Scottish COVID-19 Inquiry

Witness Statement

Statement of Graham Pirie of the Royal College of Podiatry - Witness Number HSC0187.

Introduction

1.My name is Graham Pirie. My details are known to the Inquiry.

2.I am an Employment Relations Officer with the Royal College of Podiatry.

3.I am willing to provide a statement about the experiences of the Royal College of Podiatry and our members during the COVID-19 pandemic in Scotland.

4.I have signed the consent form provided. I consent to my information being contained within reports and I am agreeable to this statement being published. I have agreed to the recording of this statement. I would be happy to give oral evidence at hearings.

Organisational Overview and Responsibilities

5.I have been an Employment Relations Officer with the Royal College of Podiatry since 2001. I work part-time in this role. I am a qualified Podiatrist, and I worked in podiatry in the NHS and the private sector before I took on this role.

6.I am the Pensions Lead for the Royal College of Podiatry, so I also sit on the Special Advisory Board for the NHS pension scheme. I am also a Staff Side member of the Scottish Terms and Conditions Committee, which negotiates terms and conditions and pay for NHS staff in Scotland.

7.The Royal College of Podiatry is the academic authority for podiatry in the UK, and the professional body and trade union for the UK's registered podiatrists. We provide information to the public, media and health organisations. We also give professional and employment support to podiatrists across the UK.

8.Generally, we do any campaigning work alongside other NHS trade unions, rather than as a singular trade union. For example, we sometimes do this with fellow allied health profession unions, such as

the Chartered Society of Physiotherapy, the Society of Radiographers or the British Dietetic Association.

9. In my role, I provide employment related advice and support to our members across Scotland and Northern Ireland. The majority of our members are Health and Care Professions Council (HCPC) registered podiatrists, but we also have members who are podiatry assistants or orthotic technicians. As of 2023, we had around 1,250 members in Scotland, working in the NHS, independent sector, retail sector, higher education, research and charities. In simplistic terms, around half of our members work in the NHS, and the other half in the independent sector. During the COVID-19 pandemic, we had members who worked in the retail sector for a company called Shuropody, but they closed their stores in Scotland in May 2023. Our membership is about 78% women UK wide.

10. Our employment relations responsibilities include general workplace issues, such as disciplinary matters, grievances, bullying and harassment, and terms and conditions of service. Our responsibilities for those in independent practice come down to contractual issues, issues that they have with associates or employees.

11. In terms of structure, the Royal College of Podiatry is a UK wide organisation, governed by a Council. There are between 12 and 15 elected Council members, including a Chairperson.

12. Under the Chairperson, we have a Chief Executive, who is also the General Secretary (this post is advertised and appointed through interview rather than election). Then we have various Directors and Heads of Department. We have around 40 paid members of staff UK wide. Most are based at the office in London, although we do have some like me who are based elsewhere. I work from home in Scotland, and I have always worked from home.

13. We have a finance department, a communication department, a policy department, an employment relations department and an education department. Within the employment relations department, we have Employment Relations Officers, as well as Professional Support Officers (who must be registered podiatrists).

14. The education department is one of the big areas for the professional body part of the organisation, because we are committed to continually educating our podiatrists to make sure that they are able to deliver the best possible service. We also provide education to patients and to anybody who has any concerns with foot health in any respect.

15. As a professional body, we try to promote the profession to others in the healthcare system or those in government, as well as promoting the benefits of podiatry to patients. We do a lot of publicity to promote podiatry and to encourage people into the profession. Our numbers of full membership have gone down by 1.9% between 2021 and 2023 due to the number of members retiring and fewer people coming into the profession.

16. The Royal College of Podiatry has a branch structure, with local branches across the UK (and some overseas, for example in Barbados). Each branch has a Chairperson, Treasurer and Secretary. The primary focus of those branches is on delivering continuing professional development (CPD), which our members have to undertake to remain on the HCPC register.

17. We have a network of trade union representatives across the UK, who are all volunteers. We also have health and safety representatives, and union learning representatives. We are now trying to recruit equality and green representatives as well.

Impact of the COVID-19 Pandemic on the Royal College of Podiatry

Working from Home

18. Prior to the COVID-19 pandemic, most of our staff did not work from home, as decided by our then Chief Executive. When it was announced in March 2020 that people were to stay at home, we had to close the office, and staff were told to work from home. We could tell that an announcement was coming. We had already moved to a hot desking situation, and staff had work laptops. Most of our phones come through the computer system anyway, so diverted calls can come through our laptops. Working from home had no impact on service delivery at all, because we had the equipment to continue to deal with email enquiries and phone calls.

19. In many respects, the organisation was a lot more efficient working from home. As a result of COVID-19, we now have a trial period where all staff can work from home, but they should aim to spend 40% of their working week in the office.

Impact on Staff

20. As time went on, we realised that our members of staff were very isolated working from home. We quickly set up weekly departmental meetings, and we also put in place catch up meetings with line

managers and directors every 2-3 weeks. We also had staff updates, where the whole team of staff would come together.

21. I am also the local GMB representative for our Royal College of Podiatry office. There was no doubt that our staff members were feeling a bit more disconnected and, to some extent, isolated because they were all working from home, and they were used to the office environment. They couldn't just turn around in the office and speak to someone about something, they were now having to put in an appointment. There was initially some certainty around how to work, as some of us did not know how to use Teams, for example, and we didn't receive training on this.

22. There were some concerns about the lockdown and the fact that we were not going out to meet with people face to face. There were certain members of staff who were concerned about whether their jobs would be viable if the lockdown continued, but at no stage was any job ever discussed as being under threat because of COVID-19. Ultimately, we did not lose any staff at all as a result of the COVID-19 pandemic.

Meetings and Hearings

23. As an Employment Relations Officer, at the beginning of the lockdown, for me there was a whole raft of face-to-face meetings that were swiftly cancelled, and put on hold until we had further information. Some of these meetings were important, for member disciplinary investigations or disciplinary hearings. Any delay to these sorts of meetings is not good for our members, in particular for their mental wellbeing, although I didn't have anybody complain about that. Other meetings included return to work meetings which had been organised prior to the pandemic, for individuals who were coming back to work after a period of absence.

24. We were initially trying to have meetings through telephone conferencing, which was not the best way but seemed okay at the time. Then Teams came along, which helped facilitate a lot of the meetings. It actually made us consider which meetings we really had to attend face to face.

25. We also help our members through HCPC processes. Generally, our role for HCPC processes is just to assist and guide our members, and then we ask lawyers to deal with the actual hearing. However, we had to support our members whose hearings were being postponed, and there was uncertainty over when the hearings were going to happen.

Conferences

26. As a professional body, we organise various conferences. Our annual training and educational conference in Scotland had to be cancelled in 2020. This was at a time when hospitality was shut down anyway. The conference was rescheduled for the following year, in 2021, but then had to be rescheduled again.

27. There was a loss of income for the Royal College because our main, UK wide, annual conference was also cancelled in 2020. The conference was due to be in Liverpool and expected to be attended by somewhere between 1,000 and 1,500 podiatrists, which is about 10% of our whole membership. The conference can be good for bringing in additional resources because most of our income generation (I think around 90%) is through membership subscriptions.

COVID-19 Working Group and Communications

28. Following the lockdown, the Royal College established a COVID-19 working group. Communications to members were sent via this group, which was the Royal College's version of COBRA, and was set up by the Chief Executive. We decided that the best way of contacting members was electronically, so communication was mainly by email. At one stage, we were sending out emails to members almost every day, about UK and Scottish Government announcements and reminders of where we stood in the pandemic. We also had information on our website, which we updated as and when required. I know there was also some form of communication on Facebook, but not all our members are on Facebook.

29. Our guidance came from a broad spectrum of sources. We sent out anything that we thought would help our members, including circulating information that had been sent to us by our members (which had been provided to them by their NHS employers, for example). Our Policy Officers were constantly looking out for any official statements or information that was coming out from the UK Government. We would also get information from the different devolved countries. At the outset, everything was on an even keel, but then Scotland seemed to be doing things at a different pace to England.

30. We paid particular attention to what was coming out of the different NHS providers, NHS Scotland and NHS England. We were constantly checking their websites for updates.

31. There was also a lot of information coming in through the various national groups in Scotland, for example, the Scottish Partnership Forum, the Scottish Workforce and Staff Governance Committee, and the Scottish Terms and Conditions Committee. Sometimes we were getting the same information from three areas, but three was better than none. Any information that came in through these groups would be forwarded to the Royal College, to ask if they were aware of it. We then sent the information to the communications department, to either be immediately sent out to members or assessed for whether we needed to provide some particular advice about it.

Vaccinations

32. In Scotland, a vaccination implementation group was set up. The Group was called Vaccination Service Delivery, and it later changed its name to FVCV Delivery Group (which understand meant Flu Vaccination Covid Vaccination). They were looking for representatives from trade unions and the request was received on 13 November 2020, so I put my name forward on 18 November 2020. The first meeting I attended was at the end of November or early December 2020. When consideration was being given to the priority groups for vaccination, there was a list of healthcare professionals who were in Priority Group 2. At a meeting, I suggested that podiatrists should also have been included in that group, and this was agreed. We had to wait for the amendment to come out, and then I informed the Royal College of this change. I believe, from there, the same change was made for England.

33. I alerted our members in Scotland of this change through the communications. A lot of our members were concerned that they had not been included in the priority groups for vaccinations, but I explained to them that they were included, and they were then able to go along to have their vaccinations.

34. The amendment was supposed to cover all podiatrists, but we got some feedback that some Health Boards were saying that the priority was only for NHS podiatrists. We had to follow those cases up, and eventually those people in private practice did get their vaccinations. There were only a few of these cases, and some podiatrists in private practice were actually vaccinated before some people in the NHS. The amendment didn't say "podiatrists in all sectors". I naively thought that just including the word "podiatrist" was enough.

Impact of the COVID-19 Pandemic on Podiatrists and Other Members

35. We received a lot of phone calls to the office from our members during the pandemic. We triaged the calls, so that anything to do with employment relations came in via a particular phone number. Members in Scotland also have my phone number and email address. We were receiving information either through direct contact to myself or to the Royal College via email or phone. There were also people contacting us through the website.

36. The local representatives in Scotland generally meet three times in a year, but I would also always contact them to see how things were going. As well as getting information directly from our members, I was getting information from the local representatives in different Health Boards across Scotland, or from the Royal College itself.

    For the private sector, we have a committee rather than local representatives. The committee is called the Independent Practice Group (IPG) and is made up of members from various parts of the UK that meet either on Teams or in person. I didn't get information from the PPG but what was raised by this committee was fed into the College.

37. From the information that I was receiving during the pandemic, I am able to identify a number of key impacts or issues faced by our members.

<u>Uncertainty and Key Worker Status</u>

38. We had a lot of members seeking guidance on whether they were key workers, as many members in the private sector felt that there was a lack of clarity in the initial information about lockdown and who were key workers. Many felt ignored by the Scottish Government and that there was no clear guidance or support.

39. At the beginning of the lockdown, only high-risk treatments were allowed to be done in podiatry (which is generally wounds in the foot, or patients with ulcers). These patients with wounds were continuing to be seen by the NHS.

40. Prior to the COVID-19 pandemic, the NHS was treating patients with wounds, but also ingrown toenails, plantar fasciitis, corns and calluses. When lockdown happened, treatment for the mainstream general conditions was stopped, and only high-risk treatments were carried out. Appointments were cancelled, and the NHS focused on wound care.

41. We provided a "decision tree" to give guidance to members on what could be treated.

42. One of the biggest areas of uncertainty was for those who worked in the private sector. In private practice, or the independent sector, the caseload of podiatrists would be general or mainstream podiatry, and they wouldn't treat patients with wounds (patients with wounds would be passed on to the NHS). The initial lockdown therefore meant that those in private practice were not seeing any patients, or they might have been seeing one or two patients with an ulcer, but then passing them on to the NHS. The confusion was that podiatrists were being described as key workers, but private podiatrists had to shut down their business. They were key workers but had to close for a period of time which I recall was 4 to 6 weeks or so. This meant patients had to be cancelled without being able to give future appointments as there was no information as to when the clinic may re-open. This is a difficult conversation to have with a patient due to that uncertainty. This would also have led to a loss of income during this period, although the government's introduction of financial help will have mitigated this to an extent.

Lack of Information about Working in the Community

43. There was also confusion because the majority of our members working in the NHS work in the community, yet whenever there was anything in the news about COVID-19 and the impact it was having, the footage was all of hospitals, and all of the statistics and information were about hospitals and care homes. There was very little information about working in the community or in health centres. For example, a fair number of patients in podiatry needed home visits, but there was a lack of information, protocols or guidance about home visits. District nurses, physiotherapists and dieticians also do home visits, but there was a lack of information. Our members were confused about that.

Fear and Risk

44. At the outset of the pandemic, the biggest issue facing our members was the uncertainty and fear, in particular over having to go to work.

45. There was a real sense of fear amongst members who worked in the NHS about going to work and how safe it was. I had some members working in the NHS who emailed and asked if they could be furloughed, but because they had been identified as key workers, they were expected to go into work, unless they were shielding.

46. During the pandemic, due to the many closures of clinical sites, many more patients were seen at home. This meant that podiatrists were going into an uncontrolled environment, where they didn't know who

else might be in the house, and were unsure whether patients had COVID-19. Podiatrists invariably spend around 30 minutes in direct contact with a patient.

47. Initially the concern about going into patients' homes was only among the NHS staff because, when the initial lockdown came, the first thing that most of our members in independent practice did was to shut down their businesses. However, around six weeks into the lockdown we were able to provide enough guidance on reopening businesses because Scottish Government guidance was changed. The guidance included what we had learned from those in the NHS, and what they had done around going into patients' homes.

48. The guidance we provided to members doing a house visit was to first phone the patient and ask whether they had COVID-19, or symptoms, or whether there was anybody in the house with COVID-19. Our guidance to members was to make sure the patient was alone, but some patients are not mobile and cannot answer the door themselves and would have needed someone else in the house to open the door. If that was the case, the guidance was that the person needed to move back after opening the door to let our members have a clear path to enter. The biggest fear was contracting COVID-19. These were the types of issues that had not been addressed by any Government guidance.

49. Those who were carrying out the treatments were hearing that their managers were able to work from home. That was a good thing, because the more people we can protect the better, but members felt that they were putting themselves at risk by coming into work.

50. Over time, NHS staff started using developments in IT to have virtual appointments with patients. They had been doing that in NHS Highland prior to the pandemic, using the Attend Anywhere system. This was used to triage patients and see whether the patients needed to come in, or whether podiatrists needed to go out and see them.

51. This did help in some respects, but members also found this system unhelpful, because podiatry is a very hands-on profession. For example, when you see a patient face to face, if a patient takes off their sock, you would know if they have an infected ulcer because there is a certain smell that podiatrists recognise. Also, part of the actual treatment or diagnosis is to put your hand on the foot, palpate the foot, check for temperature or check for pulses. With that taken away, it limits members and they felt it compromised their ability to do a proper assessment of their patient's condition. It was certainly better than nothing, but not as good as it would have been face to face.

52. There was also a lack of a Scotland-wide approach and a lack of universal training on these virtual appointments. The impact of the lack of training was that people did not have as much confidence in the system. The level of training offered differed across Scotland, but as time went on, more training has been provided. A fair proportion of our patient client group is also elderly, and they might have required someone else to be there to use the technology.

53. We had two cases in particular of members retiring during the pandemic due to the fear of working. One was somebody who worked in private practice, and who was probably around 57 years old and not that close to retirement. It was probably six weeks into lockdown, when they phoned and said that they had to close their practice. I provided the guidance on reopening that had just been announced, but they had said that it was just not worth it to reopen, and they were just going to close the practice and retire. They would have been quite happy to work longer, but the fear of having to reopen was primarily in terms of being able to put systems in place to work safely. The other case was someone who worked in the NHS and was due to collect their NHS pension shortly. They said they were just going to retire now, rather than putting themselves at risk.

54. For those continuing to treat patients, the fear was of catching COVID-19 and dying, in simple terms. Members were seeing daily figures of the number of people who were dying. It was a terrible time for those who lost their loved ones. Members were realising that this was a deadly virus and they still had to go into work not knowing which patients might have COVID-19.

Long COVID

55. We have also had members retire on ill-health grounds, and members off on long term sick, due to long COVID. I am aware of four cases of members who have had long COVID. All four are female. These are the only cases that I have been alerted to, but I don't deal with all of the cases, as sometimes they are dealt with by the local trade union representative.

56. One of these members contracted COVID-19 in April 2020. As soon as testing became available, they tested positive for COVID-19. They were off for more than two years, and had to retire through ill health in December 2023, because there was no possibility of them coming back to do her job as a podiatrist. That member was at retirement age anyway.

57. We had another member who had to retire from podiatry because they said they could not mentally and physically do the job. Some days they were just not up to moving about and could not get outside. She contracted COVID-19 sometime between 2020 and 2022. She retired from the profession officially in August 2023, and she was in her early 30s.

58. The NHS were very good and supportive with these two individuals. Long COVID clinics have been set up in Glasgow, and they were referred there. They had done everything they could, but at the end of the day, they just were not going to be returning to work.

59. We also have members who have long COVID and are still struggling to attend work. One of the members has reduced her working week (moving from full time to part time and using one day of holiday every week) to ensure that she can keep working and keep her energy levels up, which has impacted on her take home pay and pension.

Shielding

60. Our Professional Support Officers provided members UK wide with a guidance note on how to apply for a shielding letter via their GP if they hadn't received a shielding letter. There were then problems due to a lack of GP appointments. However, I think there was only one member in Scotland who didn't receive a shielding letter, but they later received an apology for having been missed out.

61. Some members who were shielding felt isolated because they had no contact from their manager and there was a lack of provision of equipment to work from home. They were initially told to do some mandatory training, which they could do on their own laptop. I'm not saying every person who was shielding did that, but that was the go-to direction. However, after a week or so, they were wondering what to do next.

62. To access systems to make appointments or see patients, you would need an NHS laptop. Gradually, things came into place, and those shielding were given a work phone and a work laptop, so that they could do things like triaging patients – that was the main thing that was done. If patients had to be phoned before a house visit, then some of our members who were shielding did that. They might have also been looking at referrals, helping to make appointments, or helping to cancel appointments since only high-risk patients were being seen (although a lot of places did have an admin team).

63. Podiatrists generally work single handedly in the clinic, so they are used to a level of autonomy and isolation, but they would still interact with reception staff and with patients. At the beginning, those who were shielding felt very isolated in the fact that there were no meetings or networking with colleagues. Eventually Teams came onboard, so the meetings did come back.

64. When shielding finished, members had been out of the physical work environment for quite a while, but they were told to just go right back to work, and they felt like they just had to get on with work. One person said they just felt isolated again because they were the only one who had been shielding and things had changed while they were off and were not physically in the workplace.

PPE

65. There was a struggle to obtain PPE in the quantity and quality to give members assurance that safety was being appropriately managed, both in the NHS and the private sector. Members did not feel that appropriate PPE was available. Even when members in private practice were allowed to open up business, they could not access PPE, whether it was masks, aprons or gloves. When they could, the prices had rocketed.

66. Due to demand, or (as our members felt) due to profiteering, when gloves became available to purchase, they had gone up in price by around 200% in some cases. My wife is a podiatrist and works in private practice, and she was telling me that the price of gloves went from about £8.99 per box up to £23 per box, and that's if you could get them. Initially, if you were applying to buy them, they would just say that they were out of stock. I don't know what the cost was for the NHS, or whether that was replicated in the NHS.

67. The fear of going to work in the NHS increased when comparing the PPE shown on TV that was being worn in China as compared to what was available in Scotland. To quote some of my members, it seemed that employers were trying to get away with as little as possible, that would do. In China, they had this all-encompassing biohazard suit on, and their bodies were fully covered when they were treating patients. In comparison, when you saw footage of what we provided for our NHS staff, even if you compare hospital to hospital, it was just an apron, a pair of gloves, and a mask that our members didn't believe was fit for purpose.

68. For a good number of years, our members have used disposable gloves and aprons, so we are used to that kind of equipment.

Podiatrists are also used to wearing masks, and as such were well aware of the limitations of the surgical masks that employers and the Scottish Government were indicating as being suitable for face-to-face consultations with patients.

69. Our members used to use an FFP3 face mask pre-pandemic if someone came in with really thick nails and they used a nail drill to buff them down. FFP3 masks are contoured to the face, but all face masks are designed for the average male, and our membership is 78% female (and that is pretty well replicated across the NHS). It seems bizarre that we have face masks designed around the average male, when the majority of the workforce is female.

70. In order to determine whether an FFP3 mask would fit properly, you had to do a fit testing, which is a process that takes somewhere between 40 minutes to an hour for each person. I understand that it is difficult to do fit testing for 140,000 members of the NHS during a pandemic, but at least our members would have had a degree of confidence in a contoured mask that was shaped to form a seal around their nose and mouth, rather than a surgical mask (which is rectangular in shape with a pinch over the nose, with gaps down the side). This is particularly so when we were talking about COVID-19 being an airborne virus.

71. Our members had disposable gloves, which were single use. Then we received information that face masks were not to be single use, it was to become sessional use, which exacerbated the problem. When you're breathing or speaking to patients, face masks become damp, and therefore they are no longer as effective.

72. There was some advice from I think Health Protection Scotland (now Public Health Scotland) and the similar bodies from England that for "direct patient care", it was to be an FFP3 mask, but it if was community care, it was just the ordinary surgical mask. Direct patient care is direct patient care, in my opinion, whether it happens in the hospital or in a patient's home.

73. Our members rightly felt that this was not best practice. They wanted to feel safe going into work, and this didn't do anything to make them feel safe. What the Scottish Government was saying was safe was not the same as the professional bodies (which were saying that FFP3 masks should be used), and this confusion led members to feel unsafe. Our members were for significant periods of time exposed to direct patient care without adequate protection.

74. Our members also came across masks that were out of date, after their best before date, but the Health Board (I can't remember which

one) said that they had to use them. Not only was it not a suitable mask, but it was now expired, and they were telling members that it was safe to wear.

75. The situation eventually improved such that FFP3 masks became more available, but you specifically had to ask for one, and it was a struggle to get risk assessments undertaken for individuals so that they could get the FFP3 masks, which I do understand are more expensive. Another improvement that came about was we ended up getting clear masks for talking to patients who are deaf, which allowed them to read lips as well.

Testing

76. I think it took too long for testing to come into place. Personally, I was aware of the SARS pandemic in Taiwan in 2004, and the things that they identified from that were PPE and testing and tracing of individuals, but I think we were very slow to that during the pandemic here. I know it does take time to develop, but it just seemed fairly slow.

77. When testing became available, it was readily available. The NHS members received testing kits provided by their employers, and the private sector testing kits were those applied for and provided by the Scottish Government. No members ever came to me to say they had problems accessing testing kits; private sector members might have mentioned that the testing kits were taking a few days to arrive, but I think they had expected testing kits to just drop on their doorstep immediately as soon as testing became available, which was never going to happen.

Workload

78. Our members were exhausted both physically and mentally. Staffing levels were impacted because of the pandemic. There were some people who were shielding, there were absentees due to COVID-19 or people having to isolate because a member of their family had COVID-19, and there is a shortage of podiatrists in the NHS anyway.

79. The NHS was not treating around 60% of the caseload initially, because those mainstream patients were no longer being treated, so there was an increase in the number of wounds being seen, and that is generally because people were not being seen as often. More problems have therefore arisen through a lack of prevention, as podiatrists are generally well placed to prevent issues arising with the feet. The care being provided was therefore more complex and more demanding.

80. Within the NHS, there are different pay bandings and, generally, if you're newly qualified, you start off as a Band 5; the specialist podiatrists who would deal with wound care are Band 6; and there are some who work in the hospitals as advanced practitioners who deal with the really highly complex wounds and are Band 7. Then you might have one or two Principal Consultant Podiatrists who head a team in diabetic care or other high risk foot problems such as rheumatoid arthritis, for example.

81. When things became more complex, Band 5 podiatrists were seeing patients that they weren't used to seeing and which involved more complex matters than they were perhaps used to. It wasn't out of their scope of practice because there's always somebody to refer a patient on to, but it can be mentally exhausting seeing patients where you know that you're not able to do absolutely everything for them and you have to hand them on. You worry whether you're doing the right thing.

82. 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.

83. It was also mentally exhausting going into an environment with COVID-19. We had members who went off with workplace stress because of going into that work environment on a daily basis. The issues with the lack of PPE did have an impact on them. Members also had to take their uniforms off when they went back into their houses, bag them and put them into the washing machine to be cleaned at 60 degrees, because although within hospitals they have laundry facilities, a lot of our members work in the community, so needed to take these things home.

84. Our members are used to working under pressure anyway, but this was working under stress, and so that impacted them both physically and mentally.

85. The guidance for Podiatry was that you had to extend the patient's appointment time to treat the more complex conditions, and to prevent patients from sitting in the waiting area. Then once the patient was out, everything had to be swabbed down – the patient chair, the unit and the operator's chair. A lot of the NHS used disposable instruments, so that wasn't an additional task, but there were a lot of other additional tasks to make sure it was safe for you and the patient for the next appointment.

86. We have recently completed a UK wide survey of members in which we were asking questions about burnout and vacancy rates in the NHS. The UK-wide figures showed that 88% of those who completed the survey said that they had experienced symptoms of burnout (the figure for Scotland was also 88%), and around 70% (96% in Scotland) said that they had vacancies within their Health Board or Trust, and in Scotland 62% said they did not believe they had safe staffing levels. Almost every Health Board in Scotland has vacancies for podiatrists. If there's a shortage of nurses, bank staff can be used, but Podiatry in general does not have access to bank staff. If a member of ours goes off sick for, say, six months, the other members of the team are just expected to absorb that work.

Redeployment

87. Some NHS podiatrists were redeployed into different areas to help, such as assisting district nurses with wound care, assisting on the wards, in Test and Protect and as vaccinators. While some were comfortable with this, others were nervous about taking on new roles and responsibilities. It's always nerve-racking when you're doing something new.

88. The most common area podiatrists were redeployed to was assisting district nurses with wound care. Podiatrists deal with wounds generally on the lower limbs, so assisting a district nurse with an infected ulcer on the ankle would be pretty similar to treating an infected ulcer on the foot. However, podiatrists were also assisting with wounds on the buttocks or other areas of the body – and whilst podiatrists do have the knowledge and skill to assess, diagnose and treat wounds, the treatment in these areas would be different, which is out of their comfort zone, so some were uncomfortable with that. The cause of these wounds is generally pressure, so they are similar to the wounds podiatrists are used to treating, but the actual treatment is different.

89. We had some members who assisted on wards in relation to wound care- similar to the assistance given in community to district nurses.

90. The members who moved to vaccination were very comfortable with it. If podiatrists do nail surgery, they would give an injection in the toe, and some podiatrists give steroid injections; so, using a needle is something that they are comfortable with. A lot of our members were glad to be involved with the vaccinations, because they wanted to be a part of the way forward. The members who were redeployed into Test and Protect enjoyed that as well.

91. Some members who were redeployed were concerned about whether their insurance would cover any treatment provided. However, if they worked for the NHS and were being asked to do something by the NHS, then that would be covered. I also had a couple of enquiries from members asking whether, if something went wrong, that would impact on their HCPC registration. However, the HCPC produced some guidance which provided clarification on this, to say that podiatrists could be redeployed into these roles in these circumstances, and this provided a level of comfort to our members.

92. The redeployment of podiatrists was temporary. I have not heard of anybody who stayed within their redeployed role; I believe everybody has now returned to their original post.

Training

93. The HCPC helpfully provided a statement to say that they would not be requiring people to complete their usual Continuing Professional Development (CPD) because of the pandemic. The renewal process for registration is every two years. The CPD cycle for podiatrists would have been from July 2020 to July 2022. Normally there is a CPD audit of 2.5% of registered podiatrists to show the CPD they have done in a two-year period, but the HCPC said that they would not be doing an audit during that period, because of the pandemic.

94. The guidance from the HCPC was a relief for members, more so for those in private practice whose CPD tended to come from physical attendance at course, whereas in contrast the NHS does a lot of in-house mandatory training, most of which is online. The NHS also has staff meetings, training days, shadowing and mentoring with other members of the team, which is all done in-house. These sorts of things did stop for a while, but then picked up again through the use of Teams. In the last year or so, they are now having face to face staff meetings again.

Student Podiatrists

95. Student podiatrists do two four-week clinical placement in the third and fourth year of their studies, and I know that some of the placements had to be cancelled, but I don't know whether that impacted on their qualifications and getting their degrees.

96. There was some guidance from the HCPC about those who had passed their exams, in that they would be able to work as healthcare support workers within the NHS during the pandemic. This was about maximising the workforce.

Childcare

97. I didn't have any members come forward and say that they were having specific issues with childcare. There were some concerns about the schools being closed and members still having to go to work, but nothing ever seemed to come to a crisis point. NHS staff have always been able to take carer's leave in an emergency, and because there were people working from home, managers were able to ask somebody to cover the clinic rather than work from home if somebody else had a childcare issue. There was a lot of goodwill and flexibility shown by the podiatry managers in that respect.

Disproportionate Impacts

98. The membership of the Royal College of Podiatry is 78% women (UK wide) and, as such, women will have been disproportionately affected by the COVID-19 pandemic in Scotland, as our members generally deliver face to face care. As I have mentioned, face masks are designed for male bodies. The four members I am aware of who have been impacted by long COVID are all white women.

99. We do not hold any other statistics on protected characteristics within our membership.

Impact of the COVID-19 Pandemic on Patients

100. Some of my friends who work in private practice told me that, once they reopened their practices, they've never been so busy. They were dealing with a lot of unhappy patients who used to attend the NHS but who had been told that they didn't meet the criteria to receive treatment during the pandemic.

101. If patients come in with, for example, corns on their feet, it is not just a case of removing the corn and that is it gone; there is usually a cause of it. If you cannot eliminate the cause, then the corn is going to keep coming back. There were patients who had attended the NHS for many years, but suddenly they didn't meet the criteria and were told that they needed to go elsewhere to find care. There was a bit of anger from patients that they were told to fend for themselves.

102. In the NHS, they don't give personal recommendations, but patients can be told that there are alternative providers, and that they can go privately for treatment. However, patients felt a bit lost to be told

that they could not be seen by the NHS, but also that, initially, all of the private clinics were closed. Some people felt as if they had just been discarded.

103. Even when the private clinics reopened, another issue was whether patients would be able to afford private treatment. Patients who might have been seen, say, every eight weeks in the NHS were being seen by private practitioners only every six months, because that's all they could afford. In those cases, the condition of their feet would deteriorate, and sore feet can also become trip and fall hazards.

Lessons to be Learned

104. It is clear from the impact on our members in Scotland that the NHS was not in a fit state to cope with a pandemic. Whether this is due to adequate planning, I am not sure, but it is very clear that staff shortages had a major impact on the ability of the NHS to respond to the pandemic. I do not believe that you can plan a workforce around a pandemic. However, there seems to be a lack of political will to ensure that NHS staffing levels, for those who provide care, are sufficient. The number of podiatrists continues to fall.

105. In 2016, a report looked at whether the NHS could cope with a pandemic, and the result was that it wouldn't be able to. Since then, we have less staff in the NHS, which compounds any effect. We didn't learn the lessons from that.

106. Another lesson to be learned is that we need clearer communication. There was some difficulty with the devolved governments wanting to issue their own guidance. If guidance from NHS England is not the exact same as what NHS Scotland is producing, then there's uncertainty about why there are differences. Our members wanted clear, simple, consistent guidance from the Scottish and UK Government and from their employers, on what was expected of them.

107. The biggest area of concern and fear about going into work was over PPE. This included the quality, quantity, fitness for purpose and timely delivery. Staff didn't feel safe. The lesson that needs to be learned is not to rely on other countries on the other side of the world for PPE, which is clearly essential for any pandemic. Our members want to have quality domestic manufacturing of PPE that meets the needs of staff and ensures the greatest amount of protection.

108. We also need to realise that the NHS is not doctors, nurses and hospitals only. The NHS is far bigger, and includes podiatrists, physiotherapists, dieticians and radiographers who work in the community, in health centres and in patients' homes.

109. There needs to be more support provided by employers to assist those with long COVID, to keep them in work and contributing to patient care, and so that they are seen as a valuable member of staff.

110. There should also be recognition that some roles, or parts of a role, can be done from home, provided that the necessary equipment is in place. With staff continuing to work from home, this will help with the carbon footprint of the NHS, save staff time and money, as well as assisting with the wellbeing of individuals.

Hopes for the Inquiry

111. My hope for the Inquiry is that we at least learn lessons from our own country and our own experiences. I am disappointed that we had not learned lessons where pandemics had arisen in other countries previously. The important lesson is to act fast when there is a pandemic. I appreciate that the delay in imposing a lockdown was due to the slowness of the UK Government, but I believe that the delay was harmful to the population of Scotland and to NHS and social care staff. We should have moved into lockdown earlier.

112. There was also delay in contacting tracing through Test and Protect. That needs to be able to get up and running immediately. We now have the app, for example, which was a useful tool. We should be able to have these things in place ready to go straight away in case of another pandemic, rather than almost reinventing the wheel.

113. Our members were keen to help where they could during the pandemic, and their value must be appreciated, in the diversity of the roles they undertook and the transferrable skills that they have.

Signed .....

Date .....09/04/2024.....