Scottish COVID-19 Inquiry

Witness Statement

Statement of Annette Holliday of Unite the Union– Witness Number HSC0232.

Statement taken at 1030 hours on Friday, 22nd March 2024.

Witness interviewed by Assistant Solicitor, Personal Data. Statement noted by Paralegal Irrelevant and Sensitive Witness interviewed via Microsoft Teams.

Name Redacted of Thompsons solicitors was present at the meeting.

Introduction

1. My full name is Annette Holliday and during the pandemic I was a Health Visitor Team Leader with NHS Greater Glasgow and Clyde based in the Partick area of Glasgow.

2. I began my role as a Team Leader just before the pandemic in July 2019 and I remained in post until October 2021. I left the role to go on to become a Family Nurse Partnership Supervisor and I have been in this role since October 2021 until present. This is also in NHS Greater Glasgow and Clyde

3. I have been registered as a nurse since 1995 and I became a Health Visitor in September 2006.

4. I am also a workplace representative for Unite the Union and have been since 2018. Within Unite there is a standalone Community Practitioners and Health Visitors Association (CPHVA) and I was the Scotland chair of the Executive Committee which is the professional element of the CPHVA. I held this position for two terms.

Overview

5. Health Visitors are responsible for children from birth until school age and are the first point on contact for families who require support in those early years. A Health Visitor is a qualified nurse who has also then done postgraduate education in child development and public health and provides support and advice to all families following the birth of a child. A child stays on the health visitor caseload from birth until age 5 or when they go to primary school. Support is tailored towards the needs of the family and the child.

6. The core elements of the job are child development and public health. The role itself is a public health role and provides information and advice to try and keep the population healthy and improve health. In particular, there is a lot of involvement in discussing with parents about public health initiatives such as immunisations, infant feeding and oral health.

7. The role of health visitor has changed in several ways over the years. For example, Health Visitors used to be involved in many more elements of public health, such as sexual health. In the past there was also a lot more freedom to act and the health visitor role covered 'from cradle to grave', meaning there was work with children and families, but also adults and elderly. However, in more recent years, it has become focused on a zero to five years' service.

8. We also now have a universal pathway for all Health Visitors in Scotland to deliver. This includes a number of surveillance and health promotion contacts for families and also provides a support service for parents. The universal pathway is also linked in with other services with community based supports, third sector supports and also some targeted specialist supports.

9. Before the pandemic, health visitor services were delivered in a mixture of at home visits or clinic visits. However, pre pandemic there was a move away from community clinics and then, during the pandemic, they stopped completely. However, the focus of health visiting really is on home visiting. This is because it gives health visitors time with parents and their children in their own environment. It also allows for health visitors to spend a good amount of time with the families unlike a clinic appointment when you have a five minute appointment, home visits allow time to explore and build a therapeutic relationship between the health visitor and the children in their care.

10. At the time of the pandemic my team was made up of eighteen health visitors, one nurse and one health care support worker. There was also a team of administrators.

11. The health visitor service is part of the Health and Social Care Partnership (HSCP) but our terms and conditions are governed by the NHS. In practice, I am employed by NHS Greater Glasgow and Clyde and follow NHS Greater Glasgow and Clyde terms and conditions but the HSCP is responsible for how services are delivered. Due to the wide nature of the role, we are one of those services which fits in with multiple other services. For example, we overlap with health and social care, social care partnerships and mental health services. We fit in with any services which would link to the child or family that we are supporting.

12. We are also, usually, GP aligned. This means that health visitors would normally be responsible for children born into a particular GP practice area. For example, I worked within the Partick area in Glasgow and so this meant that we had a very clear area within which we would be the health visitor team for the GP surgeries within that area.

13. When the country went into lockdown, I recall talk that health visiting services could be reduced, however it relatively quicky became apparent that health visiting was a priority service.

Impact of the COVID-19 pandemic on the role

14. For health visitors, the role did not change significantly during the pandemic. However, there was changes made to the service before the pandemic and there have been changes since. For example, there was a belief from the Scottish Government that the Named Person Legislation would come into force (although ultimately it was struck down but is still supposed to be worked to in principle), and, as a result, there was a recognition that there needed to be an uplift in the number of health visitors in order to be able to support that vision. By way of explanation, the named person legislation, was based on there being one person who could provide timely support to families when they most needed it. This would stop families having to be passed around lots of different professionals and instead they would have one person who would be able to coordinate the support that the child would need based on a deeper understanding of the family. Between 2014 and 2019 there was a massive increase in the number of health visitors as there was to be an extra 500 health visitors across Scotland. The Greater Glasgow and Clyde area got the bulk of the new health visitors and I think this was around an additional 200 health visitors.

15. This also helped with the vision that Scotland was to reduce the inverse care law where people who are living in the most complex of circumstances are often receiving the least number of services. There was a recognition, by introducing the Named Person legislation, that if you were a health visitor, working in a more disadvantaged community, then you would have a smaller caseload than health visitors within more affluent communities. This meant that you would have more time to deal with the complexity of individual families. There was an understanding that, to deliver to all those contacts, be available to families, and to deliver a home visit service instead of a hybrid working model of home and clinic, that you needed to have an uplift of staff.

16. This allowed for the service to move from the standard approach to caseload size, wherein a health visitor would normally have approximately 250 families within their caseload, which would average approximately 50 families a day. The approach became much more targeted around the complexity of the population served.

17. However, since the pandemic, the number of health care visitors appear to be reducing again. As a result, we are now, in a post pandemic world, struggling to deliver our services and cope with the demand.

18. In my opinion, there has been a lot of changes to the complexity of families needing support following the pandemic and we are also struggling to deal with the increase in staff absences as well as an increasing number of vacant posts. My understanding is that a lot of these issues have been caused by a lack of uplift to the budget from the Scottish Government. Health visitors, before the introduction of the universal, were a band six position and then they were increased to a band seven position. However, the funding, which comes from the Scottish Government, is still funded at the midpoint of band

six. That means that the Scottish Government are not funding at the appropriate levels.

19. That results in the loss of some health visitors and the inability to fill the vacancies at the same rate as health visitors leaving. This is putting an increasing pressure on existing staff, and it is also increasing their caseload numbers. Overall, it is making the universal pathway difficult to implement and deliver.

20. I am of the opinion that the pandemic exacerbated the difficulties in staffing. I came into the position during 2019 and, as all new people are, I was unsure of what the boundaries were or how to effectively work within my new role. This was then coupled with the talk of a new virus spreading and moving towards a lockdown. From there, we had to have discussions around what health visitors would be able to do and what the expectations would be on them during a national lockdown.

21. I can only speak with regards to the experiences of my own team but we had a mixture of staff working and continuing to do face-to-fact visits but we did also have some staff working at home who were shielding and so were unable to commit to face-to-face visits. However, throughout 2020 and into 2021, before I left in October 2021, there was an increase in routine absences, and this left our team with multiple vacant caseloads that we could not get covered because of the crossover of staff absences. There was sickness leave as well as things like maternity leave and so it was all compounded.

22. I moved into the Family Nursing Partnership (FNP) which has the licence to protect levels of staff. The FNP is a licenced programme and Scottish Government requires to agree to the terms of the licence which includes staffing and caseload sizes. As a result of this, we do not have the same kind of issues in staffing insofar as posts being left vacant and caseloads remaining unassigned as a result. However, as a representative, I know that, within Glasgow, we have got chronic issues with cross-cover vacancies (when a member of staff takes up a colleagues caseload in addition to their own when another colleague is of sick etc), the management of those vacancies and the management of sickness absence. All of this contributes to tremendous pressure on staff. This has been the way now for three or four years, following the pandemic, and it has not really got any better.

23. The year of the pandemic, in comparison to post pandemic, was actually pretty okay in terms of staffing. There were obvious challenges and also the fear of infection but in terms of staffing, we had a full complement of staff at their work the majority of the time.

24. The beginning of the pandemic did bring its own challenges and considerations. There was an initial concern about whether health visitor staff would be redeployed into hospital settings or other support type roles. There was a lot of uncertainty in the beginning about what was going to happen to our roles and what our purpose would be. One example of the redeployment is that we had one of our healthcare support workers whose role was within 'Child Smile', (the dental health support service), was stopped, due to the

pandemic, and so she was redeployed to work within one of the COVID units. This was the case for a lot of staff who worked in particular services within the NHS which were categorised as unessential.

25. The use of the term 'essential workers' caused a lot of confusion amongst health visitors. We were aware that, at its core, our service requires being able to go into our service users' homes but we were also conscious that our service is not a 24/7 service, we don't work weekends or public holidays and the provision of our service is not an emergency. Many were unsure if health visitors would be defined as "essential workers" or if would be decided that entering people's homes would be essential which was then coupled with fear and doubt about individual abilities to enter hospital work in the wards. For a lot of health visitors, it had been a long time since they had worked within a hospital setting and so they did have some memory of it but they were also seeing on the news about the need to operate ventilators and they had anxieties about what they would be expected to do.

26. While a lot of our staff did continue working and, in doing so, continued to visit people in their homes this did also come with its own anxieties surrounding contracting the virus and then spreading it further.

27. There was also a frustration amongst staff as, at the beginning of the pandemic when other sectors were being told to stay home, we were very much expected to still be in the office. Before the pandemic hit, it was very much the expectation that health visitors would start and finish their day in the office. However, this had started changing when we brought in the national practice model of working which contained within it laptops, with functionality to be able to work remotely. On that basis, staff were questioning why they were still expected to be in the office. At this time, it was noticeable that staff were trying to sit apart from others in the office and give each other space. We were lucky in the base that we were working in at that time that social distancing was possible, but this was not always the case in other areas. There was a lot of anxiety around the apparent need to be in the office and frustration around the lack of direction at that time. I think that, here was a lack of trust before and at the start of the pandemic, around people working from home and the presenteeism culture which contributed to anxiety and frustration. Staff were seeing that working from home was common sense and they could not understand why there was a delay in implementing working from home practices.

28. Face-to-face visits were only postponed for a short period of time. I would say that by the summer of 2020 we were very much moving away from video calling and were mostly back doing face-to-face visits.

29. Staff absence has changed a lot as a result of the pandemic. Before COVID, and after the introduction of the universal pathway, staff sickness would be quite easily covered insofar as we would reduce visits and prioritise certain areas such as new babies and children who were in highly vulnerable situations. We also had our clinics which we would encourage people to come into rather than having to send staff out if we were short staffed. We also had

the ability to use staff nurses or support workers to carry out visits around health promotion advice and those kinds of things. However, after the introduction of the universal pathway, it seemed like all our visits were deemed to be essential and this became very hard to staff.

30. When COVID hit, there was a distinct lack of guidance from Scottish Government, it became even more difficult for staff as we were unsure of what we were permitted to be doing. The Board would say that they were waiting on government guidance on what to do. On that basis, a lot of staff were taking a common sense approach. For example, we were still visiting children who were highly vulnerable and newborn babies and their families who required support. Eventually, we were advised, by senior management and the head of social work, that we were to operate a directive to identify children who were of a particularly vulnerable status and needed to be physically seen. It was really a question of 'who should we be most worried about?' and then we would make staffing decisions from there. Following this there was also a directive from the Scottish Government to standardise visits and advise on which visits could be virtual and which visits were essential to be carried out face-to-face. But again, there was a feeling that there was a real lack of knowledge and waiting to be provided with some kind of directive.

31. There were lots of rumours at that time and, as people do, they would talk to colleagues in other teams, and they would hear things about what other teams were doing in light of the pandemic and this only increased uncertainty. People don't like uncertainty, they like to know where they stand, who they are to visit and what they must do. I think the lack of certainty in their jobs, coupled with the uncertainty of an unknown virus that was killing people, made it really difficult for people.

32. Another area of concern for some staff, particular those of a certain age, is that there were stories coming out that there were certain age groups of the population who would not be put on a ventilator because they were in high demand, and they potentially needed to ration them. This caused a lot of concern for staff, who were continuing to visit face-to-face in order to carry out their jobs, that if they were to get sick, they would not be a priority.

33. The term 'business as usual' was also used a lot in the early days of the pandemic and this caused a lot of frustration amongst staff. Some staff were very upset because they recognised that nothing about their roles was business as usual.

34. The lack of guidance was very problematic and led to a lot of anxiety and uncertainty for health visitors. For example, in the Glasgow area, by the time the Scottish Government issued guidance to say that health visitor face-to-face visits could resume, we had already been doing so for a long time. It was difficult for staff to navigate their jobs when there was little to no guidance.

35. There was also a lot of mixed messaging in the absence of guidance which also contributed to the uncertainty for staff. For example, in the very early days of the pandemic, before the lockdown was properly announced, there

were certain members of staff who were immediately told to go home and not come back to their place of work. Then, only a day or two later, they were told that they needed to come back into their place of work and resume their duties. There was a lot of confusion, anxiety and a general lack of understanding of what was expected of us. However, it was a very individual thing and some staff, maybe those with underlying health conditions felt more vulnerable than other staff. Some staff became very stoic in the face of the pandemic, and they adopted an attitude of 'this is a healthcare crisis, we're nurses and this is what we do'. So there were different attitudes for different people.

36. Scottish Government guidance was generally cascaded down from the senior management team of the HSCP. I understand that the senior managers would meet on an almost daily basis and the updated guidance would cascade down from there. The guidance would go to my service manager, then to me as a Team Leader and then I would advise the team of health visitors working below me. We also had to be conscious of feeding communication back up the hierarchy about how the guidance was impacting the staff on the front line and what their concerns were.

Impact on the delivery of services as a result of the COVID-19 pandemic

37. Just like everyone else, we moved to home working for a period because of the pandemic. I do not remember there being any huge difficulties for staff being told they had to work from home.

38. With regards to the delivery of service whilst working from home, particularly for my team, which was based in Partick in the west end of Glasgow, we were quite fortunate in that delivering our services remotely was quite straightforward due to the population in our area generally being affluent and able and less likely to suffer from digital poverty. This was fortunate for us because it made delivering our services easier than in some other areas. For example, a lot of the parents we were dealing with were professional people who would be able to engage in telephone calls and virtual calls because they had the means of accessing the technology to enable this. A lot of these families did not require an 'eyes on' approach from health visitors, insofar as we did not feel it was necessary to send a health visitor in full PPE to visit the family and confirm everything was okay, instead they were content to rely on virtual check ins to reassure that the child was okay.

39. It became apparent during the pandemic that the delivery of some health visitor services would either need to be adapted or removed completely. One example of this is the infant feeding service. In the Partick area where I was based, for a number of reasons, breast feeding rates are very high and so it was noticed during the pandemic that the infant feeding team were not doing a lot of face-to-face appointments and, in the event they were needed for an appointment, this could be done over a video call. As such, this is a service which has really struggled to come back post-pandemic.

40. With regards to our staff, one benefit of working from home for health visitors was that it provided a level of flexibility that they had never had before. Pre-pandemic almost all of the health visitor services were provided in the office, in a clinic or in service users homes so there was little to no flexibility. However, when we started working from home, we were able to work with a higher degree of flexibility. For example, staff members would volunteer what hours they could do (fitting this around things like childcare or other caring responsibilities) and we would work other shifts around this so that it worked for everyone. We were also able to allow people to work some hours that worked best for them. For example, if they wanted to work later into the evening then this was permitted.

41. However, there were issues which arose from the more flexible approach. For example, a lot of staff were working more hours and longer days than they would have done before the pandemic. This was because working from home allowed them to start working earlier because they could simply log on to their laptop rather than having to commute to the office and they could work later too.

42. Prior to the pandemic, all of our service users would have been given the office telephone number to call to make any appointments or ask questions. This meant that, should a particular member of staff not be in the office when the phone call came through, the office receptionist would take a note of the callers' details and then we would phone them back when we got back to the office. Of course, then when we went to working from home, there wasn't the same ability to gate-keep and, therefore, we were a lot more accessible and in turn we needed to be more available. This was because the mobile numbers of health visitors were given out to service users. This rapid change was hard for staff to adjust to right away.

43. It was also isolating for our staff. on some occasions, health visitors would receive phone calls from parents that they were working with who would be particularly unhappy about a certain decision that had been made about their child that they didn't agree with so they would perhaps become distressed when on the phone with the health visitor and, of course, working from home our staff members were on their own and didn't have anyone to turn to that would ease the anxiety and upset of that situation.

44. Staff were also finding themselves supporting families in ways which they had never had to do before. Many families were facing financial concerns, isolation and some health visitors felt as if their phone never stopped ringing as people's normal support network was not in place due to lockdown. Health visitors were providing additional emotional support and signposting some families to obtain financial support.

45. Another thing that really impacted health visitors was that, for many, they did not qualify to be able to put their children into the childcare hubs and so they were navigating working from home while also having to provide childcare to

their own children. For some, the reason for this was that there was another parent at home or their children were under the age of 3 years old and therefore did not qualify for the Hubs. For many this was a real struggle and not something they had faced prior to the pandemic. Some staff faced particular difficulties in caring for and looking after their own children whilst working from home, ironically to ensure that other people's children were cared for and looked after. Some staff felt incredibly guilty regarding this.

46. A lot of staff felt that through working from home they were working harder, and they were working longer. This had an impact on the mental health of our staff.

47. Within the Greater Glasgow and Clyde health board, we did put in measures to help support people and support their mental health. For example, we introduced a weekly team meeting which, of course, was held virtually but it gave the opportunity to check in with the team, give updates on the latest guidance and just to see each other.

48. The weekly team meeting was very helpful and it is something that we have carried on post pandemic

Impact of the COVID-19 pandemic on children

49. My role as a health visitor requires a great deal of working with children and particularly very young children, usually up to the age of two. Therefore, because I only deal with very young children, it can be hard for me to have any personal experience of how the pandemic has impacted on the development of older children.

50. However, health visitors did become aware of some changes amongst children as a result of the pandemic. For example, children's behaviour changed possibly as a result of the lack of socialisation with other children their age. Most children go to nursery at an early age and so they get used to being away from their parents. However, because nurseries were not open during the lockdown they were missing out on learning how to be away from their parents. I think there is likely a developmental delay for a lot of children relating to the pandemic.

51. One area in my role that has suffered as a result of the pandemic is the 'child smile' service and offers oral health support to children. During the pandemic, dentists were not seeing patients and following the pandemic there has been a delay in dentists opening back up and accepting new NHS patients. As a result, I think, that we are going to see an increase in young children with tooth decay.

52. The 'child smile' programme greatly improved oral health during the fifteen years that it operated before the pandemic. However, before that, we regularly saw children with tooth decay. Therefore, because of the lack of engagement with dentists during the pandemic I fear that we are going to start seeing such high levels of children with tooth decay returning. We're going back to the

days of 'dental clearance lists' which is when children have go into hospital (theatre) to have their teeth removed and this will have an impact in future of oral health amongst children and young people.

PPE

53. The pandemic completely changed people's routines even down to something as simple as their clothing. For those staff who were redeployed and were working in the wards or COVID units, they were finding that they had to finish their shift and then before they were able to go into their homes they would have to strip off at the door and shower immediately. However, again, people did get into the way of doing it.

54. However, initially, health visitors were told that we did not need to be wearing PPE and people were very anxious about that.

55. In the early days, when they thought that the spreading of COVID was through a droplet, they told us that we just needed to keep to the two metre apart rule and PPE was not necessary. So if health visitors were keeping apart and washing their hands then they were not at risk.

56. In some home visits, some people did not comply with social distancing and had lots of other family or friends in their homes This did affect staff's anxiety if they were routinely going into houses where people were not complying. It left staff feeling worried and uncomfortable.

57. There was a lot of anxiety and uncertainty for health visitors around this as many of them wanted to be using PPE as they wanted to feel like they were protected from the virus. Some staff were questioning whether health visitors should be in uniform or not.

58. Eventually guidance came in (but I cannot remember when exactly) which stated that health visitors needed to wear the basic PPE which was apron, gloves and a mask. There was a level of comfort that this guidance brought with it but it did then create issues of learning the 'doffing and donning' safely of PPE. At the start of the pandemic, the weather was nice and so 'doffing and donning' of PPE at your car before you were going into someone's home was not a problem. However, later on and as the winter set in you would find yourself standing at your car in the rain trying to get your PPE on and off while the wind was blowing all around you.

59. There was also a lot of questions about whether the basic PPE was fit for purpose. For example, one health visitor asked the question that if she was wearing an apron which covered the front of her body, did that mean that the virus could not infect her from her back? There was also people double gloving and using hand sanitiser gel inside their gloves. There were also questions around the use of masks. People were raising questions surrounding that although their mouth and nose was covered but what about the potential for something to get splashed in their eyes? So they questioned whether masks were enough or whether they should also be wearing goggles.

The uncertainty around the use of PPE was a result of the absence of any real clear guidance, or explanation of why we were given what PPE we were given.

60. As far as I am aware, we did not have any issues with having to use out of date PPE. I do know that some people did choose to purchase their own PPE because they were of the opinion the PPE they were provided with was not sufficient for their needs, or purchased their own PPE when the guidance still stated that they did not need to wear PPE. This was in relation to masks in particular, as some staff felt as though the surgical masks provided did not offer them enough protection.

61. I remember one particular day, I was going to do a home visit, and I was standing outside struggling to put on my apron and the neck loop broke so I was attempting to tie it together so that I still had some level of PPE on. However, when I got into the house, the family commented that they were unsure whether the apron was doing anything to protect me. It wasn't quite the same as the stories of nurses wearing bin bags but it didn't look much better either.

62. The use of gloves also caused an issue because they were quite flimsy and they ripped easily. This meant that staff were going through supplies of gloves very quickly. This then created an issue with stockpiling because sometimes there was plenty stock and then other times the order had not arrived and so the supply of gloves was limited.

Shielding

63. The implementation of the COVID risk assessment helped a lot for staff who needed to shield. I am aware there were two COVID risk assessments, there was the initial assessment and then there was a COVID age risk assessment. I think there was an element, once the risk assessments were released, of understanding and an element of self-preservation which helped people. It took the question away from people of whether or not they fitted into the shielding group and it took the question of whether someone needed to be at work away from people, especially those who felt that they were not fit to be at work in a pandemic.

64. The Covid risk assessment did help overall as it was something tangible to apply to everybody in the same standard. It allowed people to understand how decisions were made and removed any subjectivity regarding risk assessments.

65. I think that it was very important for us to have the guidance around shielding as it allowed us to better understand how to staff our services. We had one member of the team who did have to shield and so we restructured our team so that she was able to shield at home and do administrative type tasks and other members of the team who were not shielding could pick up on the face-to-face visits.

Volunteering at the Staff Hub

66. During the lockdown I volunteered at Inverclyde hospital in the Staff wellbeing hub. A friend of mine who worked in Inverclyde at the time had volunteered and she contacted me to ask whether it would be something I was interested in doing.

67. In the early days of the pandemic, as I discussed earlier, there was talk of about 50% of the health visitor staff force being redeployed into other healthcare areas. This was a concern for me as a Team Leader because I wondered what would happen to my role if there was no team to lead. So I wondered if I would be able to work in the hub as a substitute for my hours.

68. However, as it turned out, I was not redeployed and continued working in my role so I volunteered for one day in the COVID hub at the weekends. Health visitors in general were not redeployed, with the exception of some newly qualified health visitors who had come from a critical care background.

69. The wellbeing hubs were put in place to support the wellbeing of the acute staff. There was not a similar model put in place for those of us who were working in the community. I do understand that we were not working with COVID to the same extent as they were, insofar as we could decline a visit if necessary and similar, but there would have been other services, such as district nurses, who did not have that option and who could have been supported by the existence of a wellbeing hub.

70. The wellbeing hubs replaced a lot of the things that, with budget cuts and austerity over the years, had taken away. For example, in our hub, a local business gifted a machine that made coffee and hot chocolate which was a hit with the staff. This had been something that had been stripped away from them previously so the fact that the staff could just come down to the wellbeing hub and have a hot chocolate felt, to them, like being given one million pounds.

71. The point of the wellbeing hub was to make people feel valued at their work again and our role was to support people who were perhaps in a bit of a mental health crisis. We were there to listen and, of course, if someone was very distressed then we would try and arrange some kind of support for them and make sure they were okay and safe. The feedback I received from some of those who I supported was that the Wellbeing Hubs are provided too late; they were needed much earlier on in the pandemic.

Delivery of training

72. We had a number of health visitors who were on training courses when COVID hit and these were paused as a result of the pandemic.

73. Within that cohort, there were a number of nurses who were training to become health visitors. When the pandemic hit, and all the training and

learning was paused, they were moved back into the areas that they had previously worked in and so their learning was disrupted.

74. This disruption continued for many of them even after teaching resumed because a lot of the learning was done online and through remote working. For many of them, this wasn't the same or as beneficial as in-person learning and they were missing out on that experience.

75. This also carried through into their experience of learning to work within the team. For many of them, they were doing their training with teams who were only just making their way to going back into their base offices and were still, for the most part, working remotely. In that regard, the trainees have suffered from a lack of support from the team as well. As a result, the workplace experiences that I have been encountering recently, as a trade union representative, have been centred around the impact of this and we've had staff being considered to be not performing very well because they have not had that tacit learning that comes from working beside someone. I think this is an emerging problem and we potentially have some difficulties to face going forward on how we overcome this issue.

Lessons to be Learned

76. I understand that we cannot predict when a pandemic will hit or how it will impact but I do think that certainly some level of pandemic planning would be beneficial. There needs to be a better understanding of 'this is what we do' for whatever kind of virus, whether it be an airborne virus or something different, for how we stockpile, what PPE is necessary and how people are going to carry out their jobs.

77. I also think that, in another pandemic, we need to be cautious around using the term 'business as usual'. That message was heard a lot during the pandemic and it wasn't helpful. I understand that there was a lack of understanding and so people did not want to shut down services too quickly or disproportionately but the 'business as usual' message did not support staff. It didn't allow staff to focus on their jobs, but instead it gave them a lot of worry and supported the suggestion that their concerns were being dismissed.

78. I think lessons need to be learned surrounding visitation for care homes. I was not personally impacted by this during the pandemic however my mother was in long term care ward from 2018 and I know how hard that would have been for me to not have been able to visit her during that time. So, from that personal point of view, there needs to be lessons learned around the release of patients from hospitals into care homes and the screening process but also a focus on the impact of having people isolated from their families.

Hopes for the Inquiry

79. I hope the Inquiry shows the complexity of the decision making process in a pandemic but I hope is also shows the competency of that decision making. The Government is responsible for the safety of its citizens and I want the Inquiry to assure people that if it happens again the Government will know what to do.

SIGNED: Personal Data

DATE: 19 April 2024