Scottish COVID-19 Inquiry

Witness Statement

Statement of Annie Hair – HSC0180

Overview

1. My name is Annie Merrilees Hair. I work full time as a Senior Nurse for practice development for Children and Families. I have facility time of two and a half days per week, as a Senior Shop Steward with Unite the Union. I am employed by Greater Glasgow and Clyde (GGC) Health Board, within the Health and Social Care Partnership (HSCP). I work in the community and my background is health visiting and school nursing. I am nominally based in West Dunbartonshire Health and Social Care Partnership.

2. For the last 15 years, my specific professional role in Unite is for Community Practitioners and Health Visitors Association, which is a composite part of Unite. I am also Chair of the Organisation Professional Committee for Nursing for Unite the Union UK. I have been in my senior nursing role for the past 10 years but have been with GGC since 1997.

3. I can speak to the impact of the pandemic on my professional nursing role as well as the impact of members of Unite through my union role.

Background

4. I am a qualified nurse and trained in Edinburgh at the Western General Hospital. I have previously worked as an auxiliary, staff nurse, district nursing and in midwifery prior to training as a health visitor and then becoming Head of Children's Services. I have wide and extensive experience in the nursing profession.

5. The Community Practitioner and Health Visitor's Association (CPHVA) is the professional arm for Health Visitors within Unite the Union which is active in implementing health policy for Unite. This means that I am

appointed by Unite to participate in partnership on Scottish Government Committees.

Pre pandemic

6. Pre-pandemic I had 101 students on my personnel management system which was probably the peak of numbers.

Beginning of pandemic

7. As the pandemic began in early 2020, in my professional role (I was also a senior shop steward for 50% of my working time) I was managing the education of the increased number of health visitor students that had been allocated to GGC under the National Resource Allocation (NRAC) formula. This is the formula used to inform the geographical allocation of the NHS budget in Scotland. I was also looking at practice development of the qualified staff and ensuring their continued education to maintain their competency. In addition to this, I was involved in developing policy regarding clinical governance and quality assurance. This overlapped with my union role wherein I was supporting members who were perhaps struggling or had sickness absence issues.

8. In January 2020 we had a cohort of graduates who were not yet on the Nursing and Midwifery Council (NMC) register. The process of being registered normally can take a couple of months. I was on holiday in Vienna and began to hear radio reports about COVID in China. I followed news of the virus closely when we returned home.

9. I have underlying asthma so, personally, I was quite anxious but I was also anxious about how it might impact my role supporting practice development. There was also a concern for a number of specialist community practice students in health visiting and school nursing as they need to be managed as they completed their health visiting and school nursing courses. This is where I witnessed significant impacts created by the pandemic.

Early impact

10. Things began to escalate pretty quickly at the beginning of the pandemic. There was a decision by Scottish Government to cut back on what were considered non-essential services in the initial stages of the pandemic which included health visiting and school nursing. This was later changed because the First Minister recognised the importance of health visiting for children and families who were stuck at home. This was as a result of the profession and Senior Nurses raising concerns as well as Trade Unions and professional bodies such as the RCN, CPHVA Unite and RCM.

11. As the pandemic started to emerge, the Unite focus was how we utilised and supported our staff and how we, as representatives, organised to support the delivery of organisational services. The GGC freed us up to attend and participate in planning discussions. Our Unite time was increasingly used to support members and to focus on health and safety, and most of the work became remote. We started registering the work we were doing with Unite– the union might have figures that could quantify the increase in workload.

Lockdown

12. Lockdown brought changes in jobs and roles of the union members and changes in their family needs. People were concerned about their own health and that of their families, particularly vulnerable family members, and they shared the same concerns that everyone had about accessing healthcare. Some members had dependents such as babies or elderly parents and, as a result, they were concerned about living at home. Staff who were parents also had the challenges of planning for their children who needed to stay at home rather than attend school. Balancing their professional healthcare duties at the same time as trying to home school their children was clearly a massive challenge for many people.

13. The workplace changed dramatically. For example, there was a need to source and then work with and in PPE. Travelling to and from work was also more difficult.

14. As a result of the lockdown, health visitors, who would have been working intensively with some families, suddenly had to stop what they were doing. This raised safeguarding concerns surrounding the increased risks for child protection and vulnerable families as a result.

15. As a senior steward, there was peer support and support from the Regional Officer made available. Given my operational experience, which put me in good stead, I was able to help support peers in the Unite group.

Closure of universities and redeployment of students

16. By April/ May 2020, it was clear that the universities were closing and suspending their courses and they formally closed in May 2020. I was very quickly asked to look at the skills and competencies of the 2019 intake student Health Visitors who were all qualified Nurses or Midwifes with a view to moving them into some frontline facing roles.

17. At that time, I was working part time in my Unite role and part time in my student support role. I worked with my colleague from business support to identify the students and prepare a notification of what skills and competencies they had. All students had to complete a questionnaire and consideration was also given to where they had worked before, which part of the NMC Register they were on e.g. Adult, Mental Health, Learning Disability, Childrens or Midwifery. Improvised risk assessments were also carried out in respect of their personal circumstances and health. I also met each student on the list via Teams to mutually decide what was the best area for them to be redeployed to. This was preferable to what I was originally asked by Business Support which was to provide a list of names to management for deployment to Acute Covid care. I was not happy with this suggestion, so I discussed this with my Senior Nurse Manager and

sought advice from my union and it was decided this model would be applied instead.

18. Placements were diverse. Everybody had a different experience and there was a wide range of feelings among the staff. Some were very anxious or even traumatised and wanted to hide from it all, others were very purposeful and just wanted to do whatever was needed. They were all very dedicated but you had to respect that everyone was an individual. Some students had already made contact with areas where they had previously worked, for example, the Intensive Therapy Unit (ITU) or the High Dependency Unit (HDU), to let them know that they were being displaced and redeployed.

19. I recall one student who had a five year old child and suffered from cardiac anomalies and so therefore was within the shielding group. Her husband and children relocated to Arran to live with grandparents to allow the student to get a job working in HDU immediately. She was interviewed by the BBC for what she did and was a prime example of a frontline worker who was prepared to isolate from her family to help others. Some other staff contacted her to ask if there was any help with accommodation as they were living with vulnerable family members at home and wanted to protect them. Other members of staff also had to disclose that they were pregnant, perhaps at an earlier stage than they would have done so normally, or that they had a very young child at home so needed to look at measures which could be put in place.

20. I worked with senior nurses within GGC to help support them when moving these members of staff into suitable placements. For example, they were put to work on telephone triage or the data assessment centre amongst other things. Those who could not work on the frontline were assessed for shielding and, if they met the criteria, were put into less risky roles which were still required. I continued throughout the whole of the pandemic to support this group of staff until they returned, and I continued to be their line manager to ensure that they felt supported and

safe throughout. We also needed to consider geographical location, as not all staff had their own transport.

21. I listened to the students and worked hard to find a suitable placement for them. However, within eight weeks, it was clear that health visiting needed to continue and staff that had been stood down had to stand up again but were asked to work in a different way. This allowed staff, for example who suffered from asthma, to return to health visiting. Some had still been in the background working, preparing PPE packs for example, as an alternative of going off shielding. However, as the Universities did not restart courses the students who had been redeployed to acute covid care remained in these settings. This in turn meant that these students did not qualify from a one-year course which they commenced in 2019/2020 until 2022.

22. I would summarise the redeployment process as complex and challenging, understanding people's personal situations and considering the operational priorities.

Vaccinations

23. As soon as the immunisation schedules became available, myself and a significant number of my students, volunteered to do extra shifts and hours to carry out the immunisations. This was good for me as I felt as if I was being productive and working as a nurse again as opposed to mostly doing health and safety strategy work whilst working from home. I worked delivering vaccinations at the Elizabeth Jordan facility, the Hydro and local clinics. In doing this, I ran into a significant number of students who were doing the same. There was a massive camaraderie as people felt they were doing something worthwhile and this was very uplifting. I would commend the vaccination delivery in my area as it was extremely well organised within GGC. The vaccination team ensured that those staff redeployed to administer the vaccines felt welcomed, supported and ensured that they had their own vaccinations prior to offering them to

others. There was a "buzz" from the public which was amazing at that point and there were people coming in all dressed up in order to receive their vaccines. I had the impression that it was almost as if people felt they were beginning to get protected, so this was really heartening. I also volunteered to do housebound vaccinations, giving up my weekends to see these patients, and I volunteered for one of the vaccine trials.

My role as pandemic continued

24. I was in a strategic role and could work from home. I had no recent ITU skills but I did have a lot of strategic skills. I also had my experience as a union representative for health and safety and provided a listening ear before working on immunisation planning. My main role during the pandemic was to be that listening ear and take note of any concerns that anyone had. If a Health and safety issue was raised, I would escalate it, seek advice and share this within my Unite group which was meeting regularly with the health and safety team to report issues. My union and professional roles continued to overlap as I was dealing with both perspectives of staff concerns.

25. Throughout the pandemic I was pretty much glued to the news and to any research into COVID. I joined the Journal of the American Medical Association (JAMA) network which was where unpublished papers would be uploaded and I would be looking at research coming out of every country as it was being written. I had regular meetings with the Area Partnership Forum and I was on various strategy groups. I felt as if I was in a good position for getting first hand information, for example about vaccine development, even although I was largely working from home.

Issues and concerns that arose during pandemic

26. I believe that all the students rose to the occasion. However, I witnessed some real trauma and vulnerability amongst staff. I would direct certain workers to occupational health and support services as appropriate. Some students had returned to areas where they had worked before such as medical wards, so they had some experience, but some others needed more support. I set up a WhatsApp group so they could text me at any time as this was what I personally wanted to do to support them. Some of them were really quite traumatised as they felt like a fish out of water in HDU - especially if they had not worked in that area previously. Even those who had worked there before had never experienced the level of intensity and they were very frightened. The worked long hours in PPE and were exhausted with no opportunities for annual leave. In fact a great deal of normal leave in 2020 was accrued and carried over until 2021/22 This was not the students' trajectory or plan at that point. They had expected to be moving forward and studying and expecting to qualify as a health visitor or school nurse so this was a big change for them.

27. There were some fears about PPE raised by some staff, although not those working within HDU or ITU as they appeared to have good face fit masks and PPE provided. However, staff reported how difficult it was working in PPE and how intense the areas were. Some staff working in ward areas raised concerns that they were not fitted with face fit masks, they had only been issued with waterproof masks, and questioned whether that was offering them safety.

28. Some staff were asked to remove their unforms outside their houses and put them into a plastic bag before taking themselves inside to wash. There were no laundry facilities provided for community nurses which became a regular issue raised with union representatives.

29. Some staff needed a period of sickness time off because they had caught COVID but they returned to work after they recovered. No staff left the service but some, four, did not return to complete their course. This was due to the fact that they got enhanced roles in another area of practice so they just advanced their careers in a different direction.

Impact on my union role

30. My union role increased massively because of the pandemic. It became very intense supporting members and this became a virtually 24/7 commitment. The volume of emails and enquiries increased with members voicing fears in the earliest days about lack of information, being asked to do tasks that they felt unsafe carrying out, PPE being unavailable, inadequate or out of date, masks with expiry dates scored out and many other concerns. I kept a dossier of issues. Members also contacted me with concerns about family members working in care homes, such as being asked to share masks, no PPE and staff being told they would not be paid to be off sick. I gave advice and encouraged them to get their family members to join the union.

31. Questions about shielding status were a big challenge in my union role. For example, understanding how the shielding assessments would be conducted and who would make the decisions. People would come to me about their own medical conditions, fearing some of the duties that they were undertaking would put them at risk and believing that they should be in the shielding category. Occupational Health were overwhelmed so could not respond to the volume of questions that they were dealing with. Questions from pregnant workers were also a large part of my job. There was a lack of clarity about how vulnerable and at risk they were and, since then, I've heard that there have been statistics published about the increase in deaths during pregnancy and in the 3 months following pregnancy during the pandemic which reinforces some of the things that I had read on this subject by the JAMA network. Building the Evidence based care.

32. I believe that Airbnb accommodation close to hospitals was made available to key workers and I managed some enquiries about that.

33. I would say that Unite were reactive but we were a solid group with other unions. GGC recognised that we were reactive and did their best to help with that. The Area Partnership Forum, which is a group of different unions, met together to discuss the common challenges that were being experienced and to share lessons.

Policies and processes

34. The frequency and lack of clarity around process and policy changes were significant challenges for the union as well as in my professional role. We were directed by policies coming out from Scottish Government which were received through the union or from various staff partnerships forums. This would be communicated by email or in Teams meetings. There were Covid pages introduced into the Health Board's Core Brief but the frequency of changes was overwhelming and difficult to keep up with. The guidance would change, sometimes daily, and it was hugely challenging keeping abreast of this. Guidance one week would be different the next. The were also flaws in the guidance which we would be alerted to by the Area Partnership Forum. We would feed this back to the Board. There were concerns about translation of national guidance which occurred as a result of the Core Brief saying something that we believed was not the correct interpretation of the national guidance. I sometimes had the impression that national guidance was "caressed" to reflect what would better suit the NHS GGC Health Board but I have no formal evidence of this.

35. I am not aware whether there was formal consultation about the policies that were issued but there was the opportunity for informal consultation because the health visitors wrote to Scottish Government about the impact on children and families and I would have expected that to have

been considered in the policy formulation. The union did feed in views. The fact that guidance changed so often made the situation chaotic. It was extremely hard to follow. One example is there was a difficulty in understanding the PPE guidance provided for a health visitor visiting a family or a baby immunisation clinic. This is an area where I needed clarity in my professional capacity but also to enable me to advise union members. There was a lack of clarity about what could be done where and what PPE would be necessary.

36. I appreciate that some of the guidance that was changing was as a result of feedback that Scottish Government were getting. For example, feedback from the unions, who I believe were influential, and others. Some of the work which we did informed the government, such as when they outlined when people could travel to support families where there was a baby under one year and where you could form a family bubble.

37. I appreciate that the original decisions were necessarily made at speed but it all added to the challenges of keeping up with the current position.

Post-Covid and long terms impacts

38. My students returned to their courses in May 2021 and September respectively. This was all distance learning and I believe this has had a detrimental impact on their training which has now been recognised. This has been recognised in practice where there is an increase in competency issues being supported and in sickness absence levels in teams as well as staff leaving the Health Visiting profession. A number of staff have since left nursing and the UK.

39. These students felt quite isolated as a result of having no peer support. Their learning had been interrupted and the practice they were coming out to was different and more limited. The impact on these students was that they graduated nine months after they should have and they had very little experience. This particular group and the subsequent group of

students who have graduated post-pandemic have had competency issues. This causes on going stress as these are handled in staff governance and disciplinary policies and processes.

40. From a union perspective, we are dealing with many more competency issues amongst practitioners, due to many pandemic related factors. This includes the impact of remote learning which meant that they lost out on the traditional experiential learning.

41. Even amongst the staff, who were most resilient at the beginning, the pandemic took its toll. We saw increasing numbers of ill health cases, sickness absence, emotional and mental health problems, marriage and other family breakdowns and staff leaving the profession who have not returned. GGC is facing staff deletions as a result of budgetary strains post-pandemic. This has meant vacant posts being cut which have resulted in union grievances with two of the HSCPs. This is exacerbated by the number of staff who trained during this time leaving.

42. Overall, the union's workload has certainly increased, particularly around reduced staffing levels, budgetary cuts and personal cases, and mental health issues and safer staffing levels. GGC's sickness absence rates have increased from 4% to 7.5% with the bulk of this being emotional health and wellbeing. The union has had a lot of retirals of older representatives and lost a lot of organisational intelligence and experience. However, membership numbers have increased and I'm sure that the union could evidence this if required.

43. Ways of working have changed and one key area of this is through virtual meetings. I have embraced this and I think that time and cost saved on travel has increased overall efficiency. The response to hybrid working has been mixed, with some people happy but others voicing reluctance to return to the workplace. That is an ongoing challenge. I am sure that the reduced travel has had positive environmental benefits too.

Personal Impacts

44. There was a very significant event at the very start of the pandemic which severely impacted me. I was attending a strategic meeting with Glasgow City Council where Suzanne Miller, the Chief Officer, shared, quite anxiously, that they were setting up a SATA (Specialist Assessment and Treatment Area) unit to assess patients in Glasgow. It was explained that, at this time, they did not know who would be going there but they suspected that those aged 65 and over would be left at home and would not be able to access hospital. I was aged 64 at the time so this made me very frightened and I felt my blood run cold. For the first time I suddenly felt my age and thought that I and others were going to be sacrificed. At the same meeting, there was a discussion regarding the frailty scoring which basically assessed patients as to whether they would be treated or not. This was contrary to the ethics which applied in my profession and was not the NHS I was used to working in. I felt very vulnerable at that point I am aware that the frailty score was actually used in practice in the care home setting but I remain of the view that a practice which is effectively healthcare rationing contravenes the NMC code of practice. There was much discussion about the frailty scoring, including in Inquiries, in England.

45. I have two colleagues, similar age to myself, who may have carried on working but made the decision it was time to retire. The pandemic had the converse impact on me, which was possibly due to my supporting the union and carrying out essential recovery work. This made me keen to continue working.

Long term impacts on children and education

46. I believe that it is vitally important for the Inquiry to speak to health visitors when looking at the impact of the pandemic on children and I would wish my name to be put forward in relation to this.

47. From my role as practice development nurse for health visiting and school nursing and my involvement with the Community Practitioners Health Visitors Association, which is the main membership organisation for school nurses, and with Unite having most of them as members, I can speak to the impact of university courses starting and stopping and then going online which meant that students' skills competencies were not met as rigorously as they would have been previously. It should have been 50% education and 50% practice but, because of working remotely, students did not get the wide range of experiential learning that they needed. The universities deliver the education and I support the training through practice placements ensuring that the assessors and supervisors get the right experience in their HSCP areas. Out of 101 students, I had 7 who left the course, when I might have expected none or one, so the attritional rates were significantly higher and I know from feedback from colleagues that this is replicated in other geographical areas. There is no doubt that there has been a significant increase in the proportion of students where there is a concern around competency and more staff needing support in practice to increase their competency. The union is very much helping with this.

48. I would be able to put the Inquiry in contact with health visitors who have been identifying developmental issues in children post pandemic. I believe it would also be necessary to speak to community paediatricians and community speech and language therapists, as children of pre-school age have been massively impacted, resulting in delayed speech development and increased neurodiversity amongst them being recognised. School nurses are recognising a lot of anxiety in teenagers, and they would also be happy to engage.

49. There was the impact on clients that we visit. Pregnant women had no antenatal education other than online. Partners could not attend scans with them. There was minimal support with feeding babies and how to manage at home. This all combined to increase the risk of post-natal

depression. Until family bubbles were set up, many young parents had no contact with their own parents or grandparents. The education of new parents effectively stopped, as well as their engagement with other families going through the same journey.

Current role

50. I returned to my previous role until I recently moved into quality assurance. Now I am assisting with transforming nursing in the community so I now have a 50% clinical strategic role and 50% union role. My role during the pandemic was to get things opened up during that period, considering what visits were key visits, how they would be carried out, how they would support that and how staff would be supported etc. It was recognised early on that mothers and young children needed support and babies needed communication.

Disproportionate impact

51. With regards to disproportionate impact, the only example I can recall is that of a student of South Asian origin who had a vulnerable elderly father, so he moved out of the family home which he shared with his father and rented a flat. This student was also very proactive in immunising and leading immunisation clinics and trying to educate the South Asian community, through the mosque, to take part in the immunisation process.

52. I supported a BAME member who was working in ITU with Covid and could not have a face fit mask fitted to her face shape for safety. She worked for a period without fully functioning PPE until the Army issued her with a full head covering rebreather with filters that offered her protection.

Lessons to be learned

53. I believe that the vaccination planning was done very well. This was arranged in a planned and organised way with Staff side support in NHSGGC.

54. Regarding covid and working practices information sharing regarding vaccination entitlement was abysmal, with guidance and information being complex, which had to be analysed and was open to many different interpretations. I found this extremely difficult to follow, even with my experience of working in the trade union and strategy. Many health or social care workers found this really hard to follow and it was extremely difficult as a union representative to keep track of the changes. There was confusion between what was applicable in England and what was applicable in Scotland and it was extremely challenging keeping people on board with it all.

55. There was so much information differences in England and Scotland as to who could immunise, who could prepare, who could draw up and who could gain permissions.

56. I was made aware through my involvement within the health and safety group, that when patients were discharged from hospital who were COVID positive, there was very limited PPE available in health and social care to protect workers. Some PPE was out of date, and my union have documents and photos of this. Other masks which were provided caused issues as it gave off fibres when you breathed.

57. There was an impact on children and families we support. There was a big difference when health visitors were able to go back and see families, and I believe that this should never have been stopped.

I believe that the facts stated in this witness statement are true. I understand that this statement will form part of the evidence before the Inquiry and be published on the Inquiry's website.

By typing my name and the date below, I accept that this is my signature duly given.

Signed: Annie M Hair

Date: *10 April 2024*