Scottish COVID-19 Inquiry
Witness Statement

Statement of Michael John (Mike) McKirdy – Witness Number HSC0218.

Statement taken at 1300 hours on Monday, 18th March 2024.

Witness interviewed by Assistant Solicitor Personal Data. Statement noted by Paralegal Personal Data.

Witness interviewed at 232-242 Saint Vincent Street, Glasgow G2 5RJ.

There were no legal representatives present at the meeting.

Introduction

1. I am Mike McKirdy, I am the president of the Royal College of Physicians and Surgeons Glasgow c/o 232-242 Saint Vincent Street, Glasgow G2 5RJ.

2. I am willing to provide a statement, have information contained within reports and am agreeable to this statement being published. I agree to the recording of the statement.

3. I am prepared to provide evidence at the Inquiry, and I would be willing to speak to this statement. I am aware that I can withdraw my consent at any time.

4. I became the president in December 2021 and I will leave the office in December 2024. I was the president elect throughout the calendar year from December 2020 to December 2021.

5. At the beginning on the COVID-19 pandemic in 2020 I was also the Director of Global Health and Chairman of the Hope Foundation of the College and a member of the College Council and a member of the Executive Board.

6. I am a consultant surgeon at the Royal Alexandria Hospital in Paisley and have been since 1997. From 2017 onwards I only dealt with breast surgery. Therefore, at the time of the pandemic I was a consultant

oncoplastic breast surgeon in the Clyde part of Greater Glasgow and Clyde health board. I was also the national clinical lead for breast cancer services through the Modernising Patient Pathway Programme (MPPP). By 2021, this had been subsumed into the Centre for Sustainable Delivery based out of the Jubilee Hospital in Clydebank.

Overview

7. The Royal College is one of twenty-four royal colleges and faculties in the United Kingdom and our base is in the city of Glasgow. There are around 16,000 fellows and members of the college. However, the majority do not work within Scotland. We are an international medical royal college and we are the only multidisciplinary royal college in the UK with physicians, surgeons, dentists and specialists in travel and podiatry medicine.

8. Our core services are in assessment and examinations. This involves delivering exams and ensuring that those taking these are reaching the expected standards of clinical practice across medicine, surgery, dentistry, travel, medicine and podiatric medicine. Alongside the delivery of these exams, we also provide CPD activities and post graduate education. We do all of this through a variety of either courses or meetings. The delivery of CPD across medicine is very similar to other professions, such as accountancy, as there is a need to keep people up to date.

9. The college also plays a role in public policy and, in line with this, we have an ongoing interaction with the Scottish Government. We also deal with the UK government and other devolved governments where we have fellows and members working. We also have interactions with groups who are seeking to influence health policy so, for example, the UK Health Alliance on climate change is something that the college is involved in. The college also has a role in responding to Government on the medical workforce, on minimum unit pricing and a number of other matters. Lastly, we also have a role in public affairs.

Impact of COVID-19 on the organisation

10. In regard to the delivery of the college's core business, in education and assessment, that, like everything else, was paused at the beginning of the pandemic and from then on it was a lot of discussions about how these things could be restarted in a pandemic impacted world. This was similarly the case for our external public affairs work.

11. Focussing on the impact on our delivery of education, we had to stop holding physical courses, stop holding meetings and also stop any courses which were being held in lecture theatre halls. So everything that had been planned for delivering education in those first few months of the lockdown was cancelled.

12. Like a lot of other sectors, as a result of these cancellations, we had to learn to use modern technology. For many of us within the college, we had been carrying around laptops and mobile phones for years before the pandemic, however, we were now faced with having to learn how to utilise them to provide our services.

13. As we were faced with not being able to hold any in-person teaching, the decision was taken to start delivering our education through webinars and online events. This was able to be brought into place quite quickly. I think a positive of this was that we were learning to use capacity that we already had to engage with much larger audiences. For example, one webinar that we held during that time had fifteen hundred people in attendance which we would never have been able to host in a physical lecture hall. I also think that, due to the severity of the situation which we all found ourselves in at that time, there was a desire to engage and we were able to support this by hosting webinars for such wide audiences.

14. As an add on to that, the webinars were allowing our fellows and members to learn how they could comply with the lockdown restrictions while still being able to deliver the best possible care to their patients.

15. It should be noted that we, as a college, were still having to cancel certain types of events and conferences as recently as May 2022 which is 24 months since the very first event we were forced to cancel because of the pandemic.

Education and Assessment

16. In regard to assessments, career progression and assessment is of key importance to medical trainees so, in order for someone to progress through to becoming a consultant or similar, they have to take their exams in sequence. Therefore, there was a great need to find a way of using online technology to deliver these assessments.

17. With regard to online exams, those already existed prior to the pandemic but we were still using 'pen and paper centres' which allowed for people to come into those centres and take their exams in person. Of course, when the pandemic hit, all of that was stopped and the exams moved to being completely online. This was very much a challenge for us because it was something that we had not done before and we were trying to get used to switching over to this while nobody was physically in a building and we were having to discuss only through online meetings. This was a challenge faced by lots of organisations in that they had to learn how to work differently with nobody physically present in offices.

18. For clinical examinations we were in a position to contribute here in Glasgow by using the Louisa Jordan facility at the SECC which, just like the Nightingale hospitals in England, was built at great speed in the early months of the COVID-19 pandemic because the evidence, which was coming out of Italy and New York City at that time, was that a large number of hospital beds would be needed. In fact, they were never used in any great number as hospital beds and so one of the ways that we were able to make use of the Louisa Jordan was in delivering clinical examinations because the hotel adjacent to the facility could then be used

as a location for examiners and for those taking the exams to physically come to Glasgow to do so.

19. On the surgical side of our services, where we examine on ten recognised specialities of surgery in the UK, we were able to run many of these exams using the Louisa Jordan facilities. I did not have any lead role in this but our college did do that jointly with the other royal surgical colleges in the UK.

20. Overall, there was some big changes made to our education and assessment work during the pandemic but it continued as best it could.

Pubic Affairs

21. Our public affairs work continued also and we had a role in assisting the devolved governments with creating policy.

22. One example which I was involved in, due to my surgical background, was collaborating with the four surgical royal colleges to work with the Specialty Associations in Surgery. Each of these specialities has its own association of interest in that speciality. The colleges were working with these associations to do work on the prisonisation of surgery which meant determining which surgeries had to continue despite the pandemic and which surgeries could be delayed. We did this by assigning them into numbered categories and this work was carried out quickly in the early days of the pandemic in 2020.

23. The work and the sharing of that information with the fellowship and membership of all of our colleges was very important and the dissemination of that information, together with the policies to put in place in each individual place of work and the apparatus of the surgical colleges, meant that the structure of the royal colleges and the associations was a very good way of communicating that through the pandemic.

24. During this time there was a great deal of trust placed in governments but the governments, as well as their health departments, were very busy delivering the acute response to the pandemic, as were clinicians, but it was very important that our policy work continued to support and inform the decisions that were being made at a government level.

25. There was one particular issue, called Aerosol Generating Procedures (AGPs), which was centred around what surgeries could and could not be done safely during the pandemic. Examples of this were laparoscopic surgeries and endoscopy work. As I mentioned before, a lot of this work was pulled together at pace and, for some of it, we were relying quite heavily on new evidence base to inform our decision making. This was similar to decision making around things such as social distancing and mask wearing. Some of these kinds of decisions were taken on a 'best guess' basis whereas some were decisions made from the results of trials on the spread and treatment of COVID-19. As with everything else, these were undertaken quite rapidly at the outset. The college was responsible for the sharing and disseminating of these kinds of information to its fellows and members.

26. It was a time which we in the college refer to as collegiate behaviour but I think across the whole of the medical political apparatus there was good collaboration for the sharing of learning and the dissemination of that learning because there was a recognition that this was an emergency situation. I think that, as institutions, we have become much better at working collaboratively as a result of the pandemic.

Delivery of cancer services

27. In my career, I was responsible for breast cancer surgery services and so this is my area of expertise to talk about. My team is made up of four consultant surgeons and we deliver breast cancer services to around 375 women in an average year.

28. At the beginning of the pandemic, I was due to go on sabbatical and I finished up to go on sabbatical on the 28th of February 2020. I was only on sabbatical for around nine days before I had to return home. I was due to carry out some work for the World Health Organisation (WHO) while on sabbatical amongst other things but, even after negotiating the sabbatical for four years, because of the pandemic, it did not happen.

29. Upon my return we first had to determine what the implications of the pandemic would be on my team. Of the four consultant surgeons, one of them was a locum who was over the age of seventy and therefore shielding so was ultimately unable to work and one had a commitment to the general surgical service which, due to COVID, massively changed their structure. The service increased the number of consultant general surgeons on call which meant that instead of one person being on call at any one time, three people had to be on call. This meant that there was one person to do triage, one person to be on the wards and one person to be in the operating theatre. The reasoning behind this was that the 'donning and doffing' of PPE took so long and the interval between operative cases became so long to allow the air to clear in theatres because of AGP concerns. As one of my team had a commitment to servicing the general surgical service it meant that they were left unable to continue as part of my team. As a result, the impact on our service was going from four consultant general surgeons to two immediately.

30. Before the pandemic, my team was based in three hospitals namely the Royal Alexandria Hospital in Paisley, Vale of Leven in Alexandria and Inverclyde Royal Hospital in Greenock. In all three of these sites the outpatient facility was directly adjacent to the A&E department and therefore was being used as part of the COVID response. To allow this, the outpatient facilities were completely closed to any outpatient service delivery. Similarly, the acute hospitals could not be used for elective operating because of the complexity of the redeployment of staff to run ICU beds. To do this, anaesthetic and theatre nurses were redeployed and so we had less operating theatres working and because of the difficulty of

doing emergency operations, for the same reasons, we did not have access to our three operating departments to provide breast cancer surgery.

31. This meant that we had to look for new operating facilities in order to be able to continue to provide breast cancer services during the pandemic. The first thing that happened to us was that we moved all of our out-patients to the breast screening service which was based in Nelson Mandela Place in Glasgow. We did this because breast cancer screening was paused because that involved inviting around one thousand women out of their homes to receive mammograms and then inviting around thirty-five of those same women to come back for further assessment in order to find seven or eight women with breast cancer. The arithmetic of that was that breast screening services were suspended between March 2020 and September of 2020. During that time we utilised their building space but, of course, these were not built to be an outpatient clinic but we moved there with the great help of our colleagues there at Nelson Mandela Place.

32. Moving our practice came with its own set of interesting challenges such as that our IT systems from our old practice space and our new space at Nelson Mandela Place did not speak to each other at the start. To start with I had to take a Dictaphone with me from Paisley to Nelson Mandela Place and then get it back to Paisley all on my bicycle.

33. I personally did all of our clinics during this time. This meant that all of the patients for the first few weeks were seen by me because we did not have any other staff that could come to assist.

34. In regard to operating, NHS Scotland was able to negotiate with Nuffield Hospital in the west end of Glasgow, which is a private hospital, that we would use their facilities because all private procedures had been paused so all of their operating theatres were empty. One of the things that the Nuffield theatres were used for was cancer operating so we were able to use their facilities to carry out our breast cancer operating. Therefore, one

of the breast surgeons on my team based herself at the Nuffield hospital to carry out all of our breast cancer operating services and I continued to supply our outpatient clinics. We did not have any trainees to work alongside us at this time, as they had all be repurposed into other roles, so it was just the two of us providing delivering a consultant delivered service. As time went on, we did get given some more operating space and, as a result, I did start doing some operating work on a Friday.

35. Eventually, the facilities at the Nuffield were closed and so all of our operating work was moved to the Jubilee Hospital. However, again, we were repurposing the facilities that were at our disposal. It is important to note that this required a lot of moving furniture and apparatus which was a large task in itself. To be able to do this it involved a lot of clinical leadership from clinicians, who were supported by health service managers, to try things on a trial and error basis to simply try and get something to be done because otherwise we would have found ourselves in great difficulty.

36. We also had to change how we practiced. For example, the screening work, which makes up one third of our cancer work, had stopped but there were still people coming to see us for other cancer related services. In regard to patients who were over seventy, the guidance was that they should stay at home and this also applied to those who had immunodeficiency for example who had recently had a transplant or cancer treatment. Therefore, we had to change our protocols for treatment to be able to provide services to everyone who needed them. We were supported by our specialist body, the Association of Breast Cancer surgery, who held weekly webinars to share the latest thinking on how we could make our service work. This involved things such as a much higher level of communication with GPs because we had situations, for example, such as a GP referring an eighty-four year old lady to us for a suspected breast cancer and what we had to do in that situation was to contact the GP and advise that we were not able to see the patient in person and so what we asked the GPs to do in this situation was to

provide the patient with medication which would treat her cancer should she have it. This is what we call primary endocrine therapy which was our national agreed position for those first few months of the pandemic. The thinking behind this was that it would be safer in the pandemic for the patient to take an anti-cancer tablet, which would not cause her any harm should she not actually have cancer, but would be effective if she did have cancer, than what it would be for an eighty-four year old woman to come out of her house to have investigations and surgery.

37. This also had implications for how we practiced surgery. For example, we changed treatments and we were no longer able to provide complicated surgery that involved prolonged anaesthetic time. This was because a prolonged anaesthetic time posed a large risk to the patient because, if they subsequently caught COVID, they were more likely to die according to some studies. It also had a secondary impact in that it exposed all of the staff in the operating theatre to a prolonged amount of time spent with one patient. An example of this is that, during this time, we were also not able to deliver complex oncoplastic surgery during the pandemic. This means that we were unable to offer any reconstruction surgery after a mastectomy which would normally be a combined procedure. The reason for being unable to provide such a surgery was that it would take around six to eight hours of surgery. A number of these woman are still waiting, four years on, for delayed reconstruction surgery because we have not ever been able to restore the operating time that would be require to catch up on those surgeries. Therefore, I think it is important to note that there are a lot of woman who received effective cancer treatment during the pandemic but were unable to receive the optimum treatment that they would have liked to have had and would have been made available to them prior to the pandemic. As a result, many of those women are still living with the consequences of that.

38. In the same vein, we also had to suspend our delivery of neoadjuvant chemotherapy or 'up front chemotherapy' which is delivered to patients in order to shrink the tumour and avoid mastectomy and is what we would

have used, prior to the pandemic, in around 15-20% of patients in any one year to avoid the patient having to undergo such surgery. This was stopped because of the pandemic and so, similar to the example above, these woman did receive effective cancer treatment by having a mastectomy where necessary but they did not have the optimum treatment we might have been able to deliver outside of the pandemic.

39. In pre-COVID times, standard practice for patients coming in for a pre-operative visit would be met by a specialist nurse who would take their medical history and run things like blood tests, ECG and then be prepped to go into theatre the following week. That whole process had to be changed during the pandemic and so a lot of those pre-operative meetings would be carried out much closer to the time of surgery instead of a week in advance. When we had access to COVID testing for patients this allowed us to be able to test them in the afternoon of the day before their planned surgery. This meant that we were not operating on COVID positive patients and this was both for the health of the patient but also the health of our staff. In the early days, before testing came in and we were operating out of Mandela Place, we had to do temperature checks on patients before their appointments.

40. Another way in which we changed our ways of surgery practice, specifically to breast cancer surgery, pre-covid women would be injected with a radioactive isotope before their surgery which would identify the lymph nodes which needed to be removed. This had to be changed because that involved a hospital visit and the guidance meant that we needed to make sure that people were not coming out of their homes more than was strictly necessary. This took a great organisational effort to put systems in place to ensure that women who had breast cancer symptoms could still be seen at outpatient clinics to be assessed and diagnosed correctly.

41. This then carried through to putting systems in place to support women who were diagnosed with breast cancer were managed effectively both operatively and nonoperatively. This had also changed because we could

not use chemotherapy in the way that we had done before the pandemic because chemotherapy rendered people immunosuppressed and would have led to them being at greater risk of contracting COVID. Therefore, we only used chemotherapy in patients for whom there was no other alternative.

42. It is also important to note that just as the pandemic began, within the breast cancer services realm, we had just published a trial, the FAST-Forward trial, which showed that five days of radiotherapy treatment was as effective as fifteen days of radiotherapy treatment and the result of that trial might have taken us a while longer to implement had the COVID-19 pandemic not started when it did. To some extent, that was a positive of the pandemic for breast cancer services.

43. Throughout the pandemic, to keep our waiting times down because we were able to put practices in place to allow us to continue providing breast cancer services.

Impacts on Staff

44. Patients and staff were both impacted by the anxiety and fear of COVID-19. For patients, coming to a breast clinic is already an experience which can cause high anxiety and so coming into a healthcare facility where they knew there was a higher chance of COVID-19 being present and so patients were anxious. However, staff were also anxious and this was for a lot of reasons. For example, in the first few week of the pandemic there were reports coming out about the negative impacts of the pandemic on staff mental health as well as reports of medical staff dying from COVID in those early weeks as a result of exposure to the virus and there was no way of accessing testing. It was very much a time of the staff requiring their leadership to demonstrate that things were safe and that our ways of working could be adapted to make it work in the most safe way possible.

45. One example is that we all moved into wearing scrubs. It would have been completely unheard of for me, before the pandemic, to wear scrubs during an outpatient clinic along with all of the PPE. However, by doing this, we were demonstrating to staff, and patients, that we were changing the way that we were working from what we normally did and therefore were responding to the threat of COVID.

46. Communication for staff was difficult during the pandemic and this was heightened by the need to wear PPE. For example, masks made it difficult to communicate which I found particularly difficult because I am deaf. This was particularly the case with people who were frightened because some of my communication skills are centred around lip reading and looking at people to determine what they are trying to say. In a lot of my role, particularly within outpatients, facial expression of empathy is very important. For example, when you are telling someone the shocking news that they have been diagnosed with a breast cancer, your communication skills are impacted by wearing a mask and this is coupled with the anxiety around being in a new environment. We all had to be mindful of these generic things and the impact these sorts of things had on communication.

47. When we were working out of the Nuffield Hospital, which I explained earlier, my colleague who was doing the operative work at that time was able to restore a clinic to see people to tell them, sort of as a second visit, that they had been diagnosed with breast cancer. This was in the time before we were able to get telephone and Microsoft Teams meetings arranged with patients to discuss their diagnosis so, in the absence of the IT, we were still taking patients in to the clinic to give them the news of their diagnosis. As the pandemic progressed, we did move to telling patients news of their diagnosis over the telephone. Delivering this kind of news over the phone can be very challenging and this took a toll on those of us who were in the position of delivering the news and having to do it in a completely different way to what we were used to.

48. One thing that was very helpful to us in the early stages of the pandemic, when we moved from our normal three hospitals into the premises at Nelson Mandela place, was that the Glasgow City Council (GCC) waved all parking charges. This was particularly helpful for both staff and for patients because many of them were coming to appointments from outside of Glasgow City Centre and, by having the charge of parking waived, it meant that they could afford to drive to their appointment and avoid having to risk infection by taking public transport.

Delivery of Services

49. By September of 2020, there was more of a pressure to restore services as much as possible and by that point we were around six months into the pandemic and a lot of learning had occurred during those first six months and this meant that we were beginning to work out how to best utilise the buildings we had in terms of ventilation, social distancing, PPE and other similar aspects.

50. The move to restoring services meant that screening services resumed around this time and, as these were carried out in Nelson Mandela Place, which is where we had been temporarily based for breast cancer outpatients, this left us without a home. Similarly, private hospitals, including the Nuffield which, again, we had been using needed to go back to providing their normal services also and so were not going to continue to offer their facilities to the NHS. We also had realised by this time that the NHS field hospitals, including the Louisa Jordan, were not going to be used to provide beds but we could start using them for other things and, for example, NHS Lanarkshire were using the Louisa Jordan to provide outpatient clinics. Winter planning is a key time for the NHS usually and so there was a real attitude of 'how are we going to make this work' as we moved into the winter.

51. We restored our outpatient services to Inverclyde and Paisley in September 2020 and this involved a lot of physical work with the

departments that were there, including outpatients, X-ray and waiting areas, to find imaginative use of space. For example, in the Royal Alexandria in Paisley there is a very long corridor between the outpatient department and the X-ray department which usually has a lot of memorial benches along it for staff and patients to use but during the pandemic we used the benches as a way of forming a socially distanced queue for patients to wait in for their outpatient appointment. Similarly, we used a part of the outpatient department in Inverclyde hospital to queue patients who were waiting to go in for their breast imaging appointment within the X-ray department. At this time, it was very much about being imaginative, showing leadership in both the clinical and managerial side and showing that we were working to resume services but do it in a way that was safe for staff and patients.

52. Another example of how we adapted to allow our services to resume was that, prior to the pandemic, we would use paper forms to request a mammogram for a patient because we previously thought this was the best way because it mean that we could draw on it and communicate with colleagues exactly what part of the breast we were interested in. However, doing this meant that we were using a piece of paper which we then gave to somebody who would then pass it on to someone else and so on which gave the opportunity for transmission of infection and so we moved to online requests. We had always had the capacity to use online requests but we had chosen not to utilise it until the pandemic somewhat forced us into doing so. It is worth noting that we have never gone back to using paper request forms since then and this is another example of how we adapted our services to allow us to continue to deliver our services in a pandemic impacted world.

53. Adapting our services for the pandemic was also helpful in improving the way we delivered care to those patients who did not live directly within Glasgow. For example, within the Clyde catchment area, we have a number of patients who live in the Western isles and Argyll. It's worth noting here that the diagnosis of breast cancer is really only the beginning

of the journey and there may be a further need for scans or investigation. However, I am now more confident in explaining to someone the likely outcome for their tests and that would be a conversation that we will have over the telephone on a specific date. Whereas, I think before COVID, we would have been concerned to have those kind of conversations without the patient being with us in person and so we would have increased the amount of unnecessary journeys for them.

54. Before COVID we organised breast cancer follow up appointments, particularly for those who lived in remote places within our catchment area, through 'virtual follow up' which there was good literature to support as a safe way to do follow up appointments without the patient having to physically come to the hospital. COVID forced us to move everyone on to that system, not just those from the remote areas, and this is something we still use post-COVID. Overall, this has saved 600,000 miles being travelled by patients within the Clyde area which has been beneficial both in terms of COVID but also has environmental benefits.

55. We were successful in resuming our services in both Paisley and Inverclyde however, very disappointingly, we were unable to resume delivery of our services in the Vale of Leven during the pandemic. This was due to being unable to provide enough staff to deliver services and this is something that we are trying to do now, although it is four years on from the point of suspending services there.

56. In regarding to resuming operating services, we continued to deliver our operations out of the Jubilee hospital and, over time, we had become quite slick at the preparation of patients for theatre in the COVID time with COVID testing and so on.

57. We also resumed delivering chemotherapy to patients both after surgery and a little bit before surgery. We were also able to resume delivering some slightly more complex surgeries by late 2020 but we were still not able to offer full reconstruction at that time but we had begun to adapt our practice again to deliver our services in a step towards normal.

58. One of our challenges that we were faced with as we came out of 2020 and into 2021 was that, within the Clyde area, we had a weekly theatre meeting. The meeting was to allow for each of the consultants to provide an update on how many patients they would be operating on during the upcoming week and how many hours of theatre time it would require. This required a great deal of flexibility because we found that we had to move away from one consultant surgeon having an all day theatre list we had to instead act as a team and we as 'the breast service' need a certain amount of hours and so, if we did not have a full day list, then another consultant surgeon from another discipline could use the remaining time that day. We did this working through the facilities that we had because a lot of the nursing staff from the theatre environment had been redeployed and so we had less theatre capacity. This meant that all the way through 2021 we remained with less theatre capacity that we had previously had and we have not yet been able to completely restore that capacity.

59. Not being able to restore that capacity has meant that we have stayed behind where we would ideally like to have been in terms of delivery of our services. For example, not having as many theatres open. A lot of the reason that we have not been able to get back to our full service is down to the staff loss from COVID that I mentioned above. For example, the over fifties section of our UK work force was diminished by the pandemic. A lot of the impact of that was particularly on our nurses. What this has left us with now is that, although they may have been replaced in head count terms, they will not be replaced with the same experience and skill set.

60. This is also applicable to our trainees who started in the medical field during the pandemic. As I mentioned previously, we were not able to have trainees working with us during the early days of the pandemic. For all of our trainees we have an annual review of their competency progressions and so, during COVID, there were a large number of people across all the specialities that had not been able to reach their competencies that they should have done for their year of training. This

was a result of their lack of training during the pandemic and so, to tackle this, we created a new outcome of competency for all of the training committees. This has now been reversed and there are far less of those outcomes being given now. The challenge throughout 2021 and in to 2022 was restoring elective surgery particularly in certain specialties such as trauma, orthopaedics, urology and neurosurgery or restoring enough of our planned care in a way that our trainees could reach their competencies. As the Royal College we did a lot of work to make sure the training continued so that while there was a great pressure to get waiting lists down, and the fastest way to do that might have been to have surgeries delivered by those already trained, we recognised that unless we continued with training we would not be able to have the next class of surgeons competent enough to do surgeries. There was a hashtag on social media 'no training today, no surgeons tomorrow'. So we used trainees to help catch up on the backlog of surgeries in a way that, historically, might not have happened and we are now in a place where, specifically in surgery, our trainees have now caught up with their competencies.

PPE

61. Within my specialty of breast cancer, we did not have a specific problem with PPE at any point. One specific change we made was that we, as consultants, went from wearing our own clothes to wearing scrubs and there were plenty of scrubs available to facilitate this change.

62. We also started wearing face masks and initially these were supplied to us from the operating department but as time went on we also received face masks from various other departments. Aprons and gloves were also made available in the same way.

63. It should be noted that the washing down of rooms, including the 'doffing and donning' of that PPE, did limit our throughput and this was especially so in operating theatres. We did have slightly less patients to see which

helped in terms of time but we also did need to be conscious of the increased sanitising time in between theatre slots.

64. Social distancing also had an impact on the way we carried out our roles. For example, prior to COVID, it was common for patients to take family members or friends with them to their appointments to provide support and comfort. During the pandemic, because of the social distancing guidance, we had to tell patients that, if they were physically attending the hospital, only they were allowed to come in to rooms. There were some occasions where we had to allow for a specific patient to be accompanied but overall it was not permitted. This was very challenging at that time but thankfully this has gone back to the way it was before and now in our clinics it is completely normal to have two people arriving for an appointment.

Testing

65. Testing for staff generally worked pretty well. There was a provision of testing and particularly a rapid access for staff to testing.

66. In the early days of COVID testing, I found myself in the position of requiring a testing on the basis that one of my family members had tested positive. In this case, myself and my family were provided with testing kits to do at home and that happened quite quickly.

Supporting staff

67. It was important throughout the pandemic to ensure that our staff across the board felt like they were being supported and that we, as the governing bodies, were taking steps and precautions to keep them safe at work.

68. One thing that we did was to open staff wellbeing hubs. These were places that staff could go to get a break from being on the wards or wherever they found themselves working in the hospitals. We had an

agreement with Glasgow Airport during this time and they provided staff from various airlines to volunteer to work in the hubs as they were grounded and unable to carry out their roles as usual.

69. We were also conscious throughout the pandemic about making sure we were looking after our junior members of staff and particularly trainees. We were aware that some of our trainees would finish their shift in the hospital and then return to their family home where they had company and support. However, this was not the case for all of our trainees and, particularly for those who were from overseas, going home after their shift was more isolated and lonely. So, we were conscious of these things and tried our best to make sure they were supported.

70. Overall, by the end of the pandemic, most of the staff that we lost were those who were coming up to retirement anyway and they felt like they had had enough. I think we did a reasonably good job of keeping junior members of staff on after the pandemic.

Disproportionate impact of the pandemic on society

71. I think it was very clear that the usual gradient of healthcare inequality, from the richest to the poorest, was heightened during COVID.

72. In the area that I serve, for example, a number of my patients are unlikely to own their own car or were more likely to live in overcrowded circumstances. So, for these people, the usual health inequalities were made even more obvious than usual during the pandemic.

73. For example, for those who would be receiving our services from our base in the Vale of Leven, it would be particularly difficult to get to the Vale of Leven without access to your own transport. This would force people to use public transport, which is a very long journey, and this also increased the risk of contracting the virus. Trying to work around these challenges became part of our day to day role during the pandemic.

74. Another example is that, in particular areas of Scotland, there is a higher use of drugs and alcohol and these were more clamant issues during some points of the pandemic and this was further impacted by the degree of social support that people had being quite varied.

75. I think that COVID laid bare the societal and health differences between the richest quintile and the poorest quintile within our society.

Shielding

76. Shielding did have a very big impact on us with the breast cancer delivery service because the average age of a breast cancer diagnosis in the UK is around the age of sixty-five and so this means that a lot of the people who are diagnosed with a breast cancer are over the age of seventy and this was one of the groups who were being told that they had to remain at home and shield. This impacted us on because, within the first few months of the pandemic, we had several long phone calls with women where we had to explain to them that the safest thing for them, at that time, was to not leave their home. This was particularly the case for those women who had long journeys to make.

77. One particular example of this is that I had with a patient and their GP on Islay and explaining that it was much safer for them to remain on the island and take an anti-cancer tablet than what it would be for them to risk a COVID infection by traveling to a clinic in Glasgow.

78. In regard to shielding, we followed the national guidance and that formed the basis for our ways of working. It was very important to us within the medical profession to feel like we were not making up any rules and instead following wider guidance. Of course, we had to make sure the guidance was speciality specific, but overall it was nationally agreed upon guidance.

79. Another group of patients that was specifically impacted by shielding were those who were already undergoing chemotherapy, and therefore already

immunosuppressed, but they were unable to stop receiving chemotherapy and shield as they would have done had they not already been undergoing chemotherapy treatment. This was a very difficult position to be in for those patients because they knew that, if they did contract COVID, they were more likely to die as a result. Therefore, it became a part of our role to limit the risk as much as we could for these patients and also make sure they felt supported and safe.

80. Shielding also impacted on those patients who were going to be undergoing surgery. For example, patients who were due to undergo planned surgery were asked to go into self-isolation for a period of two weeks before their surgery. This was enforced to limit the risk of infection to the patient before surgery and therefore limit the risk of cancellation.

Impact on mental health

81. Overall it can be seen that the mental health of the nation was impacted by the pandemic.

82. I think one particular group that was impacted was women and in particular young women. For a number of years, and prior to the pandemic, I have run a clinic for young women under the age of thirty with breast cancer symptoms. My reflection on that would be that we know that there is a fairly large percentage of the general population who have some form of mental health issue, for example anxiety or depression, and this went up during the pandemic. However, for some demographics, including young women, rates of poor mental health during the pandemic were much higher. For those women who then had breast cancer symptoms this increased their anxiety even more so.

83. This carried over into those women who were diagnosed with a breast cancer during the pandemic because they knew that cancer treatment was being impacted by the pandemic so they were anxious that their treatment would not be optimal.

Lessons to be learned

84. In a positive framing, I think there are things that we can take positively from the pandemic. The first thing is communication and how this has gotten better as a result of the pandemic. Particularly in utilising methods of communication that were available to us before but the pandemic gave us the push to really use them. For example, my first meetings of today have been with colleagues in Manchester and London via Microsoft Teams. It would have been impossible to attend both of these meetings in one day before the pandemic where I would have been expected to attend both in person. All of these ways of working are better and more convenient now.

85. Better use of online facilities can also be seen from a institution point of view we can see this in our college council meetings. These meetings are made up of around forty colleagues and historically these meetings were always held with all forty people in one room and that meant a lot of travel. All of these meetings are now hybrid meetings and so some of those forty people will still be physically in the room but others may well dial in from elsewhere in the world. This has also provided us with a learning curve of understanding how to best chair a meeting of forty people with some people online but I would say that this is overall a positive thing.

86. Another positive is collaborative efforts on behalf of the profession to share experience and learn from others. I think the pandemic has showed that there is professional power to enact rapid change where there is good evidence to do so. I think working through COVID has shown that we can collaboratively work together to find different ways of working which I think, before the pandemic, our human nature made it quite difficult to work collaboratively to change things. I think it is a positive of the pandemic to show that change can be made even to ways of working that have not changed for years and these can be made better.

87. I think there has been an obvious negative impact on the health service in that there was the decision taken to delay work that had to be done and to diminish our capacity to deliver those kinds of work. This has left us now in a situation where it feels like, for some people, that this has left us in a problem which feels too big to solve. I think this is contributed to by a political gap where people do not feel like the UK or devolved governments actually have a capacity to deliver the restoration of the NHS which we used to talk about in 2021 and 2022 when there was talk of rebuilding and restoring the NHS. I did many interviews with the media in 2021 and 2022 around the restoring of the NHS and I worry now that I was perhaps too optimistic because I fear now that people feel that this is now too big a hill to climb. I think that we need to recover some of that spirit that was felt in 2020 that we had an issue but if we put our minds to it this is something we can deal with. I think this is particularly noticeable in numbers on waiting lists for the NHS.. The impact of COVID on the ability for the NHS to deliver planned care has had a negative societal impact and I fear that there is now, after the pandemic, still a loss of faith in the NHS to deliver services.

Hopes for the Inquiry

88. My hope is that the Scottish inquiry focuses on the lessons that we might learn if there was a further pandemic. I have found it very disappointing watching the UK COVID inquiry with how much of the inquiry has been focused on inconsequential interactions between government ministers, advisors and such like. I recognise that it is of political interest to know how our government representatives are behaving but we will learn absolutely no lessons from these kinds of conduct to assist with any health service response or societal response to the medical emergency of a future pandemic.

89. I think we also need to be conscious that it can be seen from other pandemics in human history that generally pandemics impact on children and young people more so than other groups in society. However, the

unusual thing with COVID is that it had huge impact on the elderly and we need to draw lessons from that for any future pandemic, we also need to remember that the next pandemic may be quite unlike Covid. So my hope for the Scottish COVID Inquiry is to learn lessons so that we are better prepared, for any future pandemic.

SIGNED: M McKirdy (*via Email*)

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