because we're trying to stop the spread of infection, but telling vulnerable old people that's got severe dementia, that's mobile, that they've got to stay in their own room just didnae work.
Q. No.
A. Somebody with dementia disnae understand self—isolation. They don't understand everything that was going on.

That was very difficult because then that led to a member of staff having to walk around a care home with somebody with dementia and somebody had to clean every surface the person with dementia touched. Staff were working under severe pressure as it was. In that team, one member of staff, they go off the floor, wandering about with somebody with dementia that didnae understand, and that's why I think a lot of the guidance was written from somebody that really didnae understand care homes.
Q. Yes. I think one of the things we have heard about people who have or had dementia is that there was a tendency on the part of many to wander around the care home. That presumably is one of the difficulties ?
A. Yes. And, again, somebody with dementia, trying to keep them in their own room if they didnae want to stay in their own room, that can just lead on, you know, to distressed behaviour and that's no what we're there for. You know, we're there to try and stop distressed behaviour.
Q. If I can take you briefly —— because it's one of the points you make in your section of your statement on lessons to be learned at paragraph 72. I wonder, just so that we have it in your own words —— perhaps you've already given it —— perhaps you'll just read out

paragraph 72. It will be on the screen in front of you.
A. Well, I would like to hope, if anything like this ever happens again —— I hope it never does —— but the lessons learned from it and the outcomes and the feedback that comes back from this Inquiry and staff that were involved in that —— should it ever happen again, that representatives of the workforce are consulted on guidance, which would have saved a lot of frustration, confusion, stress.
Q. I think just looking at what you actually say in paragraph 72 —— and it's from your perspective but we've heard it from others —— you say:
"Any guidance to be issued in future should only be sent out after discussion with the people who are actually doing the job, not the managers, but the people who carry out the role from day to day."
A. Yeah.
Q. Thank you. Another example you give about some of the issues relating to guidance is in paragraph 35 of your statement. You'll be aware of this. This is in relation to instructions that were being given to staff who —— the instruction was that they should not car—share. Obviously we are conscious that some care homes are in remote locations and car—sharing pre—pandemic would have been a normal activity for care

home staff, but instructions were being given, as you say, that they should not car—share. Was that an instruction that came locally from management or was that something that came more generally from the Government, do you know?
A. Right, that one was quite hard to find out exactly where it came from. A lot of the companies made it their company policy, tied in with infection control ——
Q. Right.
A. —— policy. If I remember correctly, there was some kind of vague guidance, but again it all came back to how managers and above, senior managers, were interpreting the guidance because everybody seemed to be interpreting it differently at times and the car—sharing was one of them. That just takes us back to just something else that come out that didn't seem to make a lot of sense to staff. Staff were working alongside a colleague for a 12—hour shift, sometimes in quite close proximity, if it was somebody that needed the assistance of two members of staff, but then were told they couldnae share a car to come into work for a five—minute journey. That didnae sort of —— staff couldnae sort of get their head round why that made sense. They cannae be in a car together for five minutes but it's okay to work a 12—hour shift together.

It led to a lot of difficulties as well with people getting transport to work. A lot of care homes are quite rural, they're not all on bus routes and, again, having to use public transport wasnae an ideal situation either.
Q. You also tell us about rules and guidance on infection control. Now, again, going back to what you said a little earlier, was that something that carers within care homes would have been particularly aware of pre—pandemic?
A. Very basic infection control, you know, sort of around norovirus, that type of infection control, but nothing on the scale of COVID. I don't think actually any of us had the sort of knowledge of COVID because it was sort of a progressive thing.
No, I would say again it takes us back to carers had basic infection control knowledge, but this sort of —— COVID infection control was on a different scale. It was just huge —— quite overwhelming for them to begin with.
Q. You use the words at paragraph 38, "Staff were bombarded with [various instructions on] extra infection control training". Is that ——
A. Yes. It just seemed to be —— staff would just be having all this extra infection control training, then they

were having to pull on and off PPE in the correct order. It all seemed to happen at once. You know, a lot of infection control —— extra infection control training was done online via e—learning, things like that. Again, staff —— there was not the time for staff to do this within their working hours. They were having to do it at home in their own time. And actually it just got to the point where staff felt they were never getting away from COVID. It was either at their work or at home doing extra training, just —— it was huge.
Q. One of the points you make is that the pressure of these additional infection control measures, taken together with Public Health inspections and also the Police Scotland investigations in the event that there was a care home death, that these all added pressure to care home workers, who felt, as you put it, under scrutiny. You were working in a care home. Is that how you felt?
A. Yeah. Just sort of —— it felt as if everybody, whether it be Public Health, Police Scotland, whatever, wanted to blame the staff for the deaths in care homes and it wasnae our fault. We'd done the best we could.
Q. You go on to say that —— I suppose reading into what you say, it was a public perception that care home workers were to a certain extent to blame for the spread of the

virus. Was that something you felt?
A. Yeah, that's how it did feel.
Q. Obviously somebody -- a group of people that you and your care home worker colleagues would be interacting with would be families of residents within the care homes. Normally, as I understand what you say -- this is really 39 and 40 of your statement -- normally time would be taken to talk to members of families, to give families an update on how their relative was and, as I'm reading what you say, there was a limitation on how that could be done during the pandemic; is that correct?
A. Yes. During normal circumstances, you know, if we're phoning families for an update or just to tell them what was going on, you know, there would be a bit of chit-chat and a bit of social chat, sort of, you know, "How are you doing? How's your family doing?", blah blah blah, but during the pandemic, staff were so overstretched with the workload that these sort of conversations didnae happen. The only conversations to have with the families was sort of very brief and to the point, you know, because you were maybe sat with a list of about five or six families to phone one after the other, you know. And staff would have liked to have spent more time, but you were sort of looking at the list and thinking, "Oh, I've still five more people to

phone and then I've got this to do and that to do", so conversations were cut shorter than probably normally would have been.
Q. There was also I suppose the other circumstance, which I think we're probably all aware of, of residents who had no family or, if they did, their family lived a considerable distance away and couldn't get to see the relative who was in a care home. In your experience and from your own personal experience, was it important for care home workers to act -- I won't say as a quasi family member, but to assist in those circumstances to alleviate the isolation that that resident might feel?
A. That I don't know.
Q. You don't know?
A. I don't know.
Q. Did you feel sorry for people who didn't have any family to come to see them?
A. Yeah.
Q. Obviously many of your members who are working in care homes would have to deal, during the pandemic, particularly in the early months of the pandemic, with the deaths of residents. Inevitably in a care home, elderly residents, death is an inevitable occurrence, but this obviously was very different. How did your members find coping with that?

A. They done very well. In a care home setting you're used to dealing with deaths but not on the scale that we were dealing with. I mean, you know, there was some homes were having five/six deaths per shift, you know, as opposed to one now and again, which was quite overwhelming. It was also quite sad that staff couldnae spend the time that they normally would providing end-of-life care. The circumstances of providing end-of-life care -- you know, this kind of contact was missing because you had to wear gloves. To me, that makes a huge difference to somebody at end of life. If you can feel somebody holding your hand, feel a bit of skin against yours, having a glove while you're holding somebody's hand just wasnae the same. So as well as having to deal with all the deaths, staff are having to deal with all these small things that normally they would have done that they couldnae do and they sort of felt a bit guilty because they couldnae provide the care that they normally gave.
Q. You do make the point at paragraph 42 that staff also had to deal with families who were angry following upon the death of their relative and took it out on members of staff. Is this something you heard about on occasions?
A. That was in one particular place. Yes, families were

angry at times. Again, like grief does a lot to people and -- but we were all living in strange times which was putting a strain on everybody. I thought it was understandable to a certain extent if a relative lashed out at staff because it was staff that were phoning them, saying, "Look, I'm sorry, your relative has passed away", blah blah blah. So, yes, there was times they lashed out at staff because I think staff were the only ones they could lash out at at the time. But there was a couple of instances where maybe relatives had taken it a wee bit too far with staff in particular settings.
Q. Right.
A. You know, standing outside a care home with media there, going on about the staff having killed your relative, that's never nice for staff when they've tried to do their best.
Q. Another aspect we maybe don't appreciate so much is that staff members would have their own families and there would be presumably an impact on those staff members and their relationship with their own families. Is that something you were encountering?
A. Yeah, it had a huge impact. You know, there was -- staff were having to have very difficult conversations that they never ever thought they were going to have -- you know, conversations regarding putting measures in

place for your children to be looked after should something happen to you. You know, for younger staff members that shouldnae have been a conversation they should have been having at that time.

The fact that there's also —— other than close immediate family, there was kind of extended family people werenae having contact with and, again, it was very difficult for the family members as well because staff were having to deal with illness during their shift, come home either angry or despondent or emotional and, because of confidentiality issues, they really couldnae discuss a great deal with their family. So sort of staff's families didnae know how to deal with things at times, so it was a strain on them as well.

Q. You do make the point, Mrs Martin, that care home staff did consider that they were perhaps wrongly compared with staff in the NHS; that perhaps they weren't as appreciated as NHS staff. Is that something you were coming across in representations being made to you?

A. Now I'm not decrying the NHS, they're just doing their job, but at the beginning of the pandemic care home staff were seeing NHS staff getting free meals, coffee, special shopping hours in supermarkets, even sort of hubs that they could go to during a break for psychological support. Care home staff didnae get any

of that, and that sort of hurts quite a bit because we were dealing with people with COVID as well. The free coffees and meals, that wasn't so bad, but the shopping —— the supermarket shopping hours was a big thing to begin with. NHS were getting in early in the morning at special times that nobody else could get in, just NHS staff. Care home staff didnae get that, so by the time they finished their shift, I mean, supermarkets, at the beginning there was nothing left. That became difficult. There probably was at that time a bit of resentment. Sort of, as time went on, these things kind of levelled out a wee bit, but initially there sort of was.

Q. You mentioned just a moment ago about the absence of what I think are called "well—being hubs", which were available for NHS staff but similar hubs weren't available for care home staff. One of the points you make at paragraph 55 of your statement is the concern for the mental health of care home staff. Now, you tell us a little bit about that in paragraph 55 and in particular you tell us that the union was eventually able to point staff whose mental well—being had been impacted during the pandemic and what they had been experiencing to various organisations that could assist. Is that something you were doing?

A. Yeah. Again, as I said earlier, the NHS seemed to have sort of well—being hubs that they could go to during their break or whenever they felt the need to speak to somebody. Within the care home setting, that wasnae available. If I was speaking to any of my members that were sort of experiencing stress, distress, whatever, I was no mental health trained, I wasnae trained to deal with any of that. I could listen to them but that was as far as it could go, and what we then would —— we sort of put together various different organisations that we could sort of signpost them to for help.

As things moved on and nearer the end of the pandemic, a lot of the companies actually set up employee assistance programmes, but that wasnae available right at the beginning. That's when these things were needed. So maybe if staff were able to lift the phone at the end of the shift and speak to some counselling service, maybe mental health within the social care setting wouldnae be as bad as what it is now.

Q. Right. That's what I was going to ask you. In your experience as the union rep, is this something that has had an ongoing effect on members within the care home staff sector?

A. Yeah. I think there's been a major increase in mental

health problems within care home staff.

Q. I'd like to ask you just very briefly about PPE. We note what you say about this. It's really at around about paragraph 52. You tell us about a situation which —— well, a situation that you became aware of, where in one care home there was a re—using of masks that —— after a care home worker had been into a room perhaps with somebody who had COVID, they were asked to take their mask off, bag it up, but then subsequently, when they went back into that room, they were expected to use the same mask. Can you tell us just a little bit about that?

A. Yeah, it's disgusting. Yeah, there was a home where that's what staff were told to do. They were told if they were wearing a mask, they were to take it off, put it in a polythene bag, tie it up, leave it in the room, and when they went back into the room later on, re—use the same mask.

Q. What was your attitude towards that as the union representative?

A. Well, I was horrified and I went, "No, that's just disgusting". That in itself is an infection control issue. Again, that was —— might come down to managers that I think panicked possibly due to the lack of PPE to begin with, right, but it cannot be things like putting

a used mask in a poly bag and then re—using it again, which was a bit ridiculous, to be honest.
Q. Okay. Can I ask you just a little bit about what you say about testing? You say this at paragraph 61 of your statement. You indicate some of the difficulties that could occur when testing became mandatory for care home staff. Could you just explain what —— some of the timing difficulties that were causing problems in that regard?
A. Right, when it became mandatory —— right, testing in the care home was only getting done on certain days. Say if staff were off duty, they had to go into their work on their days off. Again, it takes us back to another issue of where they were just never getting away from COVID.
Initially, as well, there was loads of issues with the results coming back. The results didn't come back very quick to begin with, so it was actually at the stage where some staff were actually halfway through their shift and they would get the result back saying they had tested positive, you know, but they'd already done, you know, sort of half a shift. So they'd immediately leave. Obviously then trying to get somebody to cover that shift was very difficult, so most times it ended up staff were working short because

people had to go home. As time went on, the results came back a bit quicker, but initially —— you know, sometimes it could take two days for the result to come back.
Q. Now, another matter that we've heard about in the Inquiry, which you tell us about from your perspective at paragraph 63, and that's about the difference that existed between guidance applicable in England and guidance that was applicable in Scotland and the difficulty presented when the care home management company was based in England.
A. Yeah, that was ...
Q. Was that a problem ——
A. (overspeaking — inaudible).
Q. Sorry, we're talking across each other. Was that a problem that cropped up in your experience?
A. Right, again, it just caused more confusion. A lot of the care home companies are English based, they were going with what was happening in England, but the care homes were actually in Scotland and it just caused even more confusion for the staff because policies that were coming out were based on what was happening in England. You know, the likes of the vaccine being mandatory in England but it wasnae mandatory in Scotland, that just caused confusion and, you know, some of the

English—based companies were saying, "The vaccine is mandatory", and up here we're saying, "Well, in Scotland they've made it quite clear it's not mandatory". So that just added to confusion.
Q. Now, Mrs Martin, we've got your lessons to be learned —— some of them —— well, one of them certainly we've looked at —— and we have also your hopes for the Inquiry. I think you say at paragraph 77 —— I think possibly one of the important points you make, looking at the work of the Inquiry, is that you would "like to hope that someone, somewhere acknowledges [that] they", and I assume by that you mean the Government, "did not properly understand life working in a care home and that we also carried out an equally important role as the NHS staff". Is that one of your real important points that you want to get across?
A. Yeah. Yeah, for somebody to stand up and acknowledge that they didnae understand what life in a care home —— it would probably make a huge difference to staff in a care home for somebody to just acknowledge it.
Q. Mrs Martin, thank you very much. Those are all the questions that I have to ask you. As with all witnesses, I ask at the end of their evidence if there's anything else that you would like to tell us that we haven't perhaps touched on in your evidence so far. If

there's anything else, this is your opportunity to do so.
A. I don't think there is anything else of a great deal I want to say. The only thing I'll say is that I find it very hard to find the correct word to describe what it was like working in a care home during the pandemic. I've thought of various different descriptive words but they don't quite seem to fill what it was like —— a bit like a rollercoaster at times, up and down, but that really disnae get across how bad it was. Horrific —— yeah, it was horrific, but that doesnae totally describe it either. I don't have the words to describe what it was like. I don't.
MR GALE: Right. I think that probably says a lot in itself. Mrs Martin, thank you very much indeed for your evidence. Thank you, my Lord.
THE CHAIR: Yes, thank you, Mrs Martin. I appreciate that. Right, a quarter to 11 then. We'll have a slightly extended break today.
MR GALE: Thank you, my Lord.
(10.20 am)
(A short break)
(10.45 am)
THE CHAIR: Good morning, Ms Bahrami.
MS BAHRAMI: Good morning, my Lord. Our next witness is

Graham Pirie of the Royal College of Podiatry, and his statement reference, for the record, is SCI-WT0238-000001.

MR GRAHAM PIRIE (called)

THE CHAIR: Thank you. Good morning, Mr Pirie.

A. Good morning, Lord Brailsford.

THE CHAIR: Right, good. Now, all ready to go? When you're ready, Ms Bahrami, off you go.

MS BAHRAMI: Thank you, my Lord.

Questions by MS BAHRAMI

MS BAHRAMI: Good morning, Mr Pirie. Please could you start by telling us briefly about your own background and about the Royal College of Podiatry?

A. Yes. My name -- full name is Graham Stuart(?) Pirie. I qualified in 1984 as a chiropodist, as was the official term in those days. I moved on to using the word "podiatrist". I worked in the NHS. I have done some private work as a podiatrist and in 2001 I started work for the Royal College of Podiatry as an employment relations officer and I cover Scotland and Northern Ireland.

Q. Thank you. Could you tell us a bit about the Royal College as well?

A. The Royal College is both a professional body and a trade union, so we are two aspects. The office is

based in London where we have round about 40 members of staff in total. And we have different departments, one around education, because one of our primary goals is around educating not only our members but educating governments and educating the general public around foot health; we also have a communications team; we have a membership team, which encompasses employment relations and the professional support officers; and we have a finance department, and this is all overseen by the council. We have a chair of council and the council members vary between 12 and 15. The minimum is 15 -- is 12, sorry.

Q. Thank you. Could you tell us a bit about the range of work that podiatrists carry out and the type of health conditions that require podiatrist input?

A. There's a whole range of podiatrists that we have who are members of the Royal College of Podiatry and they work in different sectors. So our members work in the NHS, they work in independent practice, the retail sector, charities, research and higher education. So there's a broad range where we work.

The types of conditions that we see across the board is from simple problems with nails, Ingrown toenails, musculoskeletal conditions, such as plantar fasciitis. A lot of people complain about that. We deal with

corns, callus, and then problems relating to diabetes and peripheral vascular disease, which could include ulceration and wounds. I think that would cover about -- you know, the broad spectrum of that. We also have individuals who work as podiatric surgeons, so they do surgery on the feet.

Q. Okay, thank you. At the point of the first lockdown, could you tell us what the immediate impacts were on your organisation and on the members?

A. For our organisation we had -- I think it was the Friday before the announcement of the official lockdown our chief executive had locked down the office, so he had moved in advance of it. So he'd asked everybody to work from home, which -- before that, he wasn't keen on people working from home. We had the -- we were fortunate that most of our communications with members is either through email or through the phone or our website, and our phones were linked to our IT system so that allowed a seamless transfer. So we had already moved into working from home before the actual announcement came that we were moving into lockdown and everyone to stay at home.

For our members working, there was a difference between those who worked in the independent sector, in higher education, as opposed to those who worked in the

NHS. Those who worked in the independent sector were basically told to close their businesses. The NHS, because it was key workers or essential workers, whatever the terminology was used at the time, they were to go back into work. But that caused a bit of a problem because, even going back into work, the main types of patients that were to be seen had changed because, within the NHS, prior to COVID-19 was that they saw mainstream podiatry patients, so that would include general MSK conditions, it would include those with, you know, pain from corns and callus, you know, problems with their nails, and it would -- I mean, like real problems, not just, "Oh, my nails need cut", because we'd moved away from social nail care.

What happened was that it was determined that only urgent and emergency care would be delivered, so those who were mainstream podiatry. Those appointments were cancelled and patients were informed of that and we concentrated mainly on wound care or those who had potential difficulties with their feet, as in possible infections or conditions that might cause future ulceration.

Q. Thank you. At paragraphs 32 to 34 of your statement, you talk about vaccinations. Initially podiatrists hadn't been included in the priority group of healthcare

professionals, but through the college being part of the Vaccination Service Delivery Group, as it was called then, you were able to change that. Do you know why podiatrists weren't initially included and on what basis was it agreed that they should be included?
A. I don't know if I could answer why we weren't included and I suppose the problem has always been around —— within the NHS, it's always seen that it's doctors and nurses, so, you know —— and we do value the work that they do, but when they start producing a list, it's easy to miss somebody out and I'm hoping it was just that we got missed out. And at one of the meetings I suggested that podiatrists should be included in that because of the direct patient contact that podiatrists have. And it is —— I mean, most podiatry appointments range from between 20 to 50 minutes, depending on the condition that you're seeing, so there is a fair time of exposure with each patient.
Q. Yes. Thank you. In your opinion, if podiatrists hadn't been included —— if the Royal College hadn't been included in that group, do you think making representations as a non—member would have had the same effect? If you're not able to comment, that's fine.
A. Well, I think —— to speculate, I think it would be harder to have had podiatrists included because it would

have been trying to find out who to write to, who to take the issue to. So from that point of view, yeah, I think it would have been more difficult. I still think we would have been included but it might have taken longer.
Q. Thank you. At paragraph 38 you speak about key worker status —— and you touched on that briefly before —— and the uncertainty of who was included. You then state:
"Many felt ignored by the Scottish Government and that there was no clear guidance or support."
Others have also told us about the fact that they found the guidance to be unclear, but please could you expand on what you mean when you say that members felt ignored and why it was that they felt ignored?
A. Well, I think because of the variety of locations that podiatrists work in, whether it's private or NHS, and there was that discrepancy between podiatrists working in the NHS were seen as key workers or essential workers and yet those who worked in private practice, who are podiatrists, weren't seen. And there seemed to be very little information coming out, and particularly if you watched the television, there was so much focus on hospitals and the NHS and there wasn't enough for those in the independent sector or the third sector to get the same level of information. And members were —— because

of access to the internet, members were out looking for anything that they could and there was very little there. So they just felt as if they hadn't been given the same due care that those who worked for the NHS had been given.
Q. Okay. Thank you. You then, at paragraph 42, explain that —— and you've touched on this again in your answer earlier that those in the NHS were deemed key workers while those in private practice weren't and had to close their practices for four to six weeks. You also explain that NHS podiatrists treat patients with wounds while those in private practice do not. To your knowledge, was that the sole basis for designating NHS podiatrists as essential or key workers and not private practice, the treatment of wounds?
A. No, I think the definition for key workers —— I wasn't there when the decision was made, but I think the definition is based on the fact that it was NHS, so therefore NHS —— everybody who worked for the NHS was therefore a key worker, and that was really the basis for it.
Q. Okay. So it may be that enough consideration wasn't given to the exact nature of podiatry work because is it not the case that, while those in private practice don't treat wounds or provide emergency care, the nature of

their work is that it prevents conditions from escalating to becoming wounds?
A. Yeah, I would say that there's a lot of work done not only in private practice but also within the NHS with podiatrists and other AHPs around preventative care, and the prevention is to prevent patients from being admitted to hospital. So there is a lot of that gets done and, you know, painful foot problems can lead to trips and falls which ends up as an admission. So the lack of care that was given —— you know, being able to be given by those in private practice will have had an impact. It's not something that I've got any figures on.
In private practice they do come across wounds but I can't —— the SIGN guidelines —— and I can't remember what "SIGN" stands for. It's similar to the NICE guidelines in England —— does recommend that, if you have a patient with a wound, that it is referred within 24 hours to a multi—disciplinary team. That's particularly important not only for patients with diabetes but also those with peripheral arterial disease as well.
Q. So the consequence of suspending preventative podiatry care could potentially be an increase in demand on NHS resources and services?

A. Yes. Yes.
Q. Thank you. Now at paragraph 43 you state that, while NHS —— sorry —— you state that the majority of your NHS members work in the community but —— and because of that they carry out a lot of home visits, but there was a lack of information and guidance which they found confusing. Could you tell us where the confusion arose in relation to home visits and perhaps give examples of information and guidance that members would have liked to see?
A. Yeah, well, I suppose it goes back to what I was mentioning about, if you watched anything on television —— and I still do and I always have done —— if you see anything about the NHS, it's always round hospital base. You don't generally have camera crews at health centres or around patients' homes, so it's a very different setting. And I suppose what our members would have liked was some guidance around, you know, home visits because that's —— within health centres and hospitals the NHS can control the environment, but when you're going into a patient's home, that is an environment that you can't control.
So they were looking for advice on how do they transport instruments and materials that they use, for example, for dressings; what about going in there with

their PPE on, whether it was supposed to be worn on the way in and what do you do on the way out; and, you know, what happens if a patient has COVID and you're going in; what about other people being in the house. So the Royal College of Podiatry issued some guidance and it was —— and it came —— some of this guidance came from what we heard from what some of the local —— what some of the health boards were doing or some of the trusts in England were doing, and that was around phoning the patient in advance to get some information from them. But there wasn't clear guidance on what to do for home visits. There was more guidance —— there was an awful lot of guidance around, you know, if a patient was coming to the hospital, in particular, or coming to a health centre.
Q. Thank you. You go on at paragraph 45 and then later at paragraph 54 to state that your members had concerns about safety, a real fear of going to work, catching COVID—19 and dying, and this is again something that we have heard from other professional healthcare bodies as well. Did you find that that was the case across your membership or was that concern more prevalent amongst members working in a particular setting?
A. I think it was —— it was members who worked in the NHS in particular because they were in full—time and they

were in environments where patients were coming and potentially had COVID. So they were just concerned that they were putting themselves at risk by going into work and had a variety of concerns raised about, "Well, I'll just not go in". One member asked if she could be furloughed, to which I said, "You can't because you're a key worker". So it was mainly the NHS, just concerned going into that environment on a daily basis and being exposed —— potentially being exposed to the COVID—19 virus whereas everybody else is being told to stay at home. And when the message is, "Stay at home, this is around your health, safety and well—being, but you have to go into work", yeah, it added an awful lot of stress on to our members.
Q. In paragraphs 50 and 51 you talk about the NHS Attend Anywhere system and, as many will be aware, that's the NHS video call system that allows patients to call their allocated health professional at a set time and date to have a virtual consultation. You state that members found this system unhelpful and that it was better than nothing but not as good as it would have been face to face. Firstly, can you tell us about the things that could be done or picked up at an in—person assessment that couldn't be done by video call?
A. Podiatry is very much —— it's hands—on, and that's not

only in the treatment but it's also in the assessment and diagnosis. For example, one of the indications of infection could be heat in the foot, which you can only get if you are physically there with them. Sometimes it is around palpation of a deformity which requires the podiatrist to actually have their hands on the patient's feet.
There's also, you know, feeling for pulses, which is —— you know, and we use a machine called a "doppler", which assesses blood flow and therefore you can pick up early problems with a patient's circulation by doing this. And also, I know I put it in the statement and it's something that probably only podiatrists recognise —— is that sometimes, when a patient takes off their shoe and sock, there's an unpleasant smell when an infection is present, and these kind of things you cannot do through a virtual call. And I did say, whilst it's not great, it's better than a phone call and it's better than nothing.
Q. The second thing I wondered is whether it's —— while members were aware of the risks of in—person consultations, whether it's the case that they would have preferred to at least see some patients face to face so that they could investigate these things. Would they have liked greater freedom to choose which patients

they should be able to see in person?
A. The answer to that would be "Yes" and "No". The "No" is in, "I want to have —— I want to expose myself to the virus as little as I possibly can so therefore not seeing patients is good", but there is also that —— there is that need of podiatrists to actually physically be there with the patient so that they can do a full assessment. They've got —— podiatrists will have confidence in their ability to do the assessment properly when they can bring all the aspects to it, you know, all the senses, touching the patient's foot, you know, seeing what it is, feeling, and just being in the room with the patient gives a far better chance of accurate diagnosis and therefore assessment and a better treatment.

I think we've —— there's a lot of patients that we did see because we had provided a decision tree and a treatment grid that I think a lot of the NHS podiatrists also used, so they did see some patients who probably wouldn't have been under the emergency and wound care.
Q. Thank you. I want to move on to long COVID. Could you tell us generally about the impacts of long COVID, both on the Royal College and on your members?
A. Well, if you mean about how it's impacted the staff at

the Royal College, it's probably more with those who deal with the members —— you know, with their issues because a lot of members, you know, if they've had long COVID, come to the Royal College and they've got their issues that they want to discuss and it's —— we don't actually have —— we don't provide counselling. We do have a helpline, but when somebody phones and they've got an issue, you're not going to say, "Well, it's not my job. Off you go". So there is an impact on hearing, you know, some really sad stories about what's happened to members.

The members that I know of in Scotland, you know, there's —— one has had to leave the profession early —— I think she's early 30s —— and we've had some people who, with long COVID, have reduced hours or have done things just to try and keep themselves in employment, and another person retired before they wanted to because of long COVID, and just the absolute fatigue that it has and they weren't able to get up. And some days are better than others. So I think it's got —— it has people worried about, if they've had COVID and they haven't really returned to what they felt like before, is there any long—term effects on it, and that's something that's unknown.
Q. You mentioned early on in your statement that there has

been a decline in your membership numbers. Is your view that long COVID is partly to blame for that or do you think that that's a separate issue?
A. I think COVID and its impact on the NHS will potentially have had some downturn on it but there's a whole host of other factors because the NHS is one of the —— it's the biggest employer of podiatrists and, if you see it as a career and then you see all the news headlines about the NHS, that's not really particularly inviting. But I do know —— I think one of the universities down south did have quite a large increase in numbers for one year, and that was, you know —— and I don't know whether that relates to, "Oh, well, if you're a key worker, then you'll be working should there ever be a pandemic again", but I don't know the answer to that completely.
Q. Thank you. I want to move on now to PPE, please. Did your members in private practice have any difficulties in sourcing PPE?
A. Yes, they did. There's various suppliers that provide to, those who work in the independent sector and, you know, once they were open again and if they were looking for PPE, they would send in an order form and they would just come back, "Out of stock". There was difficulties all round in getting PPE so I don't think it was a surprise to members, but there was quite a delay in

getting this so therefore it caused problems on opening up their practices again, that we can't open and do, for example, five days a week because we don't have the personal protective equipment to do that. So, yes, there was difficulties.
Q. And I understand there were issues with pricing as well, that pricing —— the prices had gone up significantly?
A. Yes. Prices for gloves is the one that I remember. That's because —— well, my wife is a podiatrist in the independent sector and it had gone up from about £9 to £23 for the same amount of gloves. She was not particularly happy about that. And that was —— that was across those in private practice. I don't know if the charge increased for NHS, but it did seem —— it jumped massively when they became available and it was probably due to demand.
Q. Thank you. Were NHS members provided with PPE? Did they have sufficient PPE?
A. Yes. I mean, in podiatry we've always used some form of PPE, whether it's the disposable gloves, the disposable apron or face masks. We also have goggles that we use when we're doing nail surgery. So we've always had that. Yeah, there was interruptions with supply of this. I'm not aware that it created an awful lot of a problem because of the reduction in the

caseload of —— in patients that they were seeing and also because I think the delivery of PPE was —— the NHS was prioritised for that.

Q. Yes. You mention in paragraph 74 that the face masks that were provided to NHS staff were expired but they were told to use these. What was the situation there? Did they claim that these masks —— that the expiry date didn't matter? Did the Royal College raise issues with this —— about this with the health boards and what was the response?

A. This actually came to light after the event so the Royal College of Podiatry weren't able to challenge this. But this situation was that there was out—of—date —— I think it was face masks in a cupboard and it was "Just use them" because —— and whilst members weren't happy about that, it was —— it's like, "Well, it's better than nothing", because there's still the need and the demand to see patients because of —— the nature of the work that we were doing in the NHS, it was pretty serious conditions, you know, open wounds and ulcers that needed treatment, so it's not —— you didn't really —— I suppose members felt they didn't really have a choice on that.

THE CHAIR: Can I pick you up on a detail, Mr Pirie, and it may well be simply a matter of interpretation. You were

giving an answer in relation to paragraph 74, which says:

"Our members also came across masks that were out of date, after their best before date, but the Health Board [singular] (I can't remember which one) [again singular] ..."

I appreciate your information on this is probably a little incomplete, but on the basis of what I read, does that mean that this problem appears to have been experienced only in one health board area?

A. I can only tell you what I was told and I was only informed of this happening in one health board.

THE CHAIR: Thank you. That's fine. The reason I ask is perfectly straightforward. I'm not condoning it at all, but plainly, if it's in one health board, it's a different magnitude of issue than it would be if it was across the board of all health boards.

MS BAHRAMI: Do you recall if —— while you can't recall which health board, do you recall whether it was one of the larger ones or smaller ones?

A. It was one of the larger ones. I wish I could recall now.

Q. That's okay. Perhaps you could look into that and let us know post hearing.

THE CHAIR: That would be reasonable.

MS BAHRAMI: Yes. At any point —— after this, when you became aware of it, did the health board concerned refer to any studies or guidance on masks on which they were relying to say that these masks still provided a benefit?

A. Not that I'm aware of, no.

Q. Thank you. You mention at paragraph 69 that your members used FFP3 masks for work requiring a nail drill. Did they also use FFP3 masks prior to the pandemic for that type of work?

A. Yes. Sorry if it's not clear. What I'm saying was that, before COVID, our podiatrists, if they were using a nail drill, were using that kind of mask and were familiar with it. It wasn't —— and a lot of health boards have since —— even before COVID had stopped using nail drills to reduce very thickened nails and they would just use it by using the nail nippers and a scalpel to reduce the thickness of the nail because of the concerns of nail dust.

Q. You say that these masks tend to be designed for the average male face while the majority of your members are female. You say 78% there. I just wondered, prior to the pandemic, were they using a different brand that was suitable and during the pandemic was that brand of mask not available, thus making the mask unsuitable for your

average member?

A. It would depend on what the podiatrist was doing. We did use the surgical mask for nail surgery, but if it was for nail dust, where something would be —— it was more likely to be airborne rather than a particle coming towards your face, then you used or were encouraged to use FFP3 masks. The reason for that is that they are at least contoured to the face. And to use these masks properly you had to undertake some face—fit testing, which was done —— and it takes quite a while to do that because it's about basically putting on the mask, checking that it fits and —— I can't —— I'm not 100% sure of the process, but it's about, if you can smell something pretty noxious, then it doesn't fit.

So podiatrists, certainly in a lot of departments, would be face—fit tested for these masks, so they knew that these were used for anything that was airborne. They were available as required and it wasn't a daily occurrence to be using the FFP3 mask, but if there was something that you were around, using the nail drill, then that is what members would use and that's what the Royal College of Podiatry would recommend using, either the FFP2 or FFP3 mask.

Q. Okay, thank you. At paragraph 72 you state that the advice was to wear FFP3 masks when providing direct

patient care in a hospital but not when providing direct patient care in the community. Are you aware of the basis for this difference in approach ——

A. No, no.

Q. —— and what did your members think about this?

A. This was somebody who contacted me to say that they had seen this advice, and I have since gone back to find out where this individual had seen it and they said that, you know, the advice is that we've to use different masks, you know, in community as opposed to what they're wearing in hospital. I searched for that advice and, when these things were coming in —— because there was a lot of phone calls coming in to myself and to the rest of the Royal College —— you know, you'd get this information, and I have since tried to find out where that information came from and I couldn't personally find that —— where he got the information from. So that is just a comment that somebody somewhere, because of probably going on the internet, found something that contradicted what was happening.

Q. I want to ask you about the effect on your members' workload once services started to resume. Was there an increase in the number of people requiring NHS podiatry care?

A. The ——

Q. So really I'm thinking about wounds and the more severe work that would be ordinarily referred to the NHS.

A. I would say that there was a slight increase that had been reported, not a —— there was no massive increase across the NHS in Scotland. What I've told —— there was a slight increase in some areas and the reasons for that I don't know. But the NHS podiatry, the workload has always been pretty high because in some areas —— and I think NHS Ayrshire and Arran —— they weren't —— or for quite a while weren't, like, having patients come to the health centre. They were doing more in the way of home visits, which is a bit more —— it's more time—consuming. It's easier when patients come to you rather than you going out to them. So workload is —— you know, was heavier in that respect.

Q. Do you think the lack of private and NHS preventative care could have led to more severe issues that required more significant intervention?

A. Well, it could but I don't have any evidence to back that up. Obviously prevention is always better than the cure so I'll stick with that, kind of, as an answer.

Q. I have a few more questions about that, about the range of conditions that may have arisen following on from the lack of preventative care, but it's perhaps something that I should follow up with you later if that's an area

where you don't have the information to hand.

A. Yeah. Well, I wouldn't have the details. I know that podiatrists, they do a lot of work with patients with diabetes who have got potentially —— with diabetes you can get lots of complications around circulation or, you know, sensation. They get something called "peripheral neuropathy", where they don't feel things properly in the soles of their feet, for example. A lot of the work that we do is —— particularly if a patient has had an ulceration before is —— there's a lot of treatment input to ensure that there isn't a breakdown in the future, so that prevents it. And also the treatment of ulcerations by podiatrists —— and there is evidence which I don't have to hand, but it does prevent a lot of patients with diabetes and peripheral arterial disease going in for amputations within the hospital.

Q. Yes, thank you. That's the kind of topic that I wanted to ask you about. You know, we're aware from evidence from others that care homes, for example, had to close their doors to external health professionals. Do you think that's an area where care home residents who had diabetes may have then gone on to develop conditions that required amputations where they wouldn't have otherwise or perhaps even palliative care? Would that ...?

A. I certainly think, if there's wounds anywhere on the body which aren't being properly assessed, diagnosed and treated properly, then it could lead to that. I do know that, because care homes shut down and said, "Nobody gets in", that —— you know, we were trying to do our best, and that would be like speaking to one of the care assistants and saying, "What is the wound like and we'll send ..." —— you know, we were sending dressings to the patient —— to the care homes for them, if they were comfortable with that.

Q. Thank you. You mention at paragraph 82 that the knock—on effect of only taking on emergency care rather than preventative care during the pandemic is that "our members now feel as if they are firefighting rather than doing things to prevent conditions". Could you expand a bit on that? Is that really in hospital acute settings and is there enough resource to be dealing with that now?

A. No, it's not just in the acute setting. It's —— because of the number of wounds that are being dealt with, this is in acute and also in community. And, yeah, the more prevention you can do, the less problems you have further down the line, and podiatry is one of those professions where we look at it and —— as do other professions —— it is around preventing. So if we're

not -- if we don't have the time to do the same amount of prevention, then we end up just dealing with wounds. And, yes, well, do you know what, maybe even just treating a wound prevents, as I said earlier on, an amputation. But there is that -- there's a lot more intensity in dealing with a patient with a wound than there is when you're actually treating somebody in who you're trying to prevent it.

Q. Thank you. You state in paragraph 91 that members had concerns about the impact on their HCPC registration if something went wrong in the role to which they were redeployed because, along with other health workers, podiatrists were redeployed to other roles within the NHS. You state that the HCPC stated that podiatrists could be redeployed to these other roles given the circumstances, but did they also clarify the impact on HCPC registration if something did go wrong?

A. Well, because most of the people who were working as essential workers and who were being redeployed would have been in the NHS, issues around -- something that the Royal College also had input into is that, if something went wrong, the indemnity insurance through the NHS would cover that because your employer had asked you to take on a different role. The clarity from the HCPC was around, you know, if you were asked by your

employer to take on an additional task and you were given suitable training to do this task that you've been redeployed into, then it would not -- your HCPC registration wouldn't be affected by doing these things. And that was some assurance that I know a lot of our members appreciated because there is concerns when you're being redeployed and doing -- carrying out different duties.

Q. Thank you. At paragraph 93 you state that the HCPC suspended the usual CPD requirements. In the opinion of the Royal College, was this decision appropriate and correct? Have you seen any impact on knowledge and competence levels as a result?

A. No, I think the Royal College of Podiatry welcomed this because this is an audit of -- that's carried out every two years by the HCPC on all professions that they regulate, and podiatry was due for their HCPC audit in I think the May -- around about May of that year. And what it is is it's asking you to provide evidence to the HCPC that you've undertaken continual professional development, and their definition -- because it says "continuous", it would mean that it is continuous up until the next registration date, and obviously, when everything shut down, there was very limited opportunities for our members to undertake CPD.

For those in the NHS it was all hands on deck regarding patients, so, therefore, any learning opportunities were minimised. For those in private practice, a lot of that is -- of their continual professional development is done through -- it would be like attending branch meetings or going to conferences, which were all face-to-face kind of events. So it was welcomed. I don't think it's had -- well, I'm not aware of any evidence that says that the knowledge and skills of podiatrists are impacted on that because the CPD audit is basically you writing up what learning that you have done, but there is still a requirement for members to do CPD.

Q. Okay. Thank you. I want to move on to the impacts on patients. You state at paragraph 101 that some patients who had attended the NHS for podiatry care for many years prior to the pandemic were then, once services resumed, being told they needed to go elsewhere to find services and there was some anger among these patients, who you say were essentially told to "fend for themselves". Can you give us some examples of the types of conditions that these patients had and the types of treatment they needed?

A. Well, the ones that -- as I said, the NHS was focusing mainly on wounds and ulcers, so unless -- well, there

was also maybe acute episodes of musculoskeletal conditions and when a nail had become really bad, an Ingrown toenail, they were being seen by the NHS and -- you know, so it was really the ones that -- if you had, you know, painful corns, for example, they were no longer being seen in the NHS and being told that they didn't meet the criteria because the criteria was just, "It's wounds, that's what we're dealing with", and that they could go elsewhere.

Now, NHS doesn't recommend who they go to but makes suggestions around, you know, the voluntary sector, the third sector, "You can go privately", that kind of thing. So a lot of patients -- a lot of these patients had been attending for a long time, sometimes, you know, years and years of attending the NHS for ongoing treatment, and it's around preventing these conditions from getting worse and then all of a sudden it's just like, "Oh, I don't meet the criteria", and it was just like, "So you don't meet the criteria so you need to go and find someone else to do this". And then when they looked around -- our website, the Royal College in Scotland, you know, "Find a podiatrist" -- so if they went on to that, they go "Find a podiatrist" and, certainly in the early stages, podiatry clinics were closed in the private sector.

So this is why —— it's kind of the feedback I get from some people in private practice, where these patients just felt discarded because they didn't meet the NHS criteria, the private practitioner clinics were closed, where did they go?

Q. Yes.

THE CHAIR: You're into your last ten minutes, Ms Bahrami.

MS BAHRAMI: Thank you, my Lord.

Do you think that the lack of preventative care had led to this increase in the number and severity of wounds that caused the NHS to change its criteria or do you think there was a staff shortage —— a reduction, a significant reduction? What was the reason for the change in criteria?

A. It was just —— I believe the criteria came from the NHS of, "This is what we're going to see, this is all we're going to see", because it was —— I don't know if partly the rationale was, "We need to reduce the number of people coming into either hospital, health centres or the number of house visits that we do to limit the number of contacts. What is essential to be done?". I wouldn't disagree that wounds and ulceration is essential that needed to be done; Ingrown toenails, for example, they would be essential to be done. Not only are they very painful but they can lead to, you know,

further infection.

Q. Yes. You mentioned in paragraph 103 that patients can't afford to see private practitioners as often as they had been receiving treatment by the NHS. Do you think that has the potential to then lead to an escalation in their condition and consequently place further strain on the NHS in due course?

A. Yes.

Q. Thank you. And finally, in paragraph 105, you mention a 2016 report which examined whether the NHS could cope with a pandemic and determined that it wouldn't be able to do so. Do you recall who commissioned or prepared that report?

A. No, no, I'm afraid that was something out —— I was watching on the television and they talked about they had done this —— they had done something in 2016 to see if the NHS —— and I think it was UK—wide —— was fit to deal with a pandemic, and I believe that what was reported was the NHS wasn't ready for —— to deal with a pandemic. And since 2016, if you look at the numbers of podiatrists within the NHS, those numbers have gone down almost year on year.

Q. Thank you. Is there anything that we haven't covered today which you'd like to address at this point?

A. I would —— it goes round to getting the information out

to those who work in the NHS and realising that it's not just hospitals, it is community care. You know, the concerns that our members had when they were working was around PPE, whether the face masks were appropriate, and part of that came from kind of —— the information that you see, that was coming out around COVID, and they had individuals, care staff in hospitals primarily in China, who had the full biohazard suits on, and our members were given face masks that didn't even fit the contour of their face.

I think that, when we look at providing PPE, we should be delivering what is the gold standard rather than —— our members felt it was, "What can we get away with?" rather than "What is the gold standard?", and that would have been the FFP3 mask, because members wanted to feel safe going into work and they didn't feel safe, and primarily around face masks is that most of the staff in the NHS, not just our members, are female, so why is it designed for the average male?

MS BAHRAMI: Yes. Thank you very much.

THE CHAIR: Thank you very much, Mr Pirie.

A. Right. Thank you, your Honour.

THE CHAIR: Good. That's all the evidence we have for today, Ms Bahrami. So Tuesday morning. I'm not sure if it's 9.30 or 9.45, but no doubt participants will be

told what time we're starting on Tuesday morning. Thank you.

MS BAHRAMI: Thank you, my Lord.

(The hearing adjourned until
Tuesday, 30 April 2024 at 9.30 am)

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