Scottish COVID-19 Inquiry

Witness Statement

Statement taken at 1300 hours on Monday, 15 January 2024. Witness Number HSC0184 refers.

Witness interviewed by Witness Statement Taker Name Redacted. Statement noted by Witness Statement Taker Name Redacted Witness interviewed via Microsoft Teams.

The legal representative in attendance was Name Redacted Thompson's Solicitors, 285 Bath Street, Glasgow, G2 4HQ.

Statement: **Emma CURRER:**

Consent

1. My name is **Emma-Louise CURRER**. I am 46 years of age, and my date of birth is Personal Data I can be contacted at my work address of Royal College of Midwives (RCM), 37 Frederick Street, Edinburgh, EH2 1EP.
2. I am currently employed full-time as the National Officer with RCM and have been in this position for 15 years.
3. On the 15th of January 2024 I met with witness statement takers from the Scottish COVID-19 Inquiry team, and I am happy to provide a statement about the experiences of my members during the pandemic. I have signed the consent form provided. I am happy for my information to be contained within reports and published.

Personal Background

4. I qualified as a midwife in 1998 and am still registered as one. I practiced in a variety of clinical roles in the NHS up until 2009. I then moved into professional practice and representation in taking up my current position 15 years ago.

Overview of RCM

5. The Royal College of Midwives (RCM) is the voice of midwifery. We are the only professional organisation and trade union dedicated to serving midwifery and the whole midwifery team. The RCM was established in 1881 as the Matron's Aid or Trained Midwives Registration Society but has existed under its present name since

1947. We have a membership predominantly within the UK of midwives, student midwives, maternity support workers, maternity care assistants, affiliates, oversees members and retired members. The vast majority of the midwifery profession are members.

6. The RCM is governed by an elected Board of qualified midwives and maternity support workers who are also RCM members. The Board sets the broad strategic direction of the organisation, ensuring it is viable, properly managed and governed.
7. The RCM represents the interests of midwives in all four UK countries individually and collectively. We strive to promote excellence, innovation and leadership in the care of childbearing women, newborns and their families, nationally and internationally.
8. Our mission is to enhance the confidence, professional practice, and influence of midwives for the benefit of childbearing women and their families. We strive to operate with integrity, act in an open and transparent way, be accessible to members and support equity in service.
9. The RCM is a registered charity as well as a separate legal entity.
10. All of our branch representatives, secretaries, stewards, health and safety advisors, chairpersons and treasurers are volunteers.
11. Our services are offered in different ways such as face to face, online or telephone.
12. We are funded in the main through the membership subscriptions.

RCM – Pre pandemic

13. The demand for our services in Scotland had increased before Covid hit. In 2017, the Scottish Government implemented a 5-year strategy called 'Best Start – A Five Year Forward Plan for Maternity and Neo Natal Services.' We were three years into this when COVID happened . As a result, the demand on our services increased in relation to implementation of this strategy during this period, just before COVID.
14. However, in addition to this, when COVID happened the number of general inquiries we received from the public and employers, mostly pregnant women (mostly through our website), increased significantly. So much so, we needed to allocate existing staff to assist dealing with these.

15. During the pandemic, we could not attend anything in person so all our work was done online. We would never have done this pre pandemic. Things like disciplinary hearings and many aspects of routine business were put on hold during the pandemic unless they were of a very serious or pressing nature.

RCM – COVID-19

16. The operational and strategic considerations of COVID were how we were going to be able to continue to deliver our services if we were to shut down the offices and in person contact. Also, how we were going to be able to respond to our branches and activists and members when we could not see them face to face. A big concern was based around communication and being able to engage with our members.

17. We were not specifically prepared for COVID. But we were fortunate because in the run up to COVID we had actually changed and updated our IT to allow for more flexible home working across all staff with everyone being supplied with laptops and access to Microsoft Teams. However, providing support remotely does not mirror the in person support we provided prior to the pandemic.

18. I knew we, the RCM, would also be inundated with queries, the likelihood for which we would not have always have immediate answers for.

19. As lockdown approached, the advice we were getting was to do what the government were advising and that is what we were telling our members.

20. We did not receive any additional funding that I am aware of. This is in spite of the fact our role enhanced considerably. We had to provide significant additional support to the health service through our own funds that were not part of our core business. One example of this is the various detailed guidance on delivering maternity care and services we published. In addition, there was an enhanced demand from our members for support throughout the pandemic.

COVID-19 - Maternity in Scotland

Care Provision

21. One of the immediate actions across all services was to reduce, where possible, bringing the public into hospitals or engaging in

person with healthcare staff. In maternity services, this meant that any care that was ordinarily carried out on an acute site was reviewed with a view to undertaking it in a community setting. This presented an increased burden on community-based staff who were already feeling the pressure and anxiety of working across multiple uncontrolled environments. While it was accepted that the driver was appropriate, the solution placed our members with a depleted staffing and higher levels of workload, within the conditions around PPE and social distancing. Without a doubt this created burnout and adversely impacted on the quality of care as well as the health and wellbeing of staff and families. It also highlighted the unrecognised pre COVID pressures on this group of the workforce who had experienced increasing workload without additional staffing in the preceding period.

22. Many staff were 'redeployed' to work in clinical areas unfamiliar to them with staff they didn't know. Being out of your 'comfort zone' presents a level of stress, however this is exacerbated in high-risk situations when staff don't know each other. There was a lack of consistency in induction and orientation as well as high demand for 'upskill'. Furthermore, the isolation and detachment from usual support networks and line management reporting, when redeployed, added to stress. This presented considerable stress and anxiety at an already difficult time in healthcare.

23. The changes to GP services, meant that pregnant woman sought healthcare via maternity services, even for non-maternity specific needs. This resulted in higher demand on maternity in mitigating the impact of non-face-to-face GP services. Additionally social work adopted a similar approach, meaning they sought the support of midwives to assist in assessing and managing social care needs, including child protection concerns. These additional 'asks' created increased workload and anxiety as it was evident that maternity was very much an essential service; it also felt like it was used to solve/absorb the risks elsewhere in healthcare, without taking account of the challenges faced in delivering a safe maternity service during that time. This added further to the increased burdens on a depleted workforce who were working in considerably stressful conditions.

24. Keeping up with what felt like constant changes to guidance added further to overall anxiety in respect of understanding and applying it.

25. It was reported that the messaging around testing, isolating, and shielding felt inconsistent and fluid with mixed interpretations.

Additionally, risk around some aspects of care provision lacked clarity; for example, wearing an FFP3 mask to 'bag and mask' a newborn for resuscitation increased anxiety from differing interpretations of guidance and staff feeling unsupported or criticised to adopt what they felt safest doing. This added further to the overall burnout.

26. Many of the women and families accessing maternity care were considered well (albeit a higher risk population group) and were of course experiencing a significant life event. Others had additional higher care needs or risks. Collectively, pregnancy can be a period in their lives that can feel vulnerable, and this was more evident owing to the overall restrictions' relating to 'lockdown' and social mixing. A period where many rely on social support from friends and family, yet they were hindered from accessing it.

27. Staff reported increased anxiety from women and families around their access to care and sense of vulnerability both directly and indirectly due to COVID-19 and the associated risks and restrictions. This led to increased demand on staff in supporting women and families as best they could; however, the restrictions on women attending with their choice of support and having visitors, led to a level of hostility towards staff in enforcing national guidance.

28. It has been observed and reported that many staff who were able to, but not necessarily planning to, took a decision to retire as a consequence of their experiences during the pandemic. Many also had prolonged periods of sickness, decreased/adverse work-life balance and multiple symptoms of burnout.

29. The challenges we had foreseen were about delivering maternity services. You cannot postpone or delay the gestation of pregnancy. Maternity care is time critical and certain things need to happen at certain times to maintain the patient's safety. The challenges were to maintain this without putting people at additional risk. Safety was the principal focus. To address this, we saw an increase in home-based care which we needed to manage. This was very stressful for our members.

PPE & Fit Testing

30. From the onset of the COVID-19 pandemic, our members immediately experienced a number of significant issues both in the direct provision of care and the impact on them physically, mentally and socially, as a predominantly female workforce providing

frontline healthcare during such an extraordinary situation, which the national health service was evidently ill prepared for.

31. One of the first, and most substantial of these, related to the overwhelming demand and challenges with access to supplies of PPE. This, together with the lack of clarity and guidance in relation to how best to protect themselves and others from exposure to, and the spread of, the virus and the unknown impact of the virus, caused a high level of concern. It was immediately apparent that the high level of uncertainty and anxiety put immense pressure on all areas of the workforce to access face masks and adopt social distancing and increased hand washing. Our members reported delays in receiving adequate supplies, resulting in the reuse of disposable masks that had been handled, and concerns about engaging with staff and patients who did not have or wear masks. This was further exacerbated with the inclusion of face shields, which were felt to be less accessible and washing / reuse of same was then encouraged as considered adequate for protection. Staff felt this to be related to supply/costs as opposed to providing the highest level of infection control.

32. In particular FFP3 masks were reported to be 'rationed' with conflicting advice or guidance on the scenarios in which they should be used and issues with accessing or achieving appropriate fitting. It was felt that advice was often cost/supply driven as opposed to being based on the highest level of protection. Furthermore, there was reports of supplies not being in English, which left staff feeling less confident in using correctly. The quality of supplies was also considered to be variable at times.

33. Guidance associated with the use of PPE was considered to be mostly focused on providing care in acute hospital settings, with staff providing (increasingly) community-based care, feeling more vulnerable with lack of clarity on how to best protect themselves. Staff were also working in more uncontrolled settings such as patients' homes. In these settings there was no control over the ventilation, access to washing facilities, number of people present and the overall conditions. In particular our members who provided homebirth services did not have guaranteed access to appropriate rest areas or the ability to prepare food/drinks for prolonged periods of work.

34. The vast majority of staff launder their uniforms at home. However, the unknown cross-infection risks meant that there were high levels of concerns around even bringing them home, let alone the ability to launder effectively without putting others in the home at risk.

The lack of guidance on this among other things added further to the stress our members experienced.

35. The consequences of this were increased work-related stress, anxiety and a lower threshold for absence which was owed to the perceived levels of risks around exposure. This inevitably exacerbated staff absence levels which were already escalating due to 'shielding' and COVID absence following symptoms / exposure of positive testing. The collective impact of this was increased pressures on staff and high anxiety relating to possible exposure.

36. Many staff experienced trauma through the continual and long-term use of masks. They were reporting skin reactions, panic attacks and overheating alongside the more obvious communication barrier.

Shielding

37. The identification of staff who were advised to shield took time to be communicated to them. As a result they experienced increased risks and anxiety by attending work during a period of unclear and inconsistent access to PPE. Additionally, the messaging appeared to change, with some reporting that they weren't initially identified for shielding, only for them to be subsequently informed that they had been identified.

38. Further stress arose from staff having vulnerable family members and caring responsibilities towards people in high-risk groups. Some staff asked to work in non-patient facing roles owing to the anxiety they felt about their own possible exposure and the risks to those they lived with / cared for. The overall pressures on the workforce, meant that these requests were denied and therefore led to increased work-related stress and absence from this group.

Social Distancing

39. Midwifery supports a high number of students on essential clinical placements. This requires clinical teaching and students working closely with staff who are required to teach, observe, and assess. Community based care is a key part of overall maternity care and staff often travel throughout the day to a variety of locations. When working with students they would also travel with them. However, significant concerns arose about working and travelling so closely, which created barriers to students in accessing experience and high anxiety across both students and staff in the challenges of social distancing.

40. There were very variable approaches taken to quality and timing of risk assessments, either by undertaking them where necessary, or concluding them appropriately. Often risks were identified that related to building design yet mitigation could not be achieved. Ventilation in areas of childbirth was problematic which was due to the requirement to maintain adequate temperatures for newborn babies.

41. Many clinical areas reported perceived overcrowding (lack of social distancing) for basic care tasks such as ward rounds, handovers and access to computers / equipment. This created high anxiety and was difficult to mitigate owing to building design and ward space.

42. In order to achieve social distancing in areas such as break rooms, cafeterias and changing areas, many staff had to amend their shift times in order to stagger the use of these areas. This led to additional challenges with their own work-life balance such as travel options to work, childcare and caring responsibilities. Childcare in particular was of great concern to many of our members. Most members are female and the responsibility to look after their children fell to them.

43. All of these issues placed our members at increased risk of exposure and high stress and anxiety, likely to have increased overall absence and exacerbate the cycle of stress and absence across the workforce and overall burnout.

General Impacts on Staff and Students

44. Maternity care should have been prioritised as an essential service during the pandemic, however this wasn't always the case. Pressure for hospital beds led to services taking clinical space from maternity which further impacted on the stress and pressures felt by staff with reduced maternity beds and services being moved or reduced.

45. Staff who were shielding for a prolonged period, or redeployed to other areas, became anxious about becoming deskilled for their substantive role which was exacerbated with lack of contact from their usual peers and managers.

46. Many of our student members were impacted by shielding and the restrictions on placements which resulted in them being unable to achieve the mandatory clinical experience within the timeframe of their course. This resulted in the requirement to not only extend the timeframe of their course by several months but they also experienced difficulties in seeking that additional placement time

which was due to a cap on student numbers on placements alongside the resulted increase in students. This caused high levels of stress and financial detriment due to the delays in qualifying and beginning full employment.

47. There was a minority of our members who were able to do a degree of their work from home but many did not have the adequate space, equipment or IT skills to adequately undertake this. They also felt like there was an imposed intrusion on their personal space and work-life balance. They felt they had no choice but to use personal equipment at times (including their own broadband) as well as having to engage in meetings while in the presence of children and other home occupants. There was also a degree of anxiety about using the IT equipment due to potentially a lack of IT skills as there was a quick move towards providing and adapting care via virtual platforms such as Near Me, where women and Families would also have variable access and skill in use. This resulted in increased stress and sometimes increased workload arising from the change in care provision, imposed environment and isolation from peers. Staff felt less supported and anxiety increased.

48. The closure of school, nurseries, childminders and the restrictions on mixing households put considerable pressure on our members. Many of the members are female and mostly unable to work from home and often the main income source in their household. When added to the above challenges there is no doubt that the stress and adverse impact on their mental health was high. Coupled with the general effects on the population associated with lack of socialisation / social and family support and changes to routine and economic impact, our members have experienced a period of prolonged and significant stress that has undoubtedly adversely impacted their mental and physical health.

Long Terms Impacts on Staff and Students

49. Following confirmation of contracting COVID-19, many of our members did not achieve straightforward recovery. We have been supporting a number of members who have had long term impacts on their health with prolonged symptoms that have resulted in long term health problems, known as Long Covid.

50. Likewise, some of our members have experienced significant ill health thought to be, and supported by medical professionals, as a direct consequence of adverse reactions to the COVID-19 vaccine. While they recognise that the decision to be vaccinated was entirely

their own free choice, they firmly believe that the high pressure to do so, especially for healthcare staff, has resulted in them prioritising safety of others without considering their personal needs/views for themselves.

51. Both of the above groups have had to have prolonged periods of sickness absence, reduced quality of life and redeployment and adjustments to their role. Sadly, for some, they have not recovered to a level that has enabled a return to work and have experienced ill health termination of employment without the guarantee of any alternative level of income such as a PIP (Personal Independence Payment) or ill health pension. For those whose health won't improve, they have also lost their career and vocation alongside their income.

RCM Members' Survey

52. By the autumn of 2021 (staggered between November 21-February 22), the RCM in Scotland was acutely aware of the high levels of stress and burnout across our membership. This led to a survey of our members on a branch by branch (NHS Board) basis. The aim of the survey was to get an understanding of how our members felt about their current role and experience of working in maternity services. In addition, we sought to understand their short and long-term intentions.

53. We did not ask direct questions about any specific topic such as the pandemic or NHS policy but rather allowed them the opportunity to tell us what factors had influenced their current feelings and perceptions. The timing of this survey was around 18-24 months after the start of the pandemic and therefore there is a high probability that their experience of working during the pandemic will have influenced their responses.

54. The response rate to this survey was overwhelming with four out of ten RCM members within Scotland responding. In addition, two thirds of respondents included a narrative response. This demonstrates a desire from members for their voices to be heard.

55. This survey found that half of all respondents felt there is rarely safe staffing in their workplace/unit. Only six per cent of staff reported that there was always safe staffing in their area. This has been a long-standing problem, however, has been exacerbated by the pandemic.

56. Seventy Five Percent of respondents have considered leaving their current post due to staffing levels, dissatisfaction with the quality of care they were able to provide, and dissatisfaction with the level of support from their line manager. In addition, three-quarters stated they were considering leaving the profession. Many newly qualified midwives also expressed regretted the decision to enter midwifery, citing concerns about the impact of staying in the job for their mental and physical health.

57. Many early career midwives were routinely being expected to manage the same workload as their colleagues without access to supervision. The departure from the service of experienced midwives is having a negative impact on the training and development of those new to the profession. This has led to some early career midwives being expected to practice beyond their competency. Of the Twelve percent of respondents who had been qualified for less than two years, Fifty-one percent said they had been left in charge during that period.

58. Many respondents expressed the worry that the care being offered was no longer safe, and anxieties over potential adverse outcomes and loss of registrations were widespread.

59. Over nine out of 10 respondents worked without breaks in the last 18 months, with more than half (52%) saying this happens two to three times a week. Several midwives had experienced urinary tract and kidney infections as a result of being unable to go to the toilet or getting enough fluids while on shift.

60. RCM has published a national report of the findings which is available via this link: scotland-survey_report_2022_digitalfinal.pdf (rcm.org.uk)

Experience Supporting Midwives

61. The impact on me, as the National Officer for Scotland, was an increase in demand for requests for support and advice around how midwives were providing care and what they should or should not be doing as well as how employers were managing and advising staff.

62. I did not feel prepared to deal with this scenario at the start. The reason being that most of the questions directed to me pre COVID, I had dealt with previously and would generally have the answers. However, with COVID, everything was new and required me to often go away and conduct research or seek opinions before being

able to answer queries from our members. – Heavily relied upon source of help but not prepared better with answers.

COVID-19 Policies and Guidance

63. A lot of the guidance was written in such a way that it was often ambiguous but aimed at acute hospital-based care. This was not helpful for our nature of work especially when a lot of our members were being asked to provide care, which would ordinarily have been provided in a hospital, but in a home or community setting and the guidance did not really translate to that.

64. We would get direct communications from the Scottish Government. We received this because I sit on various working and communication groups at the Scottish Government level. They would send us the guidance due to us being on various distribution lists because of what we do.

65. As a sector we were not really directly engaged in the development of Government guidance and policy. Under normal circumstances, we likely would have been, but given the circumstances of COVID a lot of decision making needed to happen quickly, and guidance needed to be issued without lengthy consultation. The RCM published a range of UK guidance and undertook specific joint work with RCOG but had a sense that we were sometimes having to publish guidance (e.g., rights of pregnant women at work) that we felt should have been the responsibility of Government. We were involved in one piece of maternity specific guidance with colleagues at Scottish Government for Scotland which was issued late of summer to Autumn of 2020 and then updated in September 2021. This was a more localised document, but we were involved in developing it.

66. I don't think the government fully recognised or understood the unique nature of maternity care. It is a unique service which is time critical. My opinion is that the guidance did not acknowledge this and the associated mental wellbeing needs of women and families.

RCM Post COVID-19

67. The RCM has emerged from COVID with burnout and fatigue across our membership. Resilience and Goodwill have reduced. A recent survey we undertook evidenced this. We started a period of change

in the profession during 2017 and were still transitioning through this when COVID hit. By the end of 2021 we knew that our members were finding things tough, hence we undertook the survey. So we had the initial change from the 2017 strategy, then COVID, followed by the cost of living crisis and the negotiations and action over a decent pay rise. It has been really difficult for our members.

68. The benefits from the experience of COVID has been our ability to communicate and be more efficient with the increased use of virtual platforms, that we probably did not utilise pre COVID. Digitalisation has brought about some positive changes with regards how healthcare is delivered health care and how the sector communicate and share information.

69. Demand for our services have grown. We have a lot more issues with members on long term sick, requests for early retirement relating to ill health and members wishing to transfer to the retire and return scheme. We also have a lot more requests with regards fatal accident inquiries.

Lessons to be Learned.

70. Maternity care is essential and, in any scenario, where there is a need to consider what should be maintained it should be included. It is about the person as well as the physical element. The consequences of not maintaining a person centred, holistic approach, means there will likely be long term risks.

71. Staff working with solid, consistent advice, enables them to feel safe at their work. Not just physically safe but more psychologically safe. If they don't feel safe in every way, they arguably lose confidence which has a knock-on effect of losing competence, and ultimately increases risk.

72. In health care people go to work not necessarily because they feel valued at work or because they are paid really well for what they do but they go to work to serve the population and for the greater good for society. When they feel this is at their own personal expense there is, naturally, a tipping point. The lesson to be learned is that, at a high level, words don't mean a lot. They need to see action. Less than 12 months after we came out of the pandemic we were looking at pay and the Scottish Government offered another below inflation rise. This was the final insult. It undermined everything government ministers had said to them.

Hopes for the Inquiry

73. I would hope the inquiry does not focus on apportioning blame but instead looks at how we can learn from the pandemic. What have we learned about our health services, the risks and how they can function in times of pressure and where do the priorities sit within that? What is core to providing a safe health service?

Signed .....

Date .....