Scottish COVID-19 Inquiry

Witness Statement

Statement taken at 1300 hours on Monday, 12 February 2024. Witness Number HSC0181 refers.

Witness interviewed by Witness Statement Taker Personal Data. Statement also noted by Witness Statement Taker Personal Data. Witness interviewed via Microsoft Teams.

Witness represented by Thompson's Solicitors, 285 Bath Street, Glasgow, G2 4HQ who was present at the meeting.

Statement: **Claire Elizabeth RONALD:**

1. My name is **Claire Elizabeth RONALD**. I am 53 years of age, and my date of birth is Personal Data I stay at my home address at Personal Data Personal Data

2. I am currently employed full-time as a Senior Negotiating Officer with CSP (Chartered Society of Physiotherapy) for Scotland and Northern Ireland. I have been in this position for 14 years.

3. I am willing to provide a statement, have my information contained within reports and to have my statement published.

4. I am prepared to give evidence at the Inquiry and I'm aware that I can withdraw consent at any time.

5. I have agreed to the recording of my statement today. I have signed the Inquiry consent form showing my agreement to all of this.

6. I would like to tell the Inquiry about how the pandemic impacted The Chartered Society of Physiotherapy (CSP)'s members.

Personal Background

7. I qualified as a physiotherapist in 1991 and worked as such until 2010. I then became a lay representative for the CSP. In 2008 I started working for the CSP whilst also continuing to work as a physio. I took up my current position full time in 2010, which covers both Scotland and Northern Ireland.

8. There are five different directorates within the CSP of which Employee Relations and Union Support (ERUS) is one part. This is essentially the trade union section. I report to an Assistant Director who in turn reports to the Director of our directorate. She reports up to the Chief Executive of the CSP. I represent members for Scotland and Northern Ireland in the trade union.

9. If a member has an issue, such as a disciplinary or a grievance, they approach our lay reps first. The lay reps then report to me if they cannot resolve the issues themselves.

10. Support is primarily given to members by way of face to face appointment, by telephone or online. Our website was the main point of contact during the pandemic.

11. As a trade union we do work with other partners through our tripartite system which involves the unions, the NHS employers, and the Scottish government. We have Scottish Terms and Conditions (STAC), Scottish Workforce Group (SWAG) and the Scottish Partnership Forum. Within each health board you have partnership forum which we can dip in an out as required.

Overview of CSP

12. The CSP is the professional, educational and trade union body of physiotherapy students and support workers. Approximately ten percent of our members are resident in Scotland. There are 65,000 registered physiotherapists across the UK of Great Britain and Northern Ireland.

13. The physiotherapy workforce played an essential role throughout the COVID-19 pandemic across all the NHS, social care, independent sectors and education. Within education this includes the students who entered the workforce to help out. It has also been critical in enabling non COVID-19 patients' rehabilitation and discharge from hospital.

    Throughout the pandemic the CSP supported members working across sectors and this included members such as frontline NHS physiotherapists, whose efforts undoubtedly saved lives, to independent sector practitioners who saw their incomes disappear.

14. One of the key areas Physiotherapists work within is respiratory care. During Covid Physiotherapists used their skills and knowledge of respiratory care within intensive care units and acute medical wards to assist with chest clearance and breathing techniques. Some also volunteered to work within specialist 'proning' teams to assist positioning patients on their fronts to improve their ventilation and perfusion ratio (ensuring their was a good mix of oxygen taken round the body by a sufficient blood flow). Physiotherapy was instrumental in patients surviving the impacts of Covid. Physiotherapists assisted patients' rehabilitation when they were out of the acute phase to maximise their potential and return them to as active a life as possible.

15. The CSP worked at pace to interpret government advice for the physiotherapy workforce and developed physiotherapy-specific professional guidance

16. The CSP also worked with our partners on areas of shared concern, such as Allied Health Profession Federation (AHPF), Trade Union Council (TUC), the Arthritis and Musculoskeletal Alliance (ARMA) and coalitions for community rehabilitation in each UK nation.

Impact of the pandemic on CSP

17. With regard to demands for our services there was a massive increase once the pandemic and the first lockdown hit. The majority of the demand was from members seeking advice regarding the guidance and how it applied to them. Our staff were working seven days a week just dealing with all the inquiries, which were also about PPE as well as the guidance, access to funds, pregnant workers, underlying health conditions, student placements, access to vaccines and many other themes. This increase in the volume of inquiries was coupled with trying to interpret and keep up to speed with all the changes in guidance.

18. There were challenges around delivering our services during the pandemic. To counter this we set up WhatsApp groups to ensure information was shared quickly. We utilised applications like Microsoft Teams to ensure we could continue to hold our meetings. We set up the website so information was more freely available and we also ran webinars on special subjects which were delivered at different times so we could ensure we reached all the members.

19. In order to ensure reps were appropriately supported and up to date with guidance we conducted more reps meetings online so we could keep in touch with them and know what was happening.

20. We very quickly set up COVID pages on our website - especially on the trade union side. We each took ownership of specific subject areas and

linked in with work we were already involved in so we could keep abreast of the ever-changing guidelines. This worked well as nobody could know everything. My specific subject area was maternity so this was my specialist area. There were so many different aspects to this such as how many weeks you could continue to work for before going into isolation, or, for members with long term conditions, would they still get paid, discussions around death in service with pensions, trying to sort out indemnity insurance for students so they could continue with their placements and whether students would have access to death in service if they contracted COVID.

Impact on CSP members

Lockdown

21. As lockdown was imposed, the immediate consequences for CSP members was dealing with their families and, given that they were front line workers, the anxiety of what they could be taking home to them. I would estimate the ratio of female to male staff across our profession is about 80/20 so many have childcare duties or are married to fellow front line workers across the emergency services which made looking after children very difficult.

Redeployment of Staff

22. Many of our members were redeployed into the acute sector and this caused different issues. This caused anxiety for staff, particularly community staff being moved into the acute sector who were concerned about the risk to their and their family's health. However, most were redeployed within their physio roles as opposed to non-physio. There is little evidence of the planning to mitigate impact on services staff were redeployed from with many being put on hold or only emergency cases being seen.

23. At the start of the pandemic it was not very clear what patients could and should be seen and so many did not get the rehabilitation they would have required. When staff have gone back to their services they see patients who will never reach the potential they had pre pandemic and that leads to feelings of anxiety and guilt among staff.

24. Some have had their working space reduced or removed and used for storage or other services. This has led to fear that their service is not valued by the organisation and that at any time they could be pulled to areas that are seen as important and vital. Those areas are always seen as the acute service and not the community or rehabilitation services. Mental health services, learning disability services and paediatrics also experienced this. We hear from staff that no-one has spoken to them since they returned to service from the higher levels of management and they have had no reassurance that their services are valued and seen as important.

PPE

25. PPE was a huge issue for our members. This was in two main ways: first, securing of appropriate levels of PPE and, second, the sizing of it. The vast majority of PPE is made for a default male body and face and that is not the default in the health service. Many staff faced repeated fit testing and only had one brand of mask they could safely wear and so it limited where and when staff could be in areas. Gowns were often too long and gloves were not always available in small sizes so staff had to accommodate themselves to the equipment rather than the other way round.

26. Another concern for our members was the definition of aerosol generating procedures (AGPs) and the level of PPE staff were easily able to access. The international consensus was that the transmission of the virus was airborne, rather than through droplets and contact, as had been initially

thought but this was not fully reflected in the National Infection, Prevention and Control (IPC) guidance thus contradicting public health messaging at the time.

27. Numerous studies have shown that aerosols are generated by coughing, sneezing, shouting, and, to a lesser extent, speaking. IPC guidance at the time therefore failed to recognise many physiotherapy interventions as generating aerosols which placed members at risk with insufficient PPE. We advised members to conduct individual risk assessments and wear higher levels of protection (such as FFP3 masks) as indicated. This was not supported by all organisations and left physiotherapy staff vulnerable and not fully protected.

28. This was particularly because the profession had not yet been considered a priority group and it created significant anxiety and mental stress for members. The CSP and other AHP (Allied Health Professions) bodies were late to be included in IPC cell meetings therefore it was difficult to raise these issues at a national level in the early stages. It was also very unclear when decisions were UK led and when they could be adjusted in Scotland and we had no easy route into the decision-making process in Scotland either.

Disposal of PPE for Community Staff

29. For those staff who had not been redeployed and were trying to provide essential services in the community, it was difficult to get clarity on the disposal of PPE.

30. Even in winter staff had to change into PPE outside a patient's house and had to be bare below the elbow. They often had to change in their car and walk some distance to the patient's house or put PPE on in the doorway before entering the house. They then had to take PPE off outside the

door and put it all in a black bag this was coupled with a lack of clarity on how the PPE was to be disposed of.

31. Many of our community physiotherapists use their own car for work so they were very concerned about the PPE disposal and the risk it could pose to their family if they were carrying used PPE back to base.

Impact of Work and Workload

32. A lot of our members were exposed to more patients who were dying than they ever saw before COVID. This was due to the increase in bed spaces in ICU and acute medical wards to support deteriorating patients and more physiotherapists had to be moved into roles to support these patients. Members work across various sectors, however, the overwhelming majority of their patients are not terminally ill. In the early stages of the pandemic where there was a higher number of people dying and a higher number of younger people dying, members found this quite overwhelming. This had a huge impact on their mental wellbeing even for those who would ordinarily work in ICU. The numbers of deaths they were being exposed to was far greater during COVID. They were seeing people in more distress and were sometimes the only person the patient had seen for a long time. While Health boards put in place well being strategies, there is no apparent audit of uptake or effectiveness.

33. There are more physios retiring early, post COVID, than there were before. Many are fatigued and are going before their official retirement ages.

Testing

34. In September 2020 the UK Government announced they would be prioritising NHS staff and care homes for testing. However, a survey of CSP members carried out in September 2020 with 4,057 responses demonstrated that only 1 in 5 NHS physiotherapy staff reported having

regular asymptomatic testing at work. In addition 89% pf physiotherapists working in private practice said they did not have access to asymptomatic testing. The CSP argued, at a UK level, for weekly testing to be provided to health care staff in all settings who were themselves likely to be at higher risk. This included black workers, those with long term health conditions, those treating COVID positive patients and those treating patients in higher risk groups. Around 1 in 5 physiotherapy staff were believed to be in a high-risk category.

35. Testing was a problem during COVID and is even still now. You can no longer get free testing and we no longer test patients when they come into hospital. Staff who do have COVID are now classed as being off on sick leave which was not so during the pandemic. We are treating this like a seasonal flu. For those who are off work, or have left the service due to Long COVID, there is a lot of anger as it does not look like we have learned from the past experiences.

Private practitioners

36. The CSP is the professional body and trade union for all our members irrespective is they work in the NHS, in private hospitals, for sports clubs or in their own practice.

37. Even though physiotherapy private practices were technically allowed to remain open, the stay-at-home public messaging meant they were only able to see a few high-risk patients. This in effect forced practices to shut down, to the point that some members lost not only their income for that period but their whole business.

38. As we started to come out of lock down and more services were able to resume there was the difficulty of sourcing PPE for those in private practice and ensuring enhanced cleaning regimes were in place. This cost was often borne by the practitioner and not passed onto clients.

39. Vaccinations were made available to NHS healthcare staff quickly once approved, however it was harder for non-NHS Physiotherapy staff to access vaccines initially. We recommended vaccination to our members, while opposing compulsory vaccination as a matter of principle

Loss of rehabilitation space in hospitals

40. During the pandemic many rehabilitation spaces, such as gyms and hydrotherapy pools, were repurposed and many have not been returned. This reduces the quality of provision, impacts on patients' quality of life and causes physiotherapists to feel stressed, guilty and have reduced job satisfaction.

41. This is a long-term effect of COVID and this affects our ability to actually treat people properly

Travelling

42. Travel arrangements was also a concern for our members and especially for those who used public transport. There was concern about how they would actually get to their workplaces and the risks of travelling to them.

43. For those working in the community, there were times when you could only travel alone in your car, so you might have three members of staff each having to travel alone using up three pool cars which were scarce. This impacted the service delivery to the community as it reduced the number of patients that could be seen each day. Community services had to be decreased with patients being prioritised based on their need. However, this was also in line with minimising the number of staff visiting vulnerable or shielding patients.

Students

44. We anticipate giving more evidence when the Inquiry considers further education, however there is a cross over with the impact on health care.

45. There were changes within the academic and practice-based learning environments for Physiotherapy students. University based teaching transitioned to remote web-based delivery overnight and many practice placements were cancelled. To ensure graduate workforce supply final year students were prioritised for practice placements.

46. There was a lot of confusion around this time with the chief allied health professions officers in the four countries apparently attempting to co-ordinate the advice and guidance but as it then came out on a country-by-country guidance it became complicated. There was also communication with the higher education institutes and with the health boards and it felt as if the professional bodies trying to answer members communication was not always involved in the discussions. In May 2020 guidance was agreed and produced on final year student support during the covid 19 outbreak.

47. Again, the key learning for us is who is involved in the discussions and decision making. CSP at times felt removed from some of the decisions being made that directly impacted our members. We had to decipher whether infection prevention control guidance came from the UK Government or whether there was a variation in Scotland. It wasn't clear who was the appropriate body, group or person to raise challenges in relation to decisions. When the Scottish Government set up groups to inform their decision making, the reason for some professional bodies being represented within the group while others were not was not clear. Relevant professional bodies, such as CSP, should have been involved in decision making at an early stage. This would allow input to decisions in addition to a stronger understanding of the outcome of the decision making process. It must also be considered whether a UK wide decision is

appropriate or whether a different decision must be made for the unique situation in Scotland.

Post Covid Impacts

48. As we came out of the pandemic there was frustration growing amongst our members because there were patients, who they had not been able to see during the lockdown, who would never be able to recover to the point they were before the pandemic. These members know why the service was withdrawn but it is hard for them to see, for example, children whose posture and mobility has deteriorated and the members feel guilty and frustrated about this. They feel upset that nobody in their service seems to be acknowledging this and there is a fear they are seen as less important and can be pulled again at any time.

49. There was also a lot of anger and this was especially noted amongst members who were suffering Long COVID. There seems to be a reluctance from their employers to accept these members more than likely contracted covid whilst at work.

50. In regard to physiotherapists and the work they do this has also changed. Physiotherapy is a hands-on profession and, even during COVID, physiotherapists were still in hospitals treating patients. This has not gone away. There has been a move towards virtual rehab but it is a different way of working for them and a huge chunk of learning is still to come from this. However, some patients like the virtual rehab as it saves them time having to travel to see a physio in person.

Guidance

51. At the start of the pandemic the main operational and strategic challenges for us, as an organisation, was how our members could continue to do their jobs and do so safely. It was about interpreting the government

guidelines in a way that made sense to our members and answer their questions as best we could.

52. The CSP disseminated guidance to members through a Coronavirus hub, daily email briefings and regular out-of-hours webinars. They also updated the enquiries service from five days a week to seven days. Regular large-scale member surveys were carried out by the CSP in order to understand the impact on frontline services across sectors. The survey we carried out in May 2020 asked members what their biggest concerns were at that time - 53% were concerned about family's health and wellbeing, 42% were concerned about their own health (including issues with access to PPE), and 38% were concerned about the impact on non-covid services.

53. Where the guidance was unclear, we had to interpret it and tailor for our members and their work, for example, the disposal of PPE for our community staff, staff working on the acute sectors or for those working privately. The direction was not fully understood or tailored for us. This was sometimes interpreted differently across different health boards. This could have been improved if the communication network was better.

54. The level of guidance our members required to stay up to date with also had a significant impact. Members were required to keep up to date on a vast amounts of guidance. This included guidance advising on how to treat COVID patients, especially at the beginning when proning (treating patients face down) was being advised. This was a new disease and so we had to discover how to best treat the patient and this improved as time went on.

55. Another significant issue for CSP members was the uncertainty around guidance for pregnant frontline workers. If you look at the NHS data on Turas, which is an NHS Education platform, the NHS is 77% female with a

median age of 44. Physiotherapy is 82% female and with a median age of 40. So during COVID we had a higher than average percentage of female staff. Because of our lower median age there was likely to be a higher number of CSP members pregnant during COVID than other professions. The advice for pregnant frontline workers was confusing and changed frequently, and this conflicting and confusing advice, continued with the vaccines.

Consultation with Scottish Government

56. During the pandemic there was less tendency to use existing partnership groups, such as the Scottish Partnership forum and Scottish Workforce group, to communicate as these were only NHS. Instead the Scottish government set up a group called the Health Work Force Senior Leaders Group which was set up by the Scottish government to bring social care and health together because a lot of the information and concerns were coming through these two areas.

57. This is often spoken of as a brilliant example but the membership of this group was very selective and the CSP was not included. I did not find out about this group's existence until about 6 months after lockdown had started and, even then, we only got the Minutes from the meetings but we were never invited. Despite being part of so many groups and distribution lists before COVID, for some reason, we did not get included on this one even though it was a very important one. As a result, we had no avenues to try and report back on guidance or influence it. From a trade union perspective, we were out the loop and did not know what was happening and were not fully sighted.

58. The bypassing of normal processes was very confusing and left us not knowing what was being discussed and decided UK wise, and what was specifically Scottish. It was not until later when our structures were linked back in that we began to feel part of things again.

59. I felt more included and engaged with the situation in Northern Ireland than in Scotland. We had fortnightly meetings with lead trade unions, HR directors and civil servants. Even if an organisation was not in attendance there was a mechanism to ask questions. I felt disengaged from the Scottish government as we were often excluded from groups.

Lessons to be Learned.

60. For services to speak to staff who were redeployed and hear their concerns and make steps to address them. If this does not happen then we risk burnout and staff leaving.

61. For each health board to have a rehabilitation lead and a clear rehabilitation pathway to be established and in a pandemic for regular and clear communication with all professions to be standard.

62. For discussion to take place now between government and PPE suppliers on what they use as a standard face or standard height or standard glove size and to ensure that supplies can fit the majority of the workforce rather than the minority.

63. For all relevant staff groups, and their professional bodies, to be involved in groups that make relevant decisions.

64. Agreement on the production of aerosols must be a priority to better protect the public and health and social care staff from airborne diseases in the future.

65. To ensure that all professional groups have a clear and safe route for raising concerns and there is clarity on the messaging coming out.

66. For measures to be taken of where spaces have been repurposed during COVID, and details of why they have not been returned to previous use.

Hopes for the Inquiry

67. I would hope we could be doing a lot of things now rather than waiting for the outcome of the Inquiry. I understand the need for an Inquiry but my fear is it could delay some of the decision making.

Signed .....

Date .....