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Scottish Covid-19 Inquiry

Day 43

May 7, 2024

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1 Tuesday, 7 May 2024 1 brought in petting zoos: we had donkeys, horses. 2 visiting; plus also trips out as well. So we would (9.45 am) THE CHAIR: Good morning, Ms Bahrami. Good morning, 3 use -- like, you know, go to different areas. We had 4 coaches or minibuses on site as well we could use. We Mr McDonald. 5 When you're ready, Ms Bahrami. 5 did that for a lot of trips. Pretty much every single MR DUNCAN MCDONALD (called) day there was activities on for the residents, so 6 6 7 MS BAHRAMI: Thank you, my Lord. Our first witness is whether it was in group activities or whether it was 8 Duncan McDonald from Erskine Care Home in Bishopton. 8 individual activities . 9 Mr McDonald has provided a witness statement. The 9 Q. Thank you. That all stopped when the pandemic started? 10 reference number for that for the record is 10 A. Yes. SCI-WT0421-000001 11 11 Q. Did Erskine decide to stop those activities prior to the 12 Questions by MS BAHRAMI 12 official commencement of lockdown on 23 March or was it MS BAHRAMI: Mr McDonald, vou're a house manager at 13 on that date? 13 Erskine Care Home in Bishopton; is that correct? 14 A. It was four years ago, my recollection is a bit hazy of 14 A. I was a house manager during the pandemic. 15 the exact times, but I know that right up until we had Q. Thank you. Erskine is a charity for veterans which, 16 to lock down we still, as much as possible, had 16 17 among other things, has two care homes, one in Bishopton 17 activities . We more sort of segregated the house 18 and one in Gilmerton in Edinburgh; is that correct? 18 activities rather than having different houses mixing, 19 19 but we still had activities for the residents within Haig. 20 20 Q. And Bishopton has a capacity of 180 residents --21 21 Q. Did you allow visitation up until --22 Q. -- while Gilmerton has a capacity of 40 residents? 22 A. Yes. 23 A. Yeah, that's correct. 23 Q. -- you weren't allowed? 24 24 Q. Can spouses also move in with their partners? A. Yes. 25 A. Yes, they can. 25 Q. At paragraph 12 of your statement you say that the 1 3 Q. And each care home has a number of houses within it; is layout of Haig House made it easy for you to distance 1 2 that right? 2 the residents. You say there that you could separate 3 A. Yes, so Erskine Care Home, the largest, had 3 them for dining in small groups and using the lounge in 180 residents split into six different houses of 4 small groups. Was that after the restrictions were put 4 30 residents in each house. in place? Q. Thank you. You were the manager for Haig House? A. No. The layout of Haig House is sort of -- it's like a hub with spokes, so each corridor had ten bedrooms but 8 Q. And the residents of Haig House had dementia to varying 8 they had their own dining area and lounge area within 9 degrees? 9 those ten bedrooms. Other houses had a communal dining 10 10 room for the 30 residents. So we could very easily in A. Yeah. Q. At the onset of the pandemic, there were around 11 Haig -- and it was just because of the layout, because 11 12 30 residents in Haig House --12 it had been designed as a dementia house -- we could 13 13 very easily sort of segregate people into just ten 14 $Q. \ --$ as set out. You had responsibility for around 14 residents in a small area rather than having the 30 15 40 staff members in Haig House? 15 residents together, so it made that easier for us. 16 A. Yes. 16 Q. And they were kept separate to the residents of other 17 Q. What were some of the activities and services that 17 houses? 18 Haig House provided or Erskine provided for the 18 19 residents prior to the onset of the pandemic? 19 Q. You also suspended the admission of new residents at 20 A. So prior to the onset of the pandemic we had activity 2.0 that point: is that correct? 21 staff on site. So we would have concerts out within the 21 A. Yes, we did. 22 home; we had a large activity area that all the 22 Q. You talk in your statement about updating guidance as 23 residents could attend, so large concerts, football 23 soon as changes were made. How were you able to do

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that? We've heard from some care homes that they had to

have their plans approved by people within their

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matches that were on; we had religious services for

different faiths; we had in-house concerts as well; we

- organisation and some by external organisations. Was 2 that not a requirement for Erskine?
- 3 A. Yes, so we had an internal quality improvement team that 4 worked on site as well, so they -- when information came
- through and it was always a Friday afternoon/Friday
- evening -- they would disseminate the information to see 6
- 7 what we were doing that was different from the guidance 8 and then they would very quickly either put out posters
- 9 or put out information telling us what house managers
- 10 had to have in place to keep up with the guidance then.
- 11 Q. Was that quality improvement team set up prior to the
- 12 onset of the pandemic?
- 13 A. Yes, it was.
- 14 Q. Were they based in one of the two care homes or were 15 they --
- A. They were based in the main care home at Erskine and 16 17 they'd been there for years before —— years prior to
- 18 that, but very quickly their real focus became IPC.
- 19 Q. That seems to have made quite a difference for Erskine.
- 20 A. Yes, it meant that, as house managers, we didn't have to 21 go through the guidance. We had it given to us very
- 2.2 auickly.
- 23 Q. So you were able to focus on --
- 2.4 A. On the residents, aha, and making sure that we were
- 25 following everything that should be getting followed.

- 1 Q. You state that you had no deaths during the first wave of COVID: is that correct?
- A. No. That's correct, yes.
- Q. And later in your statement you state that five
- 5 residents of Haig House died throughout the duration of
- 6 the pandemic and a number of other residents in other
- houses. Were those five all COVID deaths or were
- 8 thev --
- 9 A. They were put down as COVID deaths. You can never tell,
- 10 you know. We have a population of residents who are
- elderly, a lot of comorbidities, some had been actively 11
- 12 dying before the pandemic even started. It would be
- difficult to say that COVID was the reason but it could 13
- 14 have been a contributing factor.
- 15 Q. Thank you. Once the restrictions were put in place formally, how was your work affected?
- A. So it was really just staff were scared at the time --17
- 18 you know, with the restrictions that were in place that
- 19 were changing all the time, it became more of -- we
- 20 always tried at Erskine to make it person—centred care.
- 21 you know, it was all about the residents, but very
- 22 quickly it became all about the tasks, the cleaning,
- 23 making sure we were following IPC guidelines, making
- 24 sure that everything was cleaned and it was recorded,
- 25 because the recording was so important as well for

- proof. And very quickly the focus went away from the
- 2 residents to everything else that we had to do to make
- 3 sure we were following guidance.
- 4 Q. And what was the impact on your mental health?
- I understand from your statement that you were also
- dealing with your wife's cancer diagnosis --
- 7

- 8 ${\sf Q}.\ --$ and that treatment had been stopped for that.
- 9 A. It was a scary time. I didn't know -- one, I didn't
- 1.0 know if I was taking COVID into work with me for my
- 11 residents, who are obviously all quite susceptible, or
- 12 if I was taking COVID home to my wife, who had been told
- 13 that her treatment had stopped because, if she caught
- 14 COVID, it was a serious problem for her illness . So
- 15 either way -- but it's the job that we do, so you still
- 16 turn up every day and you did it. But it was just hard
- 17 and it was a 24/7 job. It didn't stop. It didn't go
- 18 away. You went to work, you came home and you went back
- 19 to work the next day, and it just took over your entire
- 2.0
- 21 Q. Can I ask, how long was your wife's treatment stopped?
- 22 A. So it was stopped from -- she was due to get
 - chemotherapy in February. We went to the hospital and
- 2.4 she was told, no, she couldn't get it because that was
- 25 right -- just as the hospital was locking down. So she

- 1 was told, no, she couldn't get it, she had to go back
 - home again. And then, as soon as the first lockdown
- lifted in June, she went back in and got the treatment
 - then and thankfully she's absolutely fine now --
- 5 Q. I'm glad to hear that.
- 6 A. -- but at that time it was quite a difficult time.
- 7 Q. Yes, thank you. How were your staffing levels affected 8 by the pandemic?
- 9 A. It was up and down. You know, we couldn't get agency
- 10 staff because we couldn't bring people in from other
- 11 places, so it was only like Erskine staff. They did
- 12 a lot of extra shifts but a lot of people -- at that
- 1.3 time there was no testing so if you had any symptom at
- 14 all then you had to isolate. So staff were going off if
- 15 they just felt unwell, you know, had a sore head, were
- 16 having a cough. We couldn't take that chance so they
- 17 were going off sick at the time. At that time it was
- 18 a 14-day isolation so it was a long time for staff to be
- 19 off . So staffing levels -- we should have had eight
- 20 staff for 30 residents and some days we had four or
- 21 five: six if we were lucky.
- 22 Q. Did that have an impact on the care that you were able
- 23 to provide to residents?
- 2.4 A. Yes, it was just less staff, less time with the
- 25 residents. The time with the residents was cut back to

the bone anyway because we were doing so much cleaning; 2 less staff to deal with everything else. As a manager 3 you lost all your management time so -- you were working on the floor so you lost all that time that you had to 4 do all your management stuff as well so everything else became outwith work. But for staff it was tough. You 7 know, they knew they were going to be short-staffed 8 pretty much every day. 9 Q. Were staff able to gather in a staffroom or to speak to 10 each other and support each other or was that very much 11 stopped as well? 12 A. Within Erskine we had -- they had a cafe that we could all attend to before COVID. Once COVID started and that 13 14 closed, you could only -- you went into your house in

- 15 the morning, you stayed in the house for the rest of 16 vour shift -- so that was 12 and a half hours you staved 17 in that house. We at the start didn't have a break room
- 18 within Haig so we ended up having to use residents' 19 bedrooms as they became available, but again we had to
- 20 cut that back. Because of the distance requirements, we 21 had like two members of staff in each break room and
- 23 Q. You say in paragraph 21 that by the end of February and 2.4 into March -- that's before the start of the official

25 lockdown -- you had a couple of residents with

that was it, so you and someone else.

- 1 respiratory symptoms who were at the end of life and residents [sic] were allowed to visit with full PPE on.
- 3 A. Yes

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- 4 Q. Was Erskine requiring relatives to use PPE before the 5 official guidance required that?
- 6 A. Yes, I think it was just our director of care quickly 7 realised that -- you could see on the news it was 8 coming, you know, so it was just a matter of just to keep the residents safe as well and the relatives safe,
- 10 you know, as much as possible. We didn't really -- we 11 still -- all the way through COVID, at end of life,
- 12 residents [sic] came to visit, but they had to wear the 13 full PPE just for their safety as well.
- Q. Yes, but at that point it was clear to your directors 14 15 that this is a precaution that should be taken?
- 16
- 17 Q. Thank you. We've heard from others that it was 18 difficult for those in the care sector to see the
- 19 appreciation for those in the NHS, whether it was 20 clapping, special shopping hours, discounts in shops,
- 21 free coffee and the like, as it made them feel
- 22 under—appreciated. Was that also the same —— was the

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- 23 same sentiment and feeling experienced by staff at
- 24 Erskine?
- A. Yes. Social care has always been sort of the poor

cousin to care. I've got friends in the NHS and, you 2

- know, massive respect to them, especially during what
- 3 happened, but we felt that, yeah, we were second best
- again. At the start, PPE had been redirected to the NHS 4
- so we were struggling to get PPE. I had all my people
- in my street out clapping for the NHS every Thursday
- 7 night and fair play to them, but we had to get letters
- 8 from our director to say that we worked in social care,
- 9 could we get into the shops at the same time and even 1.0 then staff were getting turned away and, you know, it's
- 11 embarrassing to get turned away from shops. But, yeah,
- 12 definitely the same sentiment.
- 13 Q. We touched on this briefly just before, but at
- 14 paragraph 26 you mention that at times guidance was 15
- changed on a Friday and it was an awkward day as you had 16
- to make changes before the weekend to ensure things were
- 17 up and running quickly for Monday. We've heard that not
- 18 everyone was able to achieve that. Some care homes had
- 19 a delay of a week or two --
- 20 A. Yeah.
- 21~ Q. $\,--$ because of how things were set up. Do you think the
- 2.2 reason you were able to do that was solely down to your
- 23 quality improvement team or do you think there were 2.4 other factors that allowed that?
- 25 A. I think that was a massive reason. I think, yeah, the

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- 1 reason that they could -- and we also had internal
- communications so we had -- we used a platform called 2
- "Workplace". It's like a Meta company, it's very like
- 4 Facebook but it's locked to the company, so we could 5 very quickly -- they could very quickly put information
- 6 on that, they could put posters on that for us to print
- and we could very quickly see that so it was -- yes, the $\,$
- 8 OI team was a massive plus for us to have them. We
- 9
- didn't have to go scrabbling ourselves.

10 The other thing we had within Erskine was that

- 11 managers didn't just work Monday to Friday, we worked 12
- internal rotation, so we were sometimes available at 13 weekends as well to make sure that that was getting in
- 14 place before the Monday and we never really wanted for
- 15 any equipment. Erskine always provided what we needed 16
 - to make sure that we were following everything.
- 17 Q. Thank you. In paragraph 30 you state your "management
- 18 guidance was clear but just changed quite a lot". By
- 19 that do you mean Erskine issued its own guidance for
- 20 management purposes and did that seek to implement
- 21 Government guidance or was it in addition to Government
- 22 guidance?
- 23 A. I think what I mean by that is like -- so for stuff like
- 2.4 cleaning charts, we would attach cleaning charts just
- 25 to, say, equipment so that staff could very quickly sign

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2 guidance that would say, no, they shouldn't be attached 3 to the equipment, they should be kept in a folder, so we 4 had to change everything. So it was like small things but it was small things that were changing so much all the time and it was hard for staff to keep up with that as well. It was hard for the managers to keep up with 8 that. I mean, it was hard also to cascade that to 9 1.0 As I say. I had 40 staff. Not all of them were on 11 Workplace, not all of them had emails. Trying to put 12

off that it had been cleaned, but then we would have

information out and then bring that information back in for a change of guidance -- because if one person didn't follow it, the perception was that no one was following it . So it was quite difficult to make sure that everyone was getting that information.

- 17 Q. So that was internal guidance rather than --
- 18 A Yes aha

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- 19 Q. -- anything else from the Government?
- 20 A. It might well have came from Government guidance and 21 we've cascaded it down and made it Erskine guidance 22 then.
- 23 Q. Thank you. We've heard from others that they found NHS 2.4 assurance team inspections and requirements to be
- 25 inappropriate for care homes and to treat care homes

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- 1 like hospitals. Was this also the experience at Erskine?
- 3 A. Yes
- 4 Q. Can you tell us about the requirements that were 5 considered to be inappropriate?
- 6 A. Very much so. So Erskine and any care home who considered the care home as the residents' home, they
- 8 were asking for very clinical set-ups, so they were
- asking for yellow waste bins in every resident's room,
- 10 they were asking for separation of PPE, they were asking
- 11 for PPE to come out of rooms, and it was sort of 12
- requirements that we couldn't always put in place for
- the residents. We had residents with advanced dementia. 13
- 14 We couldn't police that. We couldn't -- you can't tell
- 15 a resident not to touch something all the time, and it's
- 16 a giant yellow bin, they're going to be attracted 17 towards it. So it was very difficult -- it was
- 18 difficult to explain to the assurance team that we were
- 19 someone's home -- I wouldn't expect that in my home so
- 20 why should I expect that in a resident's home —— but
- 21 they were quite inflexible.
- 22 Q. At points did your directors have to get involved and
- 23
- 24 A. Yeah, so there was also differences between what the
- 25 Care Inspectorate guidance was when they visited and the

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- assurance teams'. We were getting different messages
- 2 and we had to go back and question them a lot about what
- exactly $\,--\,$ who was telling us what to do and, you know, 4 could we get a consensus on it. It could be quite
- difficult at times.
- Q. So the dual inspection regime was causing more
- 7 difficulty?
- 8 A. Yes. Yeah.
- 9 Q. In paragraph 43, referring to residents, you state:

1.0 "Some of them forgot who their families were, lost 11 social interaction, dining together and activities.

12 Access to outside people, such as dentists, podiatrists, 13 dieticians was only available by telephone contact not 14 physical visits ."

What was the impact on your residents, on their mental and physical health, of not having access to those services?

A. So I had residents who, yeah, forgot who their families 18 19 were. We had families who visited every single day and 20 they had like large families . To start with there was 21 no visiting at all and it was done either through like 2.2 tablet or online and the residents couldn't always cope 23 with that. They couldn't understand what was happening.

We did start doing outdoor visits, they had to be booked

25 in, it was one person at a time and again the residents

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1 lost that contact with their families. We had residents

who lost their communication skills, we had residents

who gave up eating because again we were having to

socially distance residents within the home as well, and

5 when you have a resident with dementia, eating and

6 drinking is quite a social thing, they will copy each

other. So they will eat better in a group sometimes,

8 whereas we had to stop that. We had to have people

eating singularly, people eating in their rooms, so they

were losing skills, they were losing communication

11 skills

12 We were all wearing masks, which made communication 13 difficult with the residents as well by that point.

14 They weren't understanding us, they were scared, they 15

didn't understand it. And also -- yeah, so we had no GP

16 contact, we had no dental contact for two years, 17

dieticians, anybody else. It was by phone only. It was

18 very, very difficult for -- we were lucky -- Erskine is 19

lucky, they have advanced nurse practitioners employed 20 by Erskine who can prescribe and could see the residents

on site, but apart from that we had no other allied

22 health professionals that could see them.

23 Q. Did you have residents who developed problems with their 24 teeth or feet or --

2.5 A. They did, but we probably just dealt with it at the

- time. A lot of our residents -- and it's just at that 2 stage of life $\,--\,$ either they have dentures or very few 3 teeth by the time -- you know, people are living at home $\,$ 4 much longer. By the time they come to Erskine they're much older. It wasn't always an issue, but people maybe had to change their diet because they'd lost weight, their dentures didn't fit, so they couldn't wear their 8 dentures so they were having to get like maybe a 9 $\ different-textured\ diet,\ which\ isn't\ \ always\ the\ \ nicest$ 1.0 thing when you're -- you know, the only thing maybe 11 you've got left is your food in your life . You know, 12 everything -- family has been taken away, recreation has 13 been taken away, you know, so the thing you've got left 14 is food and that's changed as well. 15 ${\sf Q}. \ \ {\sf You} \ \ {\sf mentioned} \ \ {\sf the} \ \ {\sf on-site} \ \ {\sf advanced} \ \ {\sf nurse} \ \ {\sf practitioners}.$ 16 As you might already be aware, not all care homes are
- 17 fortunate enough to have that.
- 18 A No
- 19 Q. Do you think that having advanced nurse practitioners on
- 20 site helped lighten the workload on your staff and
- 21 improve the situation for residents? Were they able to 22 get better care?
- 23 A. Yes, without a doubt. It was a massive bonus we had.
- 2.4 We had two advanced nurse practitioners on site that
- 25 worked all through the pandemic. They would come and

- 1 they would see residents. If residents became unwell,
- 2 they were very skilled, you know, in treating those
- residents and giving us management plans for them. They
- were the ones who would order tests when tests became
- 5 available to see if the residents had COVID or not.
- 6 They were the ones who decided who was isolating. They
- could prescribe for us. They could prescribe 8
- just -in-case meds for end-of-life medication for us.
- They could have syringe drivers for people who became 10 really unwell. They did all of that and they were on
- 11 site all the way through.
- 12 They had contact with GPs, through the local $\operatorname{\mathsf{GP}}$ 13 surgery. We didn't want for anything from a medical --14 a nursing prescription point of view all the way through
- 15 COVID. It was a massive bonus.
- Q. Thank you. You also mention in paragraph 46 that you
- 17 had two GPs from Bishopton who did online calls. By 18 that do you mean video calls or were they regular
- 19 telephone calls?
- 20 A. They were either phone calls or -- I think we had
- 21 a couple of video calls for maybe some condition that
- 22 they would need to see the resident. but they didn't
- 23 come in. But they used our ANPs a lot for that so they
- 2.4 would liaise with the ANPs and sometimes they would just 25 sort of have that conversation between them.
 - 18

- Q. Once Erskine resumed admission of new residents from
- hospitals or had residents returning from a stay in
- 3 hospital, were there strict rules about residents coming 4 in?
- 5 A. Yes, so we had to have two negative tests before they
- 6 were admitted. Even then, we still had to isolate for
- 7 whatever period it was at that time. So at the start it
- 8 was 14 days. It did get less and less as the pandemic 9 progressed. But, yeah, so we still had to isolate just
- 1.0 to make sure that, after the test, they hadn't sort of 11
 - contracted COVID.
- We had to make sure that -- coming from the 13 hospital, that they were coming from a ward that didn't
- 14 have COVID on it as well. It had to be like a green
- 15 ward. And if they were coming from home as well, we had
- 16 to ask for two tests before they were admitted.
- 17 Q. Thank you. We heard from some other care homes that
- 18 they were being sent patients who hadn't been tested 19
- prior to discharge from hospital. Did you have any 2.0 experiences like that or were your residents --
- 21 A. No.
- 2.2 Q. -- or did your residents all receive two tests?
- 23 A. From my recollection everyone in Haig had had tests
- 2.4 before they came to us. Our moving-in team were very
- 25 strict on that. I couldn't tell you overall for the

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- 1 entire of Erskine but, as far as I can remember, Haig
 - didn't have anyone who hadn't been tested prior to
- 3 coming in.

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- 4 Q. Thank you. You mention in your statement your moving
- 5 team. Can you tell us a bit about them, whether they
 - existed prior to the pandemic and how they were able to
- 7 help during the pandemic?
- 8 A. So the moving—in team was —— it used to be called the
- admissions team but our director of care was very keen
- 10 that you don't get admitted to your home, you move into
- 11 your home, so they changed it to the moving—in team.
- 12 The moving—in team were a team of three people who from
- 13 first contact with Erskine right through to the person 14
- moving in on that day, they did all the contacts. They
- 15 were the ones that made sure that the tests were in
- 16 place. They would give us the assessments for the 17 residents. We would assess them and then they would
- 18 sort all the moving arrangements from financial through
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- to the tests, through to making sure they were eligible $\,$
- 20 for Erskine.
- 21 But one thing that did change was, before the 22 pandemic, if we assessed a resident, we always went and
- 23 saw the resident. Once the pandemic started, then we
- 24 didn't; we had phone call assessments. So it was never
- 25 the same, you never saw the resident before they were

actually admitted to Erskine.

7. Thank you. In paragraph 52 you state that those residents who were transferred out of the care home by ambulance were emergencies and usually had DNACPR decisions in place; is that correct?

6 A. Yes.

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Q. We've heard from others, from other care homes that they were told there was a blanket ban on care home residents being taken to hospital by ambulance or in some cases being taken to hospital at all, but that doesn't accord with your experience; is that right?

12 A. No, that's right. We — I can think of multiple residents who went to hospital for various reasons.
14 Some emergency or most — it was always emergency visits but we never had an issue with getting residents to hospital if they needed to go. A lot of the residents we could help within the home but there was always that sort of need for extra medical attention. We never had an issue.

The only issue we had was obviously we always sent an escort with the residents, so they went with someone they knew. During the pandemic that stopped. Even if they had no symptoms, they were still going to hospital without an escort, so it was difficult for the resident and obviously it would have been difficult for the

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1 hospital staff as well.

Q. You say that in emergency cases you didn't test
 patients; is that right? You just informed —

4 A. We didn't. We informed, yeah, the Scottish Ambulance
 5 Service if there was any symptoms.

6 Q. We heard from others that some had an impression that
7 some were given DNACPR decisions so that they wouldn't
8 need to be taken by ambulance or taken to hospital —
9 treated by paramedics or taken to hospital. Why was it

the case that at Erskine it was usually actually those by the DNACPR decisions who were transferred out?

residents already have DNACPRs in place, just because of the clientele that they are. But DNACPR isn't a refusal for treatment, it's just that refusal right at the end.

So we are always of the impression that if the resident has a good quality of life, if there's a good chance of survival, why do you not? You know, you're doing the best for that resident so it doesn't matter if they've

A. Because — I would — the vast, vast majority of our

best for that resident so it doesn't matter if they've got a DNACPR in place, we will still do treatment up to that point and that was always our view there.

Q. Thank you. This is a final question for you: at any
 point in the pandemic, did a healthcare professional
 contact the care home and say that they would like to
 put in place DNACPR decisions for all your residents?

A. Not that I'm aware of but, again, because of our

residents' age, comorbidities, quality of life, then
 most of our residents already had DNACPRs in place. We

4 didn't —— we never had anyone who would push to say we

5 should give them all blanket, but most of them already

6 had that anyway.

7 Q. Thank you. Is there anything we've not -- we of course

8 have your statement and we'll take into account

9 everything that's contained within it . Is there

anything we've not covered today that you particularly

11 would like to mention at this point?

 $12\,$ $\,$ A. I can't think so, no. I think we've covered everything.

You know, it was just — staff and care homes did the

14 best they could at the time with the resources they had,

with ever—changing guidance, you know, with residentsbecoming unwell. And again, these residents you maybe

17 looked after for years, they became like family to you

so it was difficult for the staff. I saw other managers

19 who had seen half their residents pass away and sat at

 $20\,$ the bedside of every single one of them and looked

shell —shocked.

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You know, it was just —— the way I felt about it, sort of like guilty syndrome because we didn't have that really in Haig. And there's another part of me that

thinks to myself we were the lucky ones. I don't know

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1 how anyone could stay in lockdown for two years in

a house. We got to see other people, we got to speak to

other people, we got to take out our frustrations on

4 each other that other people didn't have. So maybe

 5 $\,\,^{\prime\prime}$ lucky" is the wrong word, but we had that social

6 contact that other people didn't and it made that

7 camaraderie, which maybe got us through it. But no,

8 apart from that.

9 MS BAHRAMI: Thank you very much.

10 A. Thank you.

11 THE CHAIR: Thank you very much indeed, Mr McDonald.

12 A. Thank you, my Lord.

13 THE CHAIR: We've finished early. I think that was

 $14\,$ anticipated so there's no problem there. I'm not sure

if the next witness is available. They're not. So

 $16~{\rm maybe}~{--}$ it was anticipated at $11.15~{--}$ we may be able

17 to start a bit earlier than that. Apologies I can't be

18 more definite than that. We'll do what we can. Thank

19 you.

20 (10.16 am)

21 (A short break)

22 (11.18 am)

23 THE CHAIR: Good morning, Mr Caskie.

 $24\,$ $\,$ MR CASKIE: Good morning, my Lord.

 $25\,$ THE CHAIR: When you're both ready, thank you.

1 MS WENDY BATES (called) an idea of the scale of the organisation? 2 Questions by MR CASKIE 2 A. Sure. Our annual turnover is around 8.5 million. 3 MR CASKIE: Would you tell the Inquiry your full name, 3 Q. Okay. Going back now to paragraph 8, you talk about the 4 please? history of the organisation and you talk about the 5 A. My name is Wendy Bates. number of people that you support each year and the Q. Which organisation are you here representing? number of volunteers that you have. Can you just give 6 7 A. Health in Mind. us those figures? 8 Q. What's your position in that organisation? A. Sure. So every year we support around 4,000 people with 8 9 A. I'm the chief executive. 9 their mental health and we involve 150 people as 10 1.0 Q. How long have you been there? volunteers 11 A. I've worked with Health in Mind since 2001 and in my 11 Q. At paragraph 9 — and I hate this phrase and I'm sure 12 current position since March 2019. 12 Lord Brailsford will hate this phrase as well -- but you 13 Q. Can you tell us the nature of Health in Mind as an 13 provide in effect a mission statement for the 14 organisation? 14 organisation. Can you just tell us about that? 15 A. Health in Mind is a charity promoting mental health and 15 A. Yes, so we provide -- our organisation is a unique 16 well-being. Most of our services are based in 16 organisation because of the breadth of the work that we 17 Edinburgh, the Lothians and the Scottish Borders but we 17 do and we offer a unique pathway of support for people 18 do also have a number of national services covering all 18 and we also are committed to working in partnership with 19 of Scotland and we offer a range of support to people 19 others as well to make sure that people who receive 20 who have mental health difficulties . 20 support get the best support available to them. 21 Q. Tell me about what it is that you do outside your core 21 Q. At paragraph 10 you provide us with a kind of definition 22 2.2 geographic area, what are your national programmes? of the focus of the types of work that your organisation 23 A. So we offer a telephone counselling service for people 23 does. Can you just tell us about that, the types of 2.4 who have experienced trauma in childhood and we offer 2.4 work that you do? 25 25 training to organisations who are supporting people A. So we offer trauma support, which is practical support 25 27 1 who've experienced trauma. We're part of an alliance 1 with housing, budgets, relationships, as well as 2 providing two services. Future Pathways and 2 emotional support for people who have experienced Redress Support. Future Pathways offer support to trauma. We also offer a range of counselling, peer people who were abused or neglected in care in Scotland 4 support, guided self-help, art psychotherapy, well-being 5 and Redress Support supports people throughout their 5 groups, art, nature and physical activity, and the basis redress journey. 6 6 of a lot of our work is supporting people to build 7 7 natural connections within their own community. Q. Okay. In advance of giving evidence today, you provided 8 8 the Inquiry with a witness statement. Part of the Q. Moving on again to paragraph 18, you talk about another witness statement is on screen and it's known by 9 part of your work. I'll come back to the earlier 10 10 a reference number which I'll just read into the record, paragraphs in a second, but at paragraph 18 you talk 11 which is SCI-WT0433-000001. The witness statement 11 about your fundraising activities and trauma training. 12 that's on the screen, do you recognise that? 12 Can you tell us about that? A. Sure. So 83% of our funding comes from contracts or 13 13 Q. And are you satisfied the content of that witness 14 service - level agreements --14 15 statement is true? 15 Q. Is that with health and social care partnerships? 16 16 A. That's right, and the Scottish Government, and 7% of our funding comes from trusts, grants, fundraising and 17 Q. And do you want to adopt that witness statement as part 17 18 of your evidence to the Inquiry? 18 generating income. So one of the offers we have is 19 19 trauma training, where we use the trauma training 20 20 Q. Okay. At this stage I'm going to jump back and forward framework to deliver training to other organisations who 21 a little bit in the witness statement. Can I take you 21 might be supporting people who have experienced trauma 22 to paragraph 12? You tell us there that you have 22 in their childhood.

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Q. Right. We know about that because almost all of the

not with your organisation.

staff in the Inquiry have undergone trauma training but

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a staff of around 140.

Q. And can you tell us what the budget is, just so we get

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A. That's right.

- 1
- Q. At paragraph 14 you talk about the pre-pandemic
- situation and I get the impression -- and please correct
- 4 me if I'm wrong -- I get the impression from that that 5 most of the work that you did at that stage was in
- person. 6
- 7 A. That's right. Only a small proportion, our Trauma
- 8 Counselling Line, was delivered by telephone. All of
- 9 our other support was offered in person and staff worked
- 10 from office bases
- 11 Q. At paragraph 15 you give us an idea of the number of
- 12 people that you provide support to. Again, can you just
- 13
- 14 A. Sure. So at the end of March 2020 we'd supported just
- 15 under 4,000 people, and Future Pathways, which is one of
- the services we deliver through the In-Care Alliance, 16
- 17 supported a further 1.117 people.
- 18 Q. Although it's not in your statement, do you have an idea
- 19 of how those numbers changed during the pandemic period?
- 20 A. They increased slightly.

- 21 Q. Increased? And how were you able to deal with that in
- 2.2 terms of staffing and so on?
- 23 A. It was quite difficult because a lot of our staff and
- 2.4 ourselves within the leadership team and our trustees
- 25 were really aware of the unmet needs of people within

- 1 the areas that we work. What we did was we sought
 - additional funding to be able to either recruit new
- staff or give our current staff additional hours to be
- able to support more people. At times as well we
- 5 changed the way we were delivering services to offer
- 6 more group support rather than one—to—one support, which
- meant we were able to support more people.
- 8 Q. At paragraph 16 — and this is not something that we've
- seen from many other organisations -- you identify
- 10 a danger in the type of work that you're involved in.
- 11 Can you just explain that?
- 12 A. So it's really important that people we support don't
- 13 become too dependent on our organisation or our staff,
- 14 so all of the time we speak to people about when our
- 15 support will end in order to really focus them and 16 making their time with us count so that we can have the
- 17 biggest impact on them. That's why a lot of our focus
- 18 is on supporting people to make natural connections
- 19 within their local community or to use local resources,
- 20 communities groups. Some of that focus is on supporting
- 21 people to be able to develop relationships with others 22 because we know a lot of people, especially people who
- 23 have been abused in childhood, can struggle to make
- 24 trusting relationships with others. So that's one of
- 2.5 the focuses of our work and it's really important that
 - 30

- we're able to do that.
- 2 Q. One of the words that you use in that context is
- 3 "dependence" --
- A. That's right. 4
- 5 ${\sf Q.} \ \ -- \ \ {\sf avoiding \ dependence}.$
- A. Hmm-hmm.
- Q. Again tell us about that.
- A. We don't want people to become dependent on someone who 8
- 9 is effectively paid to be in their life . We want people
- 1.0 to have others within their personal social networks
- 11 that they can call upon to support them. A way of not
- 12 creating dependency is supporting people to develop
 - strategies and skills and coping mechanisms for them to
- 14 pull upon if they're starting to feel unwell or maybe
- 15 feeling anxious or being able to spot the early warning
- 16 signs that they're becoming maybe more isolated within
- 17 their life.
- 18 Q. To use a well-worn phrase, you seek to teach people to
- 19 fish rather than give them a fish?
- 20 A. That's right.
- 21 Q. At paragraph 20 you talk about your involvement with the
- 2.2 black and ethnic minority community. Tell us about
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- 2.4 A. So as well as all of our services being inclusive, we
- 25 have some particular services that are specifically for

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- 1 people from black and minority ethnic communities. We
- 2 know that people from those communities can find it hard
- to access what you might call "mainstream services"
- 4 because of issues with maybe communication, fear,
- 5 stigma, cultural issues that aren't always paid
- 6 attention to, and so our services that specifically
- reach out to people from those groups are delivered in
- 8 a way that makes them more accessible to people.
- 9 Q. At paragraph 21 you talk about volunteers within the
- 10 organisation. Where do your volunteers come from?
- 11 A. Our volunteers come from a range of different places and 12 some of our volunteers have used Health in Mind or other
- 1.3 mental health services. Some of our volunteers are
- 14 students who are looking to volunteer while they're at
- 15 university, sometimes our volunteers are looking to
- 16 change their career or get experience to start their 17 career and others have family members who have
- 18 experienced mental health difficulties and it's seen as
- 19 a way of giving back to organisations that have
- 20 supported their loved ones.
- 21 Q. Now, in the next section of your witness statement.
- 22 which starts at paragraph 23, you have a heading,
- 23 "The Pandemic". I want to ask you to begin by outlining
- 24 the immediate impact of the pandemic and lockdowns on
- 25 you as an organisation and your services users.

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- A. Sure. So 16 March 2020 we asked all of our staff to start working from home. This had a huge impact. We were really fortunate because we'd taken action to move 4 a lot of our IT structures online to cloud-based Microsoft 365 so we were able to access a lot of our files and information online, but the issue was we 7 didn't have the IT equipment to enable us to do that. 8 Only a few of our team had laptops. The majority of our 9 team worked from desktop computers. Some of our staff 1.0 were able to take those computers home: others weren't 11 able to. So some -- in the initial days, some of our 12 staff were working from a smartphone or their home 13 computer until we were able to purchase laptops for 14 everyone. 15 Q. I'll come back to that later because there's a story 16 about the laptops --
- 17
- 18 Q. — but essentially you moved from — in client dealings, 19 you moved from one-to-one contact or group work into 20 online work; is that correct?
- 21 A. That's right. So one of the first things the staff team 2.2 did was to contact everyone they were supporting by 23 telephone to let them know that we were still here, even 2.4 though we weren't working from our office bases, and to
- 25 offer support, offer people the opportunity to link in

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- 1 together, just offer that reassurance that we were still 2 there for them even though we weren't visible within our offices
- 4 Q. For people you were involved with, either individually 5 or in group work, was there a gap in the provision of 6 service as you were making the transition from
- face-to-face to online? Can you tell us about that?
- 8 A. So there was a short gap within —— in one of our services there was a gap of a week, but during that time 10 we were able to keep in touch with people, let them know 11 what we were doing, give them assurance that we would be 12 back in a position to support them very shortly. So the 13 staff team worked really quickly to be able to develop 14 new ways of working, safe ways of working online.
- 15 Q. And as chief executive, were you involved in training in 16 particular for staff or middle management, if I can put 17 it that way, in terms of providing those services in 18 a new way?
- A. The pandemic offered staff a real opportunity to show 19 20 leadership throughout the whole organisation. Some of 21 our team were really quick to get to grips with what was 22 new technology for us, like Zoom or Teams, and they were 23 able to then develop guidelines that they shared with 24 other staff. So that was hugely helpful for staff to

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25 really take the lead and that really was

a strength-based approach within the organisation rather 2 than everything having to flow through myself or others 3 within the leadership team.

We did follow up that initial work with what we call

"Netiquette training", which was training to support staff to be able to offer support online. So it ranged 7 from everything from making sure people had like 8 a blurred background or a virtual background when they 9 were speaking to people to -- yeah, just how to support

someone online and how different it is to supporting

- 12 Q. And within the organisation itself, how did the 13 organisation switch into using technology?
- 14 A. So, for example, our board meetings moved to meeting 15 online and --
- Q. How quickly did that happen? 16

somebody in person.

- 17 A. It happened really quickly. Most of our trustees had 18 access to laptops. One of our trustees used to dial in
- 19 to our Zoom meetings via a telephone, so it worked
- 2.0
- 21 Q. Right. At paragraph 27 you talk about your leadership 2.2
- team meeting daily. Can you tell us about that? 23 A. It was important to meet daily to have —— to keep
- 2.4 a sense of connection and to make sure that we were
- 25 sharing the same information across the organisation.

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- 1 It was important for managers to be able to check in to 2
 - let us know about the progress they were making in
- pre-designing services and to give us a report on the
- 4 well-being of their staff and also any concerns that
- 5 there might be for people accessing services or our
- 6 volunteers.
- 7 Q. Now, at paragraph 28 you talk about something that 8 happened on 19 March. Can you tell us about that?
- 9 A. Yes, on 19 March our funders asked us to report to them 10 how we would be delivering services for people.
- 11 Q. This was before lockdown happened?
- 12 A. Yeah.
- Q. And how were you able to respond to those requests for 13 14 information?
- 15 A. Because of our daily leadership team meetings, we had 16 all that information to hand so we were able to give
- 17 a swift response to that.
- 18 Q. At paragraph 31 you talk about starting a weekly email
- 19 update for the volunteer team. Now, before I ask you
- 20 about that -- that was 24 March -- had you already set

- 21 up some means of passing out information to your paid
- 22
- 23 A. That's right. I -- from the day that we started to work
- 24 from home, I wrote a daily update to all staff and, on
- 25 24 March, we started doing a weekly update to our

- volunteers. The daily update to staff included information that had been shared around guidance but it also included a more personal input from myself, showing my vulnerability within the situation. I think that was really helpful or staff told me that was really helpful because they felt reassured that someone else was potentially feeling the same way that they were.

 Q. But you said that you started a weekly email for volunteers.
- 10 A. That's right.
- 11 Q. Tell me, what type of information would that contain?
- 12 A. So that included information about how we were
- developing our services in relation to how they might be
- 14 able to stay involved or change how they were involved
- to help us in a different way, but it also gave them
- some information and resources in order to support their
- mental health and well—being because we knew some of our
- volunteers were in very vulnerable positions themselves.
- 19 Q. You talk about, at paragraph 32, again a difference in
- approach in the initial stages where people didn't knowif the lockdown was going to happen for a month or
- however long. Can you tell us about that?
- 23 A. Yeah, particularly within our counselling services,
- people let us know that they didn't necessarily want to
- 25 move to being supported online or by telephone; they

- 1 thought the pandemic might last a couple of weeks and so
- they wanted to just wait and then pick up support in
- 3 person again after the pandemic. We kept in regular
- 4 contact with those people because, as we got more
- 5 information about the length and the duration that the
- 6 pandemic might take, we didn't want people to feel that,
- 7 because they'd said "No" once, that they wouldn't be
- 8 able to reconsider.
- 9 Q. You talk at paragraph 34 about your relationship with 10 Volunteer Midlothian.
- 11 A. Yeah.
- $12\,$ $\,$ Q. Again, can you tell us about that and what that
- 13 organisation is?
- 14 A. So we were successful in our partnership bid to the
- Supporting Communities Fund with Volunteer Midlothian.
- Volunteer Midlothian is the volunteer hub within
- 17 Midlothian and we work together to train volunteers
- 18 across Midlothian, not necessarily to volunteer within
- Health in Mind but to volunteer in lots of different
- organisations in lots of different ways, and our input
- 21 into that was to offer mental health training to those 22 volunteers.
- 23 Q. And did that result in an upturn in the number of people
- who were volunteering as far as you're aware?
- 25 A. Yes.

Q. At paragraph 34 you say that there were 150 new

- volunteers across the area. Was that just for Health in
- 3 Mind or was it for other organisations?
- 4 A. That was for other organisations.
- 5 Q. And then you also talk at 33 about accessing additional
- funding, yes, and then at 35 you talk about the outcome
- 7 of that additional funding. Those two paragraphs are 8 obviously related to one another. Can you just tell us
- 9 about that?
- 10 A. So we were able to access a number of different grants
- from funding that was made available to support people.
- 12 For example, the Community Response, Recovery and
- Resilience Fund, we used funding from that to purchase
- 14 Zoom -- additional Zoom licences for staff and
- volunteers to use and we also used it to deliver
- 16 wellness recovery action planning groups. Those groups
- 17 focused on supporting people to identify daily and
- 18 weekly well-being tools that they could use to keep well
- during the pandemic and also early warning signs that
- 20 they might be starting to feel unwell or experience
- $21\,$ distress , and we were able to offer, for a short time,
- a well—being line for young people in the Lothians andScottish Borders.
- 24 Q. And why did that come to an end, as you indicated it
- Q. And why did that come to an end, as you indicated in did?

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- 1 A. Because funding was short term.
- Q. At 36 you talk about funders agreeing to refocus some ofyour funding.
- 4 A. That's right. We were able to involve our staff in
- 5 different ways. For example, in Edinburgh we delivered
- a service that we called the "Remote Response Service"
- 7 and it offered short-term support to people who were
- 8 impacted by COVID and we also were able to use other
- 9 funding differently to provide additional support to
- people whose lives had been impacted by trauma.
- 11 Q. Okay. Now at paragraph 38 you provide a date by which
- 12 $\,\,$ "90% of our counselling clients had moved onto phone or
- video support", and that date is 27 March.
- 14 A. That's right.
- 15 Q. That's literally within days of the first lockdown.
- 16 A. Yeah.
- 17 Q. Why were you able to move so quickly?
- 18 A. Being a charity or a voluntary sector organisation,
- 19 we're able to move quickly or make changes quickly. We
- 20 don't have lots of different layers of management or
- $21\,$ bureaucracy. We can move swiftly. We are able to -
- we're really close to the people that we work with,
- 23 both well, not at the time but normally physically
- 24 close in that we work within communities but also we
- 25 understand the communities that we work in, which helps

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- us to be able to respond to needs that we identified or 2 people have told us about.
- 3 Q. In terms of your recollection of events at the time, 4 were statutory agencies able to move as quickly as you 5
- A. No, it wasn't the case, and I think some of that was due 6 7 to the fact that a lot of attention was -- shifted to 8 people who were unwell, who had COVID and were dealing 9 with symptoms of COVID, and a lot of our work is around 1.0 early intervention, so my view is statutory services
- 11 weren't able to move as quickly as we were.
- 12 Q. Okay. At paragraph 41 you talk about providing online 13 training for volunteers and, again, you say that was 14 7 April.
- 15 A. That's right.
- Q. Is that another example of the agility which your 16 17 organisation was able to demonstrate?
- 18 A. That's right. So staff who were delivering the training 19 were able to rewrite the training so that it was
- 20 appropriate for being delivered online. They had to
- 21 learn how to use Zoom, break—out rooms, whiteboards,
- 22 different ways of working from the ways that we would 23 when we deliver training in person.
- 2.4 Q. And you talk at paragraph 43 about a positive aspect of
- 25 moving online. Can you tell us about that?

- A. That's right. So, in addition to sending out a weekly 1
 - written update to volunteers, we also were running
- a fortnightly online support space for volunteers. And
- staff and volunteers came together and it was a social
- 5 space, just a chance to get together, have a cup of tea
- 6 together, and that resulted in people who would never
- normally meet, so, for example, volunteers in Edinburgh
 - met for the first time with volunteers in the
- Scottish Borders, and it was just a lovely way for
- 10 people to spend time together with people that they knew
- 11 and new people as well, and some ongoing friendships
- 12 were developed.
- 13 Q. Was that a positive aspect for the organisation?
- A. Yes, it was really positive. 14

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- 15 Q. Okay. At paragraph 46 you talk about furloughing staff. 16 How many staff did you furlough?
- 17 A. We furloughed four staff out of 140 staff. That was 18 our -- two of our fundraising team and two people that
- 19 we employed as office cleaners.
- 20 Q. We've heard from a number of third sector organisations 21 who spoke of redeploying rather than furloughing. Why
- 22 was the decision taken in your organisation to furlough 23 a small number of staff?
- 2.4 A. The staff that we furloughed didn't have the skills or
- 25 experience to be able to offer support. That wasn't the

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- reason why we employed them. They had different skills
- 2 that weren't required at that time.
- Q. Right. At paragraph 47 you talk about lending bikes. 3
- 4 Tell us about that. That's just an interesting story 5 from the pandemic.
- 6 A. So, within Midlothian, one of the support activities
- that we offer is a cycling group, and we had five bikes 7
- 8 that we lent to NHS key workers to support them to be
- 9 able to get to and from their work when there was
- 1.0 limited other ways for them to get there. So, yeah, we
- 11 lent out the bikes to allow key workers to use them.
- 12 Q. But you had to be conscious of a danger for the 13 organisation in that?
- 14 A. Yes. We didn't want to inadvertently put the
- 15 organisation at risk if something happened to one of the
- 16 key workers when they were on our bikes. So, for
- 17 example, if like a wheel fell off and they injured
- 18 themselves, we didn't want to be liable for that so we
- 19 had to get that checked out.
- 20 Q. At paragraph 50 you talk about assisting staff and
- 21 others with -- "coping with the new normal" is the
- 2.2 phrase that you use.
- 23 A. That's right.

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- 2.4 Q. Tell me what you did in relation to that.
- 25 A. So when the lockdown measures began to lift and we were

- 1 able to have a little bit more freedom and we were able
 - to support people in person and in groups, one of the
- 3 things we noticed was that people were feeling really
- 4 scared about being back out and in areas with large
- 5 groups of people, for example going shopping or parks
 - and things were really busy at the time. So our "coping
- with the new normal" groups offered people a space to
- share some of those concerns and we supported people
- practically through breathing techniques to use if they
- 10 started to feel anxious when they were out. Having
- 11 a face covering, a mask, was difficult for a number of
- 12 people that we supported so it was also -- that was
- 13 really helpful to help with that feeling of panic,
- 14 having the mask on.
- 15 Q. Now, at paragraph 52 you talk about the first 100 days
- 16 of lockdown and your web activity as an organisation.
- 17 Can you tell us a bit about that? That I think became
- 18 quite an important part of what the organisation did.
- 19 A. That's right. So Health in Mind have our own website
- 20 and social media channels and, in addition to that, we
- 21 have four information websites covering Edinburgh and 22 then each of the Lothians. Our information websites
- 23 include information about local services as well as more
- 24 general mental health and well-being information and
- 25 both our own website and our information website became

website and find out information about what was open,

how they could access support within their local area.

Q. You talk at paragraph — and I'm going to jump

forward — but you talk at paragraph 74 about people

accessing your website and at 73 about numbers again,

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hubs, a one-stop shop, if you like, for people during

the pandemic, where they knew they could access the

- forward but you talk at paragraph 74 about people
 accessing your website and at 73 about numbers again,
 but also being a one—stop shop. Tell me about that.

 A. Sure. So in 2020/2021 over 96,000 users accessed our
- information websites and the definition of a "user" in terms of accessing the information is an individual, so it could be someone has returned a couple of times —— but, as I say, yeah, over 96,000 people accessed our information websites over that year, so I think that shows that they were seen as a one—stop shop for people to get reliable and up—to—date information.
- A. So there was contact information there for people to be
 able to do that for themselves rather than us doing it,
 but where we were key was that the other organisations
 would contact us to let us know up—to—date information
 about the services they were able to provide and how
 people could access them.

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- Q. And you talk about, at paragraph 52, the number of posts
 that you put up as an organisation: 434 social media
 posts.
- 4 A. That's right, focusing on well—being and resources. So
 5 that was for example, around our information that we
 6 developed around the five ways to well—being, so
 7 supporting people with practical tools and techniques to
 8 be able to support their well—being during COVID.
- 9 Q. You talk at 53 to 55 about changes over time in relation
 10 to the guidance you were receiving, that early guidance
 11 was black and white and later it became more nuanced.
 12 Can you tell me how, as an organisation, you coped with
 13 that?
- 14 A. It was really quite challenging. We had to be really
 15 careful to understand where and how guidance should be
 16 applied. Sometimes that involved checking our
 17 understanding with peers, colleagues and at times the
 18 health and social care partnerships.

What I did with the guidance was I had to interpret where our services sat within the guidance because it wasn't always clear. So, for example, for a day centre it was really clear what the guidance was but we didn't operate day centres, we weren't social work. We were somewhere —— you know, it was sometimes quite challenging to find where our services sat but ... so

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what I had to do was interpret where I felt our services

the sat. I then had to look at the risk appetite of our

board, the needs of people accessing support, the safety

of our staff, the safety of people accessing support,

and in the end it wasn't a one—size—fits—all across the

organisation. We ended up with guidance that differed

for different services that we were providing so it

became quite a complex picture.

Sometimes, by the time we'd worked that through and we'd written our guidance for staff, the formal guidance had changed again, so we wanted to make sure we weren't lagging behind what the guidance was saying. So that was one of the main focuses for me during the pandemic, was always trying to keep ahead of the guidance or keep up to date with the guidance.

- Q. Listening to the answer that you gave, there were a lot
 of "I"s and "me"s and very few "we"s in terms of the
 organisation. Was the responsibility for dealing with
 the guidance did that rest with you primarily?
- A. As the chief executive I held responsibility for
 ensuring the safety safe operations of our work, but
 I did liaise really closely with my colleagues within
 the leadership team, in particular the deputy chief
 executive of Health in Mind.
- 25 Q. Please don't name that person.

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- 1 A. I won't.
- 2 Q. I think you wanted to say something about your deputy.
- A. Hmm—hmm. I think it —— just how important it was, their input and support, both professional support and
- 5 personal support, that we were able to offer each other 6 during that time. We had a daily phone call to make
- during that time. We had a daily phone call to make
- 7 sure that we were both on the same page, that we were
- both okay and to highlight any issues or challenges thatwe were facing.
- Q. Now, you talked earlier about the shift from in—personto online and the use of laptops. Tell me about that.
- 12 A. Yeah. So we worked out -- of course the price of
- 13 laptops just skyrocketed at the early weeks of the
- 14 pandemic. We worked out that, in order to purchase the
- number of laptops we needed, we would need to spend
- £30,000. We had decided -- the board had agreed that we
- 17 would take that money from organisational reserves.
- 18 Q. So you were going to eat into your reserves to meet that
- 19 £30,000 --
- 20 A. That's right because --
- 21 Q. outlay?
- 22 A. Yeah, because it was a non-negotiable. We needed that
- 23 equipment to be able to support people. But we were
- 24 really fortunate in that we actually received a donation
- from someone who wanted to cover the cost of those

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- 1 laptops for us so we didn't have to use reserves in the 2 end
- 3 Q. Now, you say in the statement that that person doesn't 4 want named and I'm not going to ask you to name them or
- identify them, but was that someone who just effectively out of the blue said, "Have this £30,000 to buy your
- 7 laptops"?
- 8 A. It was someone who had a connection to the organisation
 9 already and was really wanting to help and had asked,
- 10 "What's the best way that I can help you?".
- 11 Q. And that person doesn't want identified?
- 12 A. No.
- $13\,$ $\,$ Q. At paragraph 56 you talk about facilities for staff,
- particularly those working in their own home. Tell us

 a bit about that.
- $16\,$ $\,$ A. Asking staff to work from home was really challenging,
- 17 especially for a number of our staff who lived in shared
- 18 accommodation so the only private space that they had
- 19 was their bedrooms. We were asking people to support
- others, hear and hold pain, the pain of others, within
- 21 their own private personal space and it was really
- 22 challenging. Other staff maybe had a bit more space but
- 23 then had home—schooling on the go. Others had other
- 24 caring responsibilities . Altogether it was a real
- 25 juggling act for our staff team. We are normally really

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- 1 clear about the boundaries between work and home and 2 it's really important, because of the work that we do.
- that we don't take the work home, but in fact work was
- home during those months so it was extremely challenging for the staff.
- 6 Q. And how as a management team did you respond to that?
- 7 A. Where we could, we were able to help in practical ways.
- 8 so, for example, purchasing desks or chairs for people
- 9 if they needed it, but also, in terms of emotional
- $10\,$ support, we upped the amount of support that we were
- giving staff. We encouraged everyone to take their
- daily walk during their lunchtime to make sure that they
- weren't only at home and to try and find some way to
- split the work day and the rest of the day.
- Q. You also talk about concerns in relation to dataprotection.
- 17 A. That's right. Information security is really important
- 18 to an organisation like Health in Mind, where we're
- dealing with and handling a lot of personal information.
- We drew up new guidance for staff working from home to
- $21\,$ $\,$ make sure that they were taking necessary steps to
- 22 protect the personal information of people we were
- 23 supporting. That included everything from purchasing
- 24 headsets so other people within their home wouldn't hear
- what was being said to making sure security patches were

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- updated on laptops, making sure that there was no names
 - used if people were writing notes before they uploaded
- 3 them on to the cloud, things like that.
- 4 Q. Okav. Another area which caused concern for the
- organisation was Scottish Government's £250 recognition
- payment for people involved in caring, stating that broadly. Were some of your staff able to access that?
- 8 A. Some of our staff were able to access the 250 payment
 - but other staff weren't, and at a time where all of our
- 10 staff had given so much of themselves, we didn't want to
- 11 cause any feelings of not being valued or not being
- $12\,$ $\,$ recognised for what had -- what people had given. So
- our trustees decided, again from charity reserves, that
- 14 we would offer the -- or give the £250 payment to all
- $15\,$ staff within the organisation rather than just those who
- were working within services that were registered with
- 17 the Care Inspectorate.
- 18 Q. So those who weren't getting it from the
- 19 Scottish Government got it from the organisation?
- 20 A. That's right.
- 21 Q. So everyone got £250?
- 22 A. Yeah.
- $23\,$ $\,$ Q. You then talk about several of your staff testing
- 24 positive for COVID. What impact did that have --
- 25 A. We were fortunate in --

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- 1 Q. -- on the organisation?
- 2 A. On the organisation. We were fortunate in that we
- 3 didn't have large numbers of staff being infected at the
 - same time. We were able to cover support. But what
- $5\,$ $\,$ that did mean was that other staff within the team had
- 6 to do more in order to cover for people who were off
- 7 sick.

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- $8\,$ $\,$ Q. And at 65 you talk about providing additional support to
- 9 staff
- $10\,$ $\,$ A. Following -- yeah, following the -- well, I was going to
- 11 say the "end of the pandemic". I'm not sure if I would
- 12 necessarily call it that, but we offered reflective
- 13 sessions for our staff to just have a safe space -- it
- 14 was externally facilitated -- a safe space to be able to
- talk about the impact that COVID or working throughout the COVID pandemic had had for them and we were also
- able to tap into some Scottish Government initiatives,
- like Coaching for Wellbeing, which was available to
- 19 staff, all staff.
- $20\,$ Q. Unusually, your organisation is slightly self critical
- about the reflective period that you've given to staff.
- 22 Can you tell us about that self-criticism?
- 23 A. Yeah, it's my view that we did the reflective practice
- 24 sessions too quickly. People were still -- our team

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25 were still kind of in the throes of what they had

- experienced and, if we had waited three/four months to 2 offer the reflective practice sessions, I think it would 3 have been more beneficial, when people had more space to 4 really consider the impact that working through the pandemic had had for them. 6
 - Q. And you talk about, at 66:

7 "Staff were also impacted by the knowledge that [they] were unable to meet need within [the] communities

Tell me about that.

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- 11 A. So every day we were getting telephone calls from people 12 that were looking for support, people in distress. We
- 13 were receiving referrals for people from third parties
- 14 on behalf of people who were looking for support.
- 15 Knowing that waiting lists were growing while staff were
- 16 working as hard as they could and to full capacity was
- 17 really distressing for staff and it was just this
- 18 feeling of never doing enough. I think that was
 - particularly evident within our Future Pathways service,
- 20 which was for in-care survivors, where we just were
- 21 never able to meet the needs of everyone who wanted to
- 22 access support. It was really difficult.
- 23 Q. At 67 you talk about "additional support for our team".
- 2.4 Tell me about that and the longer-term impact of the
- 25 pandemic on your team.

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- A. Hmm. So two people have left the organisation because 1
- they were no longer able to work because they had
- long COVID and the lasting impacts of that meant they
- didn't have the energy or capability to be able to keep
- 5 working. We also noticed that we've lost more staff --
- 6 we've had a higher turnover than usual since the
- pandemic. It's not a significant number but we have
- 8 noticed an increase in turnover of our staff.
- 9 Q. Prior to the pandemic were you an organisation with low 10 staff turnover?
- 11 A. Yeah, our turnover has always been under the national 12 average.
- 13 Q. Aha. and now?
- A. And now we're still slightly under but it has grown. 14
- 15 Q. Okay. You tell a strange story at paragraph 68
- 16 regarding PPE and testing kits. You say there were no
- 17 problems with PPE.
- 18 A. Yeah, there was no problems with PPE and there was
- 19 certainly no problems with testing kits because we
- 20 received huge boxes of testing kits and they just kept 21 coming and kept coming and kept coming.

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- 22 Q. Where from?
- 23 A. We don't know.
- 24 THE CHAIR: They just arrived out of the blue?
- 2.5 A. Yeah.

THE CHAIR: How bizarre.

- A. Yeah. And we looked on the -- there was no real
- information on the boxes apart from the postage. We
- contacted the distribution centre. They weren't able to tell us where they came from. And it ended up, we had
- cupboards and cupboards full of tests -
- MR CASKIE: Are you talking hundreds or thousands?
- A. Thousands -- well, 1,000. But certainly lots more than 8
- 9 we could have ever used, and so what $--\ \mbox{we}$ were
- 1.0 encouraging all of our staff to use them obviously. The
- 11 staff could share them with people accessing our
- 12 services, volunteers. We work in a shared building, we
- 13 offered other organisations, and it's a shame because
- 14 actually some of the test kits went past their expiry
- 15 dates and we had to just, well, recycle what we could 16 and throw out the rest. To this day we still don't know
- 17 where they came from.
- 18 THE CHAIR: It's very strange, isn't it?
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- 20 MR CASKIE: At paragraph 70 you talk about the impact on
- 21 volunteers and we've heard from a number of sources that
- 2.2 the desire to be a volunteer increased during the
 - pandemic. Can you reflect on that for us?
- 24 A. We did have some increased interest in volunteering with
- 25 us, but, because of the nature of the work that we do,

- 1 we have to make sure that we have proper checks in
 - place, so that includes reference checks, interviews.
- application forms, and we also ask for PVGs. What
- I mean by "PVGs" is for people to be a member of the
- 5 Protection of Vulnerable Groups scheme in which
- 6 Police Scotland -- Disclosure Scotland undertake police
- checks to help us decide if someone is suitable to work
- 8 with vulnerable people.
- 9 Q. You describe that, and then did that have an impact on
- 10 your -- well, that must have had an impact on your
- 11 requirement to conduct training.
- 12 A. Actually, because we need to have all of those checks in
- 13 place ideally before we start training, and the same is
 - the case for our staff team, staff -- in terms of people
- 15 becoming PVG members, staff in key roles were being
- 16 prioritised by Disclosure Scotland and so volunteers
- 17 were slightly further back in the queue so it meant
- 18 there was quite a long gap in getting PVGs back. The
- 19 Care Inspectorate published some advice on risk
- 20 assessments where PVGs weren't available and we did 21 follow that guidance, although I felt really
- 22 uncomfortable not having that final piece in the
- 23 recruitment puzzle and having a PVG police check back
- 24 for people because of the nature of our work.
- Q. You talk about -- I'm looking at paragraph 72 --

"additional support for volunteers" and there's a quote 1 2 there. Could you read from the quote to the end of that 3 paragraph, please?

A. Sure. So: 4

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"One volunteer said 'When COVID first struck, I found it an extremely lonely time'. Very quickly Health in Mind started a Zoom group for volunteers. It meant such a lot to me that we were not forgotten about even if our usual role was not needed at that time. The message received from this by me was that we were important enough to the organisation to be remembered."

- 12 Q. Was that an important thing for you to hear and for the 13 management team to hear? 14
- A. That's right. All feedback was really welcomed during 15 that time; things that we were doing well, things that 16 we could do better, things that we should really stop 17 doing, things that we should start doing. All of that
- 18 feedback was really helpful.
- 19 Q. At 73 and 74 you provide figures, and I think you've 20 already provided many of those figures so I don't need 21 to get you to repeat them. But you do talk about 22 problems with referrals at 75.
- 23 A. That's right. So the pathways into our services are 2.4 different. Some of our services people can self-refer.
- 25 so they just get in touch with us, but other services

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1 require a third party referral, so that's a referral 2 from a GP, a social worker, another voluntary organisation, and there was some delay in receiving referrals due to being able to safely transfer data, 5 personal information. So, for example, any referrals 6 that came from the NHS had to come by letter, but letters were being sent to our offices and there was 8 no one in the office to receive the letter. We did start to go in on a semi-regular basis to pick up post, 10 but then, when restrictions eased, we were able to be 11 there to get the referrals . But I guess it's another 12 example just where we were able to work a bit more 13 agilely -- agilely? --14 THE CHAIR: With more agility?

- A. -- with more agility -- thank you -- than some of our 15 16 statutory sector colleagues.
- 17 MR CASKIE: Thank you. Could you read paragraph 76 aloud 18 please?
- 19 A. "As was said during the pandemic, although we were all 20 in the same storm, we were all in different boats and 21 this was especially true for people accessing mental 22 health support. Mental health issues were compounded by 23 the fear of COVID-19, issues of isolation and being cut 24 off from essential connections and underlying issues of 25 stigma, social exclusion/inequality, and poverty."

Q. Read on into paragraph 77 please.

- A. "For some people we supported, they were left totally on their own -- with no family or friends to connect with.
- Our team were the only people they were in contact with.
- Others found themselves in equally challenging
- situations where they were spending extended periods of
- 7 time with people with whom they had relationship
- 8 difficulties . This too significantly impacted mental
- 9 health and wellbeing."
- 1.0 Q. At paragraph 78 you revert to talking about BAME
- 11 clients . Again, can you tell us about that and what
- 12 you're saving there?
- 13 A. So, as I mentioned previously, there are a number of
- 14 barriers to people from black and minority ethnic
- 15 communities accessing support and these were heightened
- 16 during COVID and they felt really insurmountable for
- 17 some people. What made it more difficult was there was
- 18 a lot of media coverage around at the time about
- 19 increased risks for people from BAME communities, which
- 2.0 also added additional concerns and worries on top of the
- 21 concerns around the pandemic more generally.
- 22 Q. I'll move on. You talk about additional challenges and
- 23 at paragraph 82 you talk about a feeling of discomfort
- 2.4 arising from something. Can you tell us about that?
- 25 A. So, because of my role, I was able to work from home

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- 1 throughout, but it felt really uncomfortable where I was
 - asking staff to be out working with people and
- supporting people and also our business support team,
- 4 who were travelling to the office to check on post and
- 5 answer phone calls. So there was some sense of, yeah,
- 6 discomfort and the lack of equity around that.
- 7 Q. Could you read paragraph 85, please?
- 8 A. "It was 'easier' [and I've put that in inverted commas]
- 9 to manage the organisation when there were clear
- 10 boundaries and restrictions in place. As directives
- 11 allowed for more individual choice and organisational
- 12 discretion, it became more challenging to balance the
- 13 needs of people accessing support, staff, volunteers and 14
 - other stakeholders such as funders."
- 15 Q. And at 87 you indicate that there were really, amongst
- 16 your staff and volunteers, two different types of
- attitude towards coming out of lockdown. Can you tell 17
- 18 us what those were?

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- 19 A. That's right. So some of our team were really raring to
- 20 get going, couldn't wait to get back out to support
- 21 people in person, felt that at times our approach was
- 22 being too cautious; and there was another group of staff 23
- who were really frightened and scared that they might 24 become ill if we went too quickly and we returned to
- 25 in—person support too fast without appropriate measures

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- in place; and then we had a group in the middle who were 2 kind of, "Well, I don't know". But I would say most of the staff fell into those two groups.
- 4 Q. The extreme ends of the spectrum?
- 5 A. Yeah.

- Q. At 88 you talk about effectively altering job 6 descriptions for your staff. Tell us about that and why
- 8 you did that. 9 A. That's right. So we -- by April 2022 we'd amended 10 role-specific risk assessments for all of our staff, and

that was to make sure that, as we returned to in-person

- 12 working, that we had the proper -- we'd identified and
- managed the risks appropriately. We'd also opened back 13
- 14 up our offices at that point, but with reduced capacity,
- 15 so we had to develop new systems for planning ahead who
- would be in the office when to make sure that that was 16 17 well managed and we weren't too close together.
- 18 Q. At paragraph 90 you talk about the changes that the 19 pandemic has had on the organisation overall. Again, 20 can you just tell us about that?
- $21\,$ $\,$ A. So there has been a really positive change in that we're 22 now able to offer people support in a range of different
- 23 ways, either in person, online or by telephone. Some 2.4 people want to be supported by all three of those ways
- 25 at different times during their support journey with us,

- 1 so that -- and that includes group work and individual 2 support. So that's been really positive, to be able to develop those skills to work with people differently in line with their needs.
- 5 Q. At 99 you talk about the overall demand -- sorry, 92 --6 you talk about the overall demand for the service. Tell
- us a bit about that 8 A. Yes, so demand continues to be high for all of our
- services, especially counselling, art psychotherapy and 10 trauma support. Waiting for any kind of mental health
- support can be really problematic because it's really 11
- 12 important to be available for someone when they're ready
- 13 to engage with us. If we wait too long, that time might
- 14 have passed and their mental health and well—being might
- 15 have deteriorated during that time. So, again, it's 16 a real sense of discomfort, knowing that we can't
- 17 support everyone that needs us.
- 18 Q. Give me just one second. Have you seen delays in 19
- accessing services within the statutory schemes 20 increase?
- 21 A. Yes, yeah. Certainly anecdotally from people that we 22 support, they talk about statutory services feeling less
- 23 available now and having to wait longer for those 24 services than they had previously.
- Q. At 93 you talk about the longer—term impact on your

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- A. At the beginning of the pandemic we were kind of working
- on adrenaline. It was new, it was different, we were

staff. Again, can you tell us of that?

- able to tap into new skills, there was leadership across
- the whole organisation, and although it was an extremely
- difficult and challenging time, there was some positives
- 7 within it for us as an organisation.
- 8 But, as time went on, where people didn't have
- 9 a real break, there's a real sense of exhaustion, of
- 1.0 tiredness. I think the impact of Brexit, the cost of
- 11 living crisis, increased inflation, the war in Ukraine.
- 12 the climate crisis, it just all feels really heavy for
- 13 our staff team just now and just this real $\,--\,$ a real
- 14 sense of tiredness.

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- 15 Q. You then talk about "Lessons Learned". All of those
- 16 will be read carefully by Lord Brailsford and he will
 - take account of your suggestion for "Lessons Learned".
- 18 but you highlight a couple of points -- or I want to
- 19 highlight a couple of the points. The first one you've
- 2.0 already told us about in some detail. It's at
- 21 paragraph 97 and the difficulty with the £250 payment
- 2.2 and the inequality from Scottish Government in relation
- 23 to that. Do you want to say anything else about that?
- 2.4 A. No. I think I've covered everything.
- 25 Q. Okay. Could you read paragraph 98 aloud, please?

- 1 A. "Ensuring time was taken to plan for each stage of the
- pandemic was challenging —— ensuring we were keeping up
- to date with changes. Because it was an evolving
- picture, just as plans were being shared and embedded,
- 5 they changed. This added a great deal of pressure
- 6 whilst also managing day to day operations within the
- organisation. Staff felt the impact of working within
- 8 an environment of constant change —— this became
- 9 draining on their energy and resilience levels.
- 10 Q. Okay. You state some hopes for the Inquiry. Can I just
- 11 ask, again, that you read aloud paragraph 105?
- 12 A. "I hope the Inquiry is a space where we can recognise
- 13 all that individuals and groups gave during the
- 14 pandemic."

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- 15 Q. And then 104.
- 16 A. "It is important that we do not only view through the
- 17 timeline of the ... "
 - Sorry, I've just ...
- 19 "It is important that we do not only view the
- 20 timeline of the pandemic through the lens of what we
- 21 know now, but also based on the information we knew at
- 22 the time. However, it is ... important that the inquiry
- 23 is clear about mistakes that were made to ensure they do
- 24 not happen [again] in the future."
- 25 $\ensuremath{\mathsf{Q}}.\ \ensuremath{\ensuremath{\mathsf{I}}}$ think those are all the questions I have for you.

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I indicated before we came in that, when I got to the 1 2 end, I would say, "Is there anything that we've not covered?". Is there anything that we've not covered? 3 4 A. I just wanted to just talk a little bit about the amazing efforts that our staff team put in during the 6 pandemic. It was a really difficult time for everybody 7 as we were experiencing such loss, grief, anxiety about 8 so much that was unknown to us. For our staff team to 9 be experiencing all that personally and also to support 1.0 others who were experiencing the same was quite a feat 11 and I couldn't -- I actually can't thank our staff team 12 enough for everything that they did. The leadership 13 that was shown across the organisation was just 14 phenomenal and it just really reminded me of what 15 human -- how wonderful human nature is. MR CASKIE: You are not the first chief executive of a third 16 17 sector organisation to say that. I don't have anything 18 else. Thank you very much for coming along. 19 A. Thank you. 20 THE CHAIR: Thank you, Ms Bates. 21 A. Thank you. THE CHAIR: Very good. 1.30. Thank you. 22 23 (12.26 pm) 2.4 (The short adjournment) 25 (1.31 pm) 65

Evidence given via video-link 3 THE CHAIR: Good afternoon, Ms Bahrami, and good afternoon, 4 Ms Nicholls. Can you hear me? 5 A. I can do, my Lord, thank you. 6 THE CHAIR: Let's hope that Ms Bahrami can hear you and you can hear her. I'm going to hand over to her now. 8 Ms Bahrami. 9 MS BAHRAMI: Thank you, my Lord. 10 Questions by MS BAHRAMI MS BAHRAMI: Good afternoon, Ms Nicholls. 11 12 A. Good afternoon. 13 Q. You have provided a statement for the Inquiry. For the record the statement number is SCI-WT0367-000001. 14 15 I want to reiterate that everything in your statement 16 will be considered as part of our investigations 17 alongside your oral evidence today. 18 A. Thank you. 19 Q. Could you tell us briefly about your background and 20 about the College of Paramedics? 21 A. Certainly. So I'm a paramedic myself, still registered 22 with the Health and Care Professions Council. 23 I've spent most of my working career within an ambulance 24 service in England and I progressed my way to becoming 2.5 a director of clinical quality and improvement with an

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MS TRACY NICHOLLS (called)

English ambulance service up until the end of 2019, where I then joined the College of Paramedics, which is our professional body, and I've been involved with the college for many years as a volunteer.

The College of Paramedics being the only professional body in the UK for paramedics is very much supportive of paramedics in the diversification of their careers and development, of lobbying Government and arm's length bodies to support paramedic development, to support the pre-registration and post-registration curriculum for education standards, to undertake research and support policy development in that area, and provide legal support for paramedics who may come under fitness to practice proceedings through their regulator, the Health and Care Professions Council.

- 16 Q. Thank you. Now, we've heard from some organisations 17 that their work and activities didn't seem to have been 18 taken into account by Government guidance. I understand 19 from your statement that that's also the view of the 20 college. Please could you firstly give us some examples 21 of situations your members experienced which weren't 2.2 covered by the guidance and then I want to ask you about 23 IPC Cell guidance after that.
- 2.4 A. Certainly. So I think that the major thing from 25 a college perspective was about the environment that

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1 paramedics work. We're talking particularly about the 2 ambulance sector in this case predominantly, although we do represent members who don't work in the ambulance 4 sector. The ambulance sector work is based on 5 undifferentiated care, which means 999 calls --6 predominantly paramedics and ambulance clinicians will go to the 999 call, wherever that may be. The patient 8 is normally undiagnosed at that stage in — whatever their emergency or urgent care need is, it's not really 10 known to the crew until they arrive on scene and 11 determine that for themselves. So there is a case of 12 paramedics and ambulance clinicians going to the call 13 itself , wherever that may be, and not knowing what 14 they're going to. 15 Where COVID is concerned, that was a concern in 16 terms of going into people's homes, particularly at the

beginning of the first lockdown, where the crews were unsure of the COVID status of the patients, to be fair, as were the patients. That was very tricky. Also the environment that paramedics in the ambulance sector work in, which is essentially a metal box on wheels, and with certainly social distancing guidelines that were being advocated, that was impossible in an ambulance. Certainly two crew members driving to a call cannot be 2 metres apart. The cab doesn't allow that. The saloon

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and there was a real concern from our members that they 4 were either passing COVID on to patients who were already extremely unwell or indeed, you know, receiving transmission of COVID from patients who were unwell. So the autonomous nature and remote nature of 8 ambulance work is such that you come on shift at the 9 beginning and you're out for 8/10/12 hours, depending on 1.0 your shift, and you may never see any of your colleagues 11 or managers, for example, in that time. So it's quite 12 a unique environment and I think the college really felt 13 that that consideration wasn't really given. It's not 14 just community work. It's more than community work. 15 It's an emergency service piece where you're dealing

in the back, where you're treating patients, both

patients and crew are very, very close to one another,

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18 Q. At paragraph 32 of your statement you talk about 19 IPC Cell guidance and, again, you didn't consider that 20 that was appropriate for the ambulance environment.

feel that was really closely recognised.

with the health of the Scottish public. So we didn't

- 21 Could you firstly tell us, what is IPC Cell guidance? 2.2 $\mathsf{A}.\;\;\mathsf{So}\;\mathsf{the}\;\mathsf{IPC}\;\mathsf{Cell},\;\mathsf{from}\;\mathsf{our}\;\mathsf{understanding},\;\mathsf{was}\;\mathsf{set}\;\mathsf{up}\;\mathsf{in}\;\;$ 23 England to take the evidence that was available from 2.4 a number of -- various sources to try and determine what
- 25 levels of guidance should be issued across certainly

- 1 England, and that was fed into by the Scottish rapid literature review, the ARHAI review, and that was a weekly short, snappy literature review which fed into the IPC Cell. The cell would then distill the evidence 5 it had and then update guidance around infection 6 prevention and control in most areas of health and care. So it was under NHS England, as far as we were aware. 8 We never knew who were in the IPC Cell or who was making those decisions, but I think they worked closely with 10 NERVTAG and a number of other bodies that were trying to 11 decipher the evidence to provide the guidance at that 12
- 13 Q. Was their guidance used by your members in Scotland as well, to your knowledge?
- 14 15 A. My honest answer is I think it was inconsistent, so it seemed like there was slightly different guidance in 17 Scotland than there was in England, and that was --18 where our members reported that was a problem was 19 sometimes you do cross-border work where -- people who 20 live right on the borders of England and Scotland, there 21 would be inconsistencies in how crews, depending on 22 which country they came from, would understand what the 23 guidance should be mean for them. But predominantly the 24 IPC Cell's guidance for ambulance staff was the 2.5 ${\sf fluid-resistant\ surgical\ masks,\ apron\ and\ gloves.}$

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Q. You mention the masks. Were there other shortcomings in IPC Cell guidance in the opinion of the college and what would the college have liked to have seen in the guidance, the IPC Cell guidance?

A. So it became quickly apparent to us, because of the nature of spread of COVID amongst our members and what they were reporting to us, that, whilst of course good infection prevention and control through the hierarchy of controls is gold standard -- but actually this wasn't stopping the transmission of COVID to our members and to the patients. So the evidence that we were all looking at -- and I appreciate the IPC Cell may have had sight of a much larger volume of evidence -- but the evidence we were looking at was showing that actually there wasn't enough evidence to say that it necessarily was transmitted via an airborne route but there wasn't enough evidence to say it wasn't. This was right at the beginning of COVID.

So we felt that actually that was too risky to take a chance on an entire workforce, to say that, "Actually, we don't think there's enough evidence. However, what sickness rates, et cetera, are telling us is that this may be more than droplet spread", and we very much asked for that consideration to be given to those working in the ambulance environment, and that probably stretched

to anyone who was working in a community setting at that time but particularly for us at the college.

Our members were incredibly anxious, particularly as the fluid -resistant surgical masks did not feel like PPE at all and the aprons that they were wearing were not conducive to the environment. So you might come out of that, the patient's home or care setting, and the apron would blow up into the paramedics' faces, so anything that was on the surface of the apron was then blowing up into clinicians ' faces, which seemed wholly inappropriate, however the virus was spreading.

So it didn't -- we felt the guidance didn't really account for that and no one had really seemed to think about that environment that people were working in. where they're in a patient's home -- you know, they could be collapsed in a toilet, for example, or a really small space in their home and there is no way that you could ventilate the areas that paramedics were seeing patients in.

20 Q. Thank you. We heard evidence last week from another 21 organisation which was of the opinion that, in the 22 absence of evidence, guidance should have required the 23 highest levels of protection in accordance with the 2.4 cautionary principle. This is a view that's shared by 25 the college; is that correct?

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A. Absolutely, and what we weren't saying is that everybody should always wear FFP3 and Tyvek suits. That's not what we were saying. What we were asking for is to say that the fluid—resistant surgical masks are sometimes not enough and where our crews, who are autonomous registered professionals, are able to make a risk assessment, then they should without question be able to upgrade their PPE to a higher level in some of those circumstances I describe.

And there are plenty of other examples where

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And there are plenty of other examples where a paramedic may want to wear greater protection because of, you know — for example, a patient with asthma who is being nebulised, for example, there's a lot of exchange of air, it makes patients cough — it's very dry on the throat, it makes patients cough, and particularly around things like cardio—pulmonary resuscitation. So there were many occasions where we wanted the precautionary principle to be considered until there was more evidence available.

As that evidence became available, we were very willing to then look at that evidence and say, "Does that mean that we can reduce the level of respiratory protective equipment in those cases or actually is it best to keep the protection high?", because, if you don't keep the protection high, not only do you risk

- infecting the staff and the patients, if the staff become infected to a greater degree, the workforce dwindles to a point where you run a very lean service and possibly not be able to cope with the amount of calls that are coming in. So it was very much thought about a broad range of reasons about why precautionary principles should be considered.
- Q. Thank you. You touched on cardio-pulmonary resuscitation. I wanted to ask you about that because that's something that presumably paramedics might deal with more than other clinicians. I understand from paragraph 35 of your statement that prior to April 2020 CPR and intubation were both regarded as aerosol-generating procedures or AGP but after that point they were removed from the UK-wide AGP list. What are the views of the college regarding this reclassification?
 - A. "Bemused" I think probably would be my best description because we couldn't see how the evidence correlated with the removal from the AGP list. We saw there was one paper that was continually put out by Tranital in 2012 which was based on a hospital patient's a set of hospital patients who were paralysed and anaesthetised and the aerosol—generating procedures were measured there. They're not the patients that paramedics are

dealing with. They're very often sudden cardiac arrests, and I have to say paramedics saw many more cardiac arrests during COVID than they have probably seen in their careers up to date because people were so unwell and collapses were so sudden and swift that people weren't anaesthetised and paralysed in a way you might find in a hospital, therefore you couldn't control where the patient had collapsed and that might be in a really poorly ventilated space. And it just felt — you know, when you are dealing with advanced airway management, chest compressions and defibrillation, it just didn't feel like that had really been considered in the environment.

We didn't find any evidence, weren't aware of any evidence, that we could draw upon to say definitively that the AGPs should have been removed from the list so we were asking for them to remain until such time as more robust evidence was provided.

- Q. Yes, thank you. What were the unique issues faced by
 your members in relation to administering CPR and in
 part in relation to PPE, when to wear PPE, what type of
 PPE but also, separate to the issue of PPE, what issues
 arose for paramedics specifically?
- A. So it's multi-factorial and very difficult both morally,
 ethically and you know, to be able to provide

treatment. So, as I said earlier, the undifferentiated nature of 999 calls means you could think you're going to a fall, for example, and find out that actually that fall is someone who has collapsed but they're in cardiac arrest. So the crew then have to make a very quick decision and the guidance that was offered at the time was that if you find yourself turning up to someone, a patient, who is unfortunately in cardiac arrest, then the first crew member should go out in type 2 PPE, which is the fluid—resistant mask and the gown, start CPR procedures, while the other crew member dons level 3 PPE, so FFP3 and a suit, and then comes over and takes over, allowing the first crew member to go back and upgrade their PPE.

So morally that's really difficult because many, many of our members said, "It doesn't feel right to delay time to the side of the patient by putting the PPE on to determine whether they are in cardiac arrest", et cetera, and I am very confident in saying to you and this Inquiry that many of our members went to people's sides without any PPE at all, with no protection, because the drive to support and resuscitate the patient is overwhelming. What that does, though, is it creates a sort of moral injury for paramedics, who then recognise that they may be dealing with a patient who is

paramedics are 25 recognise that they may b

COVID-positive, they've then exposed themselves to the 2 virus and they may then have to go home and, you know, they risk passing that on to their families. 4

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So I think the lack of understanding about what was best to do made our members and I think probably all paramedics and ambulance clinicians very, very anxious, that they weren't letting the patient down, that they were doing the absolute optimal best for their patients in every situation but also that recognition that they had to protect themselves, particularly if it was in a poorly ventilated state. I think —— I wouldn't underestimate the impact of that sort of situation on the mental health and well-being of our patients -- of our staff and our patients.

But also, if a patient had collapsed at home, the crew may well have needed to take that patient in, and normally you would extend the family coming with you so that there is closure for that family or there is the opportunity to see the work that's ongoing on the patient, that you're trying your absolute best, and, because of lockdown regulations, family members could not travel with the patient whilst CPR was ongoing. So it is multi-factorial.

2.4 Q. Thank you. I want to ask you about do not attempt CPR 25 decisions. Do you know whether your members noticed

- 1 a rise in the number of people in respect of whom DNACPR decisions had been made?
- A. I couldn't say definitively for that. What we did know is that we're very used to seeing do not attempt CPR 5 forms and, you know, legislation around that with 6 patients. What our members were finding during COVID is sometimes people had deteriorated so rapidly that none 8 of those conversations had happened so that there was no documentation or paperwork in place. But I couldn't say 10 definitively whether we saw more of those than not. 11 I can find out for the Inquiry after this session. 12
 - Q. Thank you. Where they discovered that such paperwork or decisions weren't in place but to them it seemed that it might be appropriate, were they left to have that conversation with the family or would they just attempt CPR?
 - A. Crews would always start CPR. There is always -- the time on to the chest is so, so important. So the conversations may well have started to happen once the history of the patient's collapse then came to fruition. So if there had been a patient who had been extremely unwell, who had multiple issues with their health, who had shown deterioration over many days or weeks, the family may then, at that stage, bring up the case of actually they don't want their loved ones resuscitated

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and then the paramedics and the clinicians have to make 2

- a really difficult decision about taking people into
- 3 hospital, given the fact that there is this virus that
- 4 is, you know, creating a huge issue. So very difficult decisions to be had at the scene of a cardiac arrest.
- That happened much more frequently than I think any of
- 7 our members had ever seen before. But if there was ever
- 8 any doubt about resuscitation, paramedics would
- 9 absolutely resuscitate and take to hospital.
- 1.0 Q. Thank you. I wonder, can you tell us, can paramedics
- 11 access a system that has a record of DNACPR decisions or 12 are they reliant on a note being visible within
- 13 someone's home or a family member telling them about it?
- 14 A. It can be inconsistent. Sometimes the access of
- 15 information, certainly in remote or rural areas, is 16
- tricky and it's not consistent, so the proof normally is
- 17 to see something that's normally left with the patient 18 through a number of healthcare professionals -- it could
- 19 be the GP or the community nursing team -- and there
- 2.0 would be evidence there that the crew could find easily.
- 21 Electronic access to information isn't always
- 2.2 consistent.

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- 23 Q. Okay. Thank you. You state in the last sentence of 2.4 paragraph 40:
- 25 "We understood from our members that they felt very

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1 strongly that they should be trusted to make their own decision about appropriate PPE." 2

> What happened if a member, if a paramedic, wanted to use more PPE or PPE that offered a higher level of protection?

- 6 A. We found that there was a minority of our members who 7 gave some quite harrowing accounts that, if they had 8 made a judgment on scene to use higher levels of 9 respiratory protective equipment, that when they 10 returned to a station $\,--\,$ it may not be their own but to 11 a place where they could restock -- they were often 12 challenged around why they had -- what was the job that 13 they'd been on that required them to use the higher 14 level of respiratory protective equipment and sometimes 15 the members told us that the equipment was actually 16 locked away. So they couldn't access it unless they had 17 given a rationale as to why they'd used higher RPE when 18 the guidance said that you should be okay using 19 a fluid-resistant surgical mask.
 - So that was very incongruent to us in terms of -- as I say, paramedics are registered autonomous pre-hospital clinicians and if they make a dynamic risk assessment about a situation, then they should be trusted to do so rather than chastised for doing something that they feel is better placed for them in that particular situation.

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Q. Yes, thank you. Now, we've heard from other organisations that the burden created by the pandemic led to burnout and a reduction in their memberships as 4 people left their professions. I understand from paragraph 46 of your statement that this is also the case in respect of paramedics; is that correct? 7 A. Yes. 8 Q. Did your members feel under-appreciated? 9 A. Certainly in the -- we did two surveys with our Scottish 10 members and that came out as a common theme in both. We 11 did one survey very soon after the pandemic —— the 12 lockdowns finished and one relatively recently, and they 13 did feel that the -- they were undervalued, and that 14 certainly left many people -- the members who we have 15 lost certainly seemed to be in -- they're not even at retirement age. You know, these are people who may have 16 17 been in —— for 10 or 20 years within paramedicine and 18 who, through COVID, have just decided that this is no 19 longer for them. And there may be a number of factors 20 that add to that, but certainly just that feeling of 21 being under-appreciated and not well cared for and, you 22 know, having managers that showed that compassion, you 23 know, in areas did affect our members. They told us that very clearly. 25 Q. Can you tell us about the wider impacts of low morale

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1 and the decline in paramedic numbers?

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A. The low morale manifested itself in a number of ways, so that sort of value of coming to work and being able to do a good job lessens and what we see is the absence for anxiety, sickness and depression has increased exponentially compared to pre—COVID levels. We also have seen a number of paramedics who are accessing specialist services for their mental health and well—being and really not wanting to continue in this career. What's changed, I think, through COVID is people were leaving beforehand — not in the same number, but they were going into other areas of health or care — and now our members are just leaving health altogether and sometimes taking either early retirement or doing very, very different roles outside of health or care, which is not something we'd seen before.

Likewise, you know, we need a pipeline of paramedics. It's a three—year degree programme and we need the wisdom and experience that our paramedic workforce has to stay in the ambulance sector to be able to nurture the newly qualified paramedics coming through the system, to be able to pass on that wisdom and experience so that patients get the best care possible.

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experience so that patients get the best care possible
 Q. In paragraph 51 you state the Ambulance Service had
 a target of 15 minutes to hand over a patient to the

emergency department with a delay of 30 minutes being considered indicative of a problem with the system. And in paragraph 52 you state:

"An average handover during [the pandemic] would perhaps be between four and six hours ..."

And in a subsequent paragraph you state that
In January 2020 [sic] delays reached between ten and 12
hours in freezing conditions. Are these Scottish
numbers or are these UK—wide averages?

A Some of them are Scottish numbers. It's really

A. Some of them are Scottish numbers. It's really difficult to extrapolate one — you know, the UK—wide and the Scottish numbers. But we know from our members in Scotland that some of the hospital handover delays still remain. They were prevalent during that period of COVID and that — where paramedics found themselves — as I said, there was paramedics working in a box on wheels and they found themselves sitting with those patients waiting for much more time than they had ever experienced before.

So you tend to find that some hospitals have -- incur more delays because of either the way the estate is laid out or the staffing numbers at the receiving hospital or that ability for hospitals to create flow through the system, and also the discharge of patients into community care afterwards can back up the delays at

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hospital. But we know even today in Scotland there are ambulance handover delays and that's no different to during COVID, and it is something that has become normalised in our view that shouldn't be.

Q. Thank you. Do you know whether the numbers reflect both

6 adult and paediatric handover times?

7 A. Yes, to the main extent the ratios haven't changed at 8 all. What our members were reporting to us and some of our Scottish members -- I remember a couple of anecdotes 10 where they had pre-alerted patients into hospital, one 11 was a child and one was an adult, and a pre-alert means 12 that you advise the hospital in advance that you're 1.3 coming in with someone who is quite poorly and you use 14 blue lights and sirens to make your way to the hospital 15 in a much more expedient way. And normally, when you 16 get to the hospital, they're waiting for you and ready 17 and have a space, et cetera. And both of these members 18 from very different areas of Scotland said, "There was 19 no space and we had to -- despite blue-lighting in, we 20 had to wait outside until space did become available". 21 and that's just not normal at all. The crew have made 22 a decision that someone is so very poorly that they need 23 to get to definitive care urgently and that lack of 24 ability to then take that patient in when clearly 25 they're still suffering from a medical emergency is

1 unprecedented. 2 Q. In your opinion, why did this become the case? Why did waiting times increase so much or handover times? 4 A. I think again it's a multi-factorial issue. I think initially during COVID the demand for ambulance services 6 dropped -- you know, Scotland as well, that showed no 7 difference from the rest of the UK at that time. Then 8 gradually the demand has built and built to the levels 9 we're probably seeing today and sometimes the demand $--\,$ 1.0 if you look back three/four/five years, you could say 11 the demand has almost reached those normative levels but 12 what's changed is everything else around it. So you may 13 find that there's less workforce both in the ambulance 14 sector and the ED and the rest of the hospital; there 15 may not be the money that's required to put the 16 community packages in place for people to be discharged 17 appropriately: and when people are discharged, sometimes 18 our members have reported that they're going back to 19 conditions that are less than optimal and people are --20 I think it's common knowledge that people are in 21 hospitals for far too long -- far longer than they $\,$ 22 should be. So it's multi-factorial, but what ends up is 23 a bottleneck at the emergency department and therefore 2.4 the ambulance is queuing outside which then means the 25 ambulances aren't available for the 999 calls in the

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- 2 Q. Does the college have any views on what might have helped with keeping handover times shorter?
- 4 A. I think what I would say worked really well for our 5 members in Scotland during COVID was the ability to 6 access senior support, so the sort of normal barriers that might have prevented that all seemed to sort of 8 melt away during COVID, thankfully, and crews were able to access maybe consultants in a specific area who they 10 could have a chat with whilst on scene with a patient to 11 say, "Does this patient really need to come in?", and 12 they may have a plan put in place that meant the patient 13 could stay at home, didn't need to come into hospital, 14 or speak to senior decision—makers within the 15 Ambulance Service themselves to make some of those 16 decisions or indeed use sort of technology to view the 17 patient before a crew had even got there. So some of 18 that system seems to have gone.

I think Scotland are definitely keeping some of the technological aspects in place, which I think is an exemplar for the rest of the UK. But it is that -- you know, I think there's probably about a 47% to 49%transportation rate for ambulance services right across the UK where not everybody comes into hospital anyway. So it's not that every patient is going in, but those

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patients that do need to go in probably need 2

risk-stratifying with all involved in their care to say,

"Is hospital the right place?", and if it is, then 3

4 obviously they need to go. If they can be helped and held in the community, then that's probably much better

for the patient and for the Ambulance Service and

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8 Q. Thank you. What were the consequences for paramedics of 9 such prolonged handovers?

1.0 A. So initially there was obviously the fear of the virus 11 itself. So, you know, paramedics would be sitting with 12 a patient for hours on end and what their concern would 13 be is -- of course that the virus, you know, had its own 14 anxiety, but the ambulances are not built for 15 a comfortable, prolonged time in them and patients do 16 not anticipate sitting in the back of an ambulance for 17 hours on end. So there is a health and well-being 18 aspect for both parties in that sense, and certainly for 19 newly qualified paramedics, you would anticipate seeing 2.0 a number of patients per shift and sometimes crews were 21 seeing one patient and sitting with that one patient 2.2 from the start of their shift to the end of their shift 23 and, in really extreme cases, crews were being sent to

> another crew would take over so that that crew could go 87

relieve the first crew at the end of their shift and

1 home. So we were dealing with situations we had never 2 encountered before, certainly from a member perspective.

- Q. And do you think that issue impacted the time that 4 people had to wait for ambulances to arrive with them?
- 5 A. Undoubtedly, because if the ambulance —— if the mode of 6 transportation is tied up, then, you know, you're very 7 much reliant on speaking to someone on the phone or 8 trying to use technology to access that patient if they have the option to do so. And I absolutely understand 10 patients were, you know, frustrated, anxious, frightened 11 and sometimes downright furious that they had expected 12 an ambulance to come quickly and sometimes patients were 13 waiting for hours for ambulances and the next crew that 14 were available to go to that patient may well have faced 15 sort of verbal and sometimes unfortunately physical 16 abuse as a consequence, but it's understandable that 17 patients are calling for an ambulance with absolute 18 expectation that one will arrive in a timely way, and 19 that couldn't happen.
- 20 Q. In paragraph 54 you state that during the pandemic it 21 became common practice for hospital staff to check on 22 patients in the back of an ambulance to see if there was 23 any deterioration. You state that at times they would 24 even have diagnostic tests done, then be returned to the 25 ambulance to wait for results. Again, did this apply

- both in adult and paediatric cases?
- $2 \quad \text{ A. Less so in paediatric cases from our members' statements} \\$
- and surveys, but certainly for adults. If children and young people were a low priority medically, then it
- 5 could happen and did happen on very rare occasions, but
- 6 most of the time this was for adult patients.
- Q. Was this down to a shortage of beds within a particularhospital, when they were then being taken back out, or
 - lack of waiting areas even --
- 10 A Yes --

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- 11~ Q. -- and were paediatric hospitals better resourced in
- 12 terms of those areas?
- 13 A. I think sometimes it was both. Again, the normalisation
- $14\,$ $\,$ of ambulance handover delays are the corridors and, you
- know, the corridor care is really not popular. It's not
- optimally sufficient for patients. You can't monitor
- them as easily and, you know, they're not in the sight
- of the emergency department's staff. I guess if you're
 - in ED and you know that at least the ambulance crew are
- 20 with the patient and monitoring them for any
- 21 deterioration, that's the least worse scenario. But the
- 22 children certainly seemed to have a quicker ability to
- 23 be able to be placed somewhere in the hospital, you
- $24\,$ know. I think it's -- you know, whether it's right or
- 25 not, I think children and young people certainly stick

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- $1 \hspace{1cm} \text{in people's mind very much, that they don't want them} \\$
- waiting outside unless there's something like a they consider a sprain or a strain, where actually it's not
- 2 Consider a sprain of a strain, where actually it
- a medical emergency but they do need to rule out
 a fracture, for example, and then they might just need
- 6 to wait a short time until they can get x-ray available
- 7 and some space. So it was a complex situation.
- and some space. So it was a complex situation.

 8 Q. Thank you. You mention in your statement there that
- leaving someone with a fractured neck of femur in the
- back of an ambulance for hours doesn't improve their
- outcome, and that's one example. Does the college
- consider that patient welfare and care standards were
- 13 compromised as a result of these delays?
- 14 A. I couldn't say anything different, I don't think.
- 14 A. I couldn't say anything different, I don't think.

 15 I think they absolutely were compromised despite
- 16 everybody's best intentions. You know, I think
- patients' perception was that they would be taken to
- hospital and moved into the hospital and, you know, find
- 19 a space there where they would be cared for. I don't
- 20 think -- in terms of the compassion of the care that was
- given, I don't think the standard of that was dropped
- anywhere, either in the back of the ambulance or in the
- ED, but I think physically , you know, and in terms of patient outcomes, it will undoubtedly have had an impact
- 25 on patient care.
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- $1\,$ $\,$ Q. Thank you. We've heard from some that they were told or
- had an impression that ambulances were told not to take

that your members reported to you, being told not to

- 3 care home residents or people who had COVID to hospital
- $4\,$ $\,$ or to take them in their ambulance. Is this something
- 6 take people in either of those categories in their
- 7 ambulances?

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- 8 A. No, not -- from my recollection, there was one or two
- 9 members who had difficulty around care homes, but it
- 10 certainly wasn't normally from the college
- 11 perspective, when you hear things multiple times across
- 12 multiple areas, you can tell that that's a theme or
 - a trend building. There was certainly concern about the
- care homes, particularly, you know, if people were going
 - back from hospital and discharged back into the care
- 16 homes, but coming in, what our members told us was that
- 17 they invariably had time to put on their PPE and, you
- 18 know, unless it was a medical emergency, they were able
- 19 to take their time and go specifically to that patient.
- 20 But certainly from a college perspective, we didn't hear
- 21 anything other than that.
- 22 Q. Thank you. In paragraphs 58 to 78 you talk about
- 23 communication and guidance. How much of a role did the
- 24 college play in interpreting and adapting guidance,
 - Scottish Government guidance, for paramedics?

- 1 A. Yeah, so I think the college recognised that we were
 - a smaller voice during COVID and it's understandable.
- 3 You know, I'm sure from a Government or an arm's length
- 4 body perspective, during this time there was a lot of
- 5 noise coming at them from a number of organisations. So
- 6 the college joined with an alliance of members,
- 7 including the British Medical Association, the Royal
- 8 College of Nursing, et cetera, and we were just trying
- 9 to get the same message across to everybody that had the
- ability to influence policy and decisions to say, "There
- are key things that we really feel need to happen. One is this precautionary principle for protecting our
- is this precautionary principle for protecting our
- 13 workforce and the other is to consider the procedures
- and environments that many of us are undertaking".
- So, you know -- for example, our cardio-pulmonary
- 16 resuscitation and the fact that, as new variants came
- $17\,$ through COVID, we were seeing sickness rates ebb and
- 18 flow with the new variants, and we were keen, as part of
- that alliance, that we had some very paramedic— or
- ambulance—sector—specific messages in there that could be landed with Scottish Government. And I think you'll
- probably see from my evidence that we've engaged in
- a number of conversations through letters with this
- alliance to try and get our message across.

 25 Q. Yes. When you contacted individuals in the

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3 A. I think there were only two responses that the alliance 4 received. That was it as far as I was aware. I think 5 everything has been shared with the college that was received back. There was nothing we received. 6 7 Q. How well do you think the college was listened to by the 8 Scottish Government and Government organisations? 9 A. I think on our own I would dare to say we weren't 10 listened to at all. As part of the alliance. I think 11 there was a consideration that there were professions 12 out there that, you know, perhaps needed some closer 13 scrutiny. But, you know, when you're dealing with 14 a pandemic, I have no doubt that it's incredibly 15 difficult to try and juggle everything at the same time. 16 But, you know, we felt unheard and our profession felt 17 unheard and, you know, what we could see was our members 18 living through this every single day, worried about 19 their families, you know, losing family members, losing 20 colleagues, and it just felt the imperative was so great 21 but we clearly didn't land our message in the way we 22 needed to 23 Q. Where members in the college considered that their 2.4 interests and welfare wasn't being adequately

Scottish Government to raise issues specific to

paramedics, what sort of responses did you receive?

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considered, did the college issue its own guidance to 93

1 members, for example, in relation to appropriate PPE 2 during aerosol—generating procedures?

A. We certainly did. We felt that having — we've got a Research Advisory Council and, certainly through integrating with them and with other stakeholders, we felt very strongly that members should have the choice to upgrade their RPE if they felt that was necessary through their risk assessment.

As I've said in my statement, the Royal College of Nursing provided a really helpful risk assessment process that we asked the Association of Ambulance Chief Execs to review and pass on and consider. But it was very much -- I think there was just -- we recognise we caused anxiety for our members and we knew that because we were saving something that countered what the initial IPC guidance said. But we didn't believe that the national IPC guidance had considered (a) the environment that paramedics were working in and (b) the growing evidence that was saying that there is an airborne element —— a very large airborne element to COVID that it just felt people weren't recognising and considering. Q. How did your members deal with the times where guidance from the college was different to guidance from other organisations and was the college able to step in and support them in potentially conversations with their

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employers?

A. I think it made people anxious and we certainly did
a study, the CARA study, which looked at three phases
during the pandemic, both pre peak of the pandemic, the
peak of the pandemic and just post the peak, where that
is one of the questions we asked because it is fair to
say that we recognised that we were saying something
that was counter to national guidance.

What we did was we said, "Here are ways that you can tackle this with your employer. Here is the evidence that we're looking at and you're very welcome to use that", and this is where we relied on some of our stakeholders, like Resuscitation Council UK, who had evidence around that as well. And what I was doing was meeting with the Association of Ambulance Chief Executives on a regular basis to say, "This is what we're saying, this is why we're saying it, and I need you to hear that that obviously makes your employees nervous, but surely there's a compromise and surely you can see why we're saying what we're saying and here's the evidence for it".

What I couldn't see, if I'm honest, was the evidence coming back the other way to say why they weren't moving their position on that. So we just felt it was right as a professional body to give our best opinion based on

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the research and evidence and we felt we couldn't do anything but that, recognising it would make people anxious.

4 Q. Thank you. In paragraphs 88 to 92 you talk about the impact on patients and paramedics. Can you tell us, did the suspension or — in your view, did the suspension or reduction in primary care and screenings affect the type of cases paramedics encountered?

9 A. Yes, I think the case mix of what paramedics were seeing 10 certainly changed and some of the -- what would be 11 traditionally primary care work, including things like, 12 you know, repeat prescriptions, for example, or trying 13 to access a particular service by default became 14 something for the ambulance sector, and I think -- you 15 know, the Scottish Ambulance Service I know tried really 16 hard to triage those calls out to try and -- you know, 17 didn't want to send an ambulance to those calls 18 necessarily because it wasn't ambulance-related and 19 didn't require an ambulance. However, sometimes -- you 20 know, people get very confused and will call because 21 they're not really sure what else to do and it's very 22 difficult to unpick that sometimes in a call. So some 23 of our members did end up going to calls that were 24 really not for ambulance transportation to hospital or 25 indeed ambulance related but ended up trying to be

1 conduits to services and sometimes spent a long time on need. You know, when, during lockdown, patients were 2 2 anxious and frightened and lonely in some cases and scene trying to access services that were very 3 difficult 3 concerned, paramedics didn't stop providing that care 4 Q. Thank you. What impact has all of that -- encountering 4 and, you know. I would really want the Scottish public 5 these cases and working in these situations, what impact to know that paramedics will remain with them now and in 6 has that had on the mental and physical health of the 6 the future despite whatever happens. 7 7 But I guess for me I would really strongly recommend 8 A. Again, I think it's multi-factorial. So there is --8 that the Inquiry considers the mental health and 9 I think sometimes some of our members felt that this was 9 $\mathsf{well}\!-\!\mathsf{being}$ impact on our profession. You know, we're 10 not within their skill set, not within their gift, to be 1.0 starting to see a reduction in those coming through the 11 able to help a patient with some of these queries. 11 pipeline for paramedicine and, as I say, people leaving, 12 There was frustration that the system seemed to be 12 and the retention of paramedics is going to become more 13 putting everything onto the ambulance sector and them 13 challenging. So just to address that mental health and 14 particularly . And sometimes people were very anxious --14 well—being of our members would be really important to 15 we saw right across the UK that some patients left it 15 me. But other than that, no, just thank you for the much longer than they would have done before they sought 16 opportunity to come and talk to you today. 16 17 help for specific conditions, which often made them much 17 MS BAHRAMI: Thank you very much for your time. 18 sicker by the time that the crew had got to them. 18 THE CHAIR: Yes, thank you, Ms Nicholls. Thank you very 19 But it's that frustration of not -- you know, if the 19 20 patient doesn't know where to go, the ambulance crew 2.0 Good. Again we're a bit early. I don't know if the 21 aren't necessarily going to know how to access some of 21 next witness is here. Do you by any chance know? 22 2.2 those services or get a repeat prescription, for example (Pause) 23 23 and, despite the best signposting you can give, if the It may be possible to start at quarter to but 2.4 services are running, you know, really thinly because of 2.4 I can't promise. I'm sorry. It would be good if we 25 25 their own workforce absences, for example, then it makes could, but it depends on the witness being here. In the 97 1 it very, very difficult . 1 meantime, thank you very much. Quarter to, but if not, 2 So there is a sort of psychosocial element to this 2 3 o'clock. (2.25 pm) 3 in that paramedics want to go out and do ambulance work, 3 4 they want to do the very best they can for patients who 4 (A short break) 5 are -- you know, have limb or life-threatening 5 (3.00 pm) 6 conditions who are requiring of their skills , and quite 6 MR EWING HOPE (called) 7 THE CHAIR: Good afternoon, Mr Edwards. Good afternoon, often now we see it's more around sort of primary or 8 8 urgent care conditions because I think the patient Mr Hope. population has changed in the way it wants to access its 9 MR EDWARDS: Good afternoon, my Lord. 10 health and care. 10 THE CHAIR: When you're ready, Mr Edwards. Q. Thank you. Now, I'm aware from your statement and 11 MR EDWARDS: Thank you, my Lord. The Inquiry will now hear 11 12 you've mentioned that the college carried out two 12 the evidence of Mr Ewing Hope, who is currently the 13 13 surveys of Scottish members to gather their thoughts on Chair of the Scottish Unite Health Committee. 14 issues such as mental well-being, PPE and guidance, and 14 Questions by MR EDWARDS 15 we'll consider the results of those surveys alongside 15 MR EDWARDS: Good afternoon, Mr Hope. 16 the entirety of your written statement and your oral 16 A. Good afternoon. 17 evidence today. Is there anything we haven't covered 17 Q. Can you give the Inquiry your full name? 18 today that you would like to highlight? 18 A. Ewing Hope. 19 A. I think I would just pay -- like this opportunity to pay 19 Q. You have before you a witness statement, I hope? 20 20 tribute $\,--\,$ you know, we lost paramedics, they lost their A. Yes. 21 lives through COVID doing a job they love, and I think 21 Q. Can you confirm that that is your witness statement --22 this is -- this seems an opportune moment to just pay 22 Q. $\,--\,$ and you've had an opportunity to read through it? 23 23 tribute to those, some of whom came out of retirement to

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A. Yes.

Q. Yes. Thank you.

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support the work that was required. And paramedics feel

very strongly that they're there in patients' times of

1 You agree to your witness statement being 2 published -3 A. Yes, I do. 4 Q. -- and also to your evidence today being recorded? 5 A. Yes. 6 Q. Yes, thank you very much. 7 My Lord, the witness statement of Mr Hope has the reference SCI-WT0443-000001. 8 9 Mr Hope, you have provided quite a substantial 1.0 statement for the Inquiry and I thank you for that. 11 There are a number of matters which have headings, the 12 first of which is in relation to PPE and the second of 13 which is in relation to infection control. The Inquiry 14 has heard quite a lot of evidence about various 15 difficulties with PPE around matters such as the availability or lack of PPE, what you describe as the 16 17 "sporadic" allocation of it once it was available and 18 then issues associated with the effectiveness of PPE. 19 Now, although I understand that this is very important, 20 because the Inquiry has heard quite a lot about PPE 21 problems, I'm going to take that part of your statement 22 auite auickly. 23 So in relation to the lack of PPE, what you say in 2.4 I think paragraph 9 of your statement is that things 25 changed from the start of the pandemic as the pandemic

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1 progressed. What you identify in paragraph 9 is a lack of PPE and then, as it started to become available, what 2 you say in paragraph 10 is confusion over PPE. Do you want to say a little bit more about that? What do you 5 mean by the "confusion" around PPE? 6 A. So in the early days of the pandemic the use and need

for PPE was not very well acknowledged within the organisations and therefore you had —— particularly as community staff were going into patients' homes on a regular basis and they didnae have the same access to PPE as those in an acute setting and therefore that became problematic.

Again, Government guidance was coming out to focus primarily on particularly patient closeness for the use of PPE and then we spoke about sessional use and about recycling PPE in the early days, which just didnae sit very well. So that distribution and availability was very, very low.

Employers, the NHS in general, wasnae really sighted on the need for PPE at that particular time as being a priority, although from a staff-side perspective, staff's safety was always our number one priority because, unless you can ensure staff safety, then you're going to have difficulty ensuring patient safety. So we were arguing it purely from a safety perspective and it

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was falling on deaf ears initially, but it got to the

2 stage -- and I make the point in the statement -- that

3 the staff side, both nationally and locally, made the

decision that, unless we could provide PPE and safety to our members -- we would advise them to do that risk

assessment and, if they felt endangered, not to be

7 providing services until they were in a safe position.

8 And that's when that changed in relation to the

9 organisation's priorities becoming the need to get PPE

1.0 because without that you werenae going to have services.

11 Q. Now, you were in a position to know about this because

12 you are the chair of the Scottish Unite Health

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14 A. Yes.

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15 Q. Can you say something about the Health Committee and vour responsibilities with it? 16

17 A. So the Health Committee meets in a normal process about

18 four times a year, which was every quarter, and it's

19 always in person. When the pandemic hit, I was the vice 2.0 chair at that particular time, but the chair wasnae very

21 well so I chaired most of the pandemic meetings. But

2.2 because we were using Zoom and media platforms, it was

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far, far easier to get meetings. So during the pandemic

2.4 we were meeting on a regular basis. Our

Health Committee is made up of representatives from

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1 every health board and every special health board, so

you've got that and, because of the nature of Unite, the

3 diversity amongst the committee, you can go from -- our

membership rather -- you can go from a domestic to

5 a director or from a cleaner to a consultant because

we've got such a wide ... so we've got that breadth of

knowledge within the Health Committee so that -- we've

8 got a rich dialogue about what was taking place and what

was really missing.

10 Q. Now, the Health Committee is a national body --

11 A. It's a Scottish body.

12 Q. $\,\,--$ a Scottish body, yes, but you have particular

1.3 responsibility and specific knowledge in relation to the 14

Avrshire and Arran Health Board --

15 A. Yeah, so within the NHS structure, Ayrshire and Arran,

16 we've got 15 different trade unions. Every four years

17 we elect a staff-side chair, who then gets appointed to

18 the board through cabinet secretary, and you assume the

19 mantle of employee director, which gives that individual 20

more access to more senior management team meetings and 21 dialogues. So the range from a normal rep to where

22 I was sitting at was far, far different.

23 But the other part and my role during the pandemic 24 was to make sure that I had regular meetings with

25 collective staff side within Ayrshire to provide

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- guidance and instruction but also to hear their concerns 2 so as I could feed it back through that management 3 structure and then back up into board. 4 Q. At paragraphs 12 and 13 of your statement — I make that 5 link between your role in the Scottish committee and your work with Ayrshire and Arran because in 6 7 paragraphs 12 and 13 you describe what you call "Bronze 8 Groups", which were set up within Ayrshire and Arran, 9 whose role it was to make sure that there were regular 1.0 supplies of PPE coming in. Now, the bronze group, is 11 that something particular to the Ayrshire and Arran 12 Health Board or -
- 13 A. No, that was the command and control structure. So you 14 had Gold Command, which was your emergency management 15 team, then you had your Silver Command, who was at an operational level within senior management, and the 16 17 bronze groups were more working groups, if that 18 clarifies it, so they had that responsibility to do the 19 work that was required to access PPE.
- 20 Q. But the structure was not just particular to Ayrshire 21 and Arran?
- 22 A. No. that was a Scottish-wide structure.
- 23 Q. But in paragraph 13 you say that Ayrshire and Arran set 2.4 up PPE champions.
- 25 A. Yeah.

- 1 Q. Was that something that was particular to Ayrshire and A. I think initially it was but that was rolled out to the 3 rest of the country.
- 5 Q. And what was the main purpose of the PPE champion? 6 A. Certain groups of staff within a health setting will have used PPE on a regular basis. The majority of staff 8 will use certain parts of PPE, like the gloves or aprons, but the masks, gloves and aprons have to be
- 10 donned and doffed in a particular way to prevent infections for the individual so that training for staff 11 12 on how to don and doff PPE was really, really important 13 because that again reduced the risk of transmission of
- 14 COVID 15 Q. In paragraph 15 of your statement you use an interesting
- 16 expression, which is that, "Staff became PPE exhausted". 17 Do you want to say more about that?
- 18 A. If you go back to the original statement I just made, 19 the majority of staff will use certain parts of PPE, but not on a regular basis . So staff were getting -- when 20
- 21 I say like they became "PPE exhausted", what I mean is 22 that the donning and doffing would probably slip, with
- 23 the inappropriate(?) use of PPE, doubling up of gloves,
- 24 et cetera, so staff were -- the guidance was changing so
- often that it made it difficult for staff to follow the 25
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- guidance every time. But the longer the pandemic went 2 on, staff became more and more -- and I will use the 3 word "exhausted" by the use of PPE because it was
- 4 a strain on them
- 5 Q. Later in your statement you talk about problems with
- 6 training during the pandemic.
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- 8 Q. Were these problems also -- did they also exist in 9 relation to the use of PPE?
- 1.0 A. Initially they did but we —— and I go back to that
- 11 statement about the infection protection and control 12 teams, so they were primarily our PPE champions, so we
- 13 were taking them away from one part of the organisation
- 14 where they were needed to undertake training for staff
- 15 in the wards and in the clinics .
- Q. Yes. Then, in relation to masks, like many other 16 17 witnesses you identify various problems with
- 18 availability of masks and then the effectiveness of
- 19 masks and expiry dates.
- 20 A. Yeah.
- $21\,$ $\,$ Q. Anything more that you want to add about that in
- 2.2 relation to masks in particular?
- 23 A. The masks thing -- and, again, if you take the FFP3
- 2.4 masks, which were face-fitted, and you have to go
- 25 through a certain process and it's timely, but to make

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- 1 sure that that mask has got a real close seal and you're
- 2 not going to be breathing in anything from the sides of
- it. But the problem with them is that they were based
- 4 on male faces -- so the majority of the workforce are
- 5 female and therefore getting face-fitting masks for
- 6 smaller-faced females was really, really problematic,
- and if you couldnae get that face-fit, then you had to 8
- move your role to where you could use an FFP2 mask.
- What that meant is you're taking really experienced
- 10 staff from one part of the organisation which they're
- 11 highly trained in, particularly in the ICU and the HDU, 12
- and moving them into other parts of the organisation. 13
- So that skill mix gets impacted upon by our ability to 14 ensure patient safety or staff safety through the
- 15 correct FFP3. So that became problematic.
- 16 The fact that initially everybody in the country was 17 looking for the same suppliers of face masks, 18 particularly FFP2 -- and that became problematic because
- 19 again everybody's fishing in the same pond for the same
- 20 commodity. So they started importing it, and one of the 21
- masks that came in -- it was called a "tiger mask". 22 I believe it came from China —— so rather than having
- 23 the elasticated loops for the ears, it had the ties.
- 24 which was stuff you used years and years ago, and what 25
 - that meant is there were huge gaps at the sides of the $\,$

masks and they just werenae fit for purpose and provided 1 no protection. 2

Staff were told unceremoniously that that's what they had and they had to use it, and it wasnae until the trade unions stepped in to say, "These are unacceptable. These have got no impact on staff safety and therefore, if that's what we're going to be using, we go back to that risk assessment and whether staff was going to be able to provide the services that you require us to provide", and that's when we got rid of the tiger masks and put back into the supply of elasticated loops.

- 11 12 Q. Yes. Then in paragraph 20, you make -- well, you've 13 just made it, but just to be clear that I've understood 14 correctly, you make a point about not so much the 15 availability or lack of PPE being a problem here but the 16 effectiveness and the ability to wear it effectively led
- 18 A. Yes.

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Q. -- and so you could get ICU -- that's intensive care 19 20 unit -- nurses, because they can't use the PPE properly 21 or the face mask because of their physical building, 22 being allocated to other areas?

to deployment issues --

- 23 A. Yeah, so you take them from that area where that is 2.4 a requirement, because they're doing aerosol—generating
- 25 procedures, and putting them up into a ward where

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- there's still very ill patients, but again it's the 1 skills they have for ICU which is slightly different or 2 considerably different from the skills in the ward-based
- 5 Q. Is it fair to say, then, that some of these PPE problems 6 led to staff being deployed not necessarily according to 7 their skills?
- 8 A. Yes.
- 9 Q. Is that right?
- 10 A. Yes, absolutely. That's the point I'm making because again it's providing the staff with a safe environment 11 12 from which to deliver their services.
- Q. As I'll say at the end -- of course the Inquiry will 13 have the benefit of your whole statement -- but before 14 15 we leave PPE, is there anything else you would want to 16 say about PPE and the issues that arose during the 17 pandemic?
- 18 A. We weren't prepared as a country for COVID and we 19 certainly werenae prepared as a health service. So if 20 you watched what happened in Wuhan -- and we could see 21 it on a daily basis on our TV sets -- and what happened 22 in North Italy, we knew it was coming in our direction, 23 but that preparation to ensure staff safety never 24 crossed our leaders' minds effectively. And it wasnae
- 2.5 until the staff side raised issues about staff safety

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- that they then became a priority because the reality is 2 we focused on emptying hospitals rather than providing
- a safe environment for our staff and our members. So
- I think that -- for me, that was one of the biggest 4
- downfalls. We knew it was coming but we were not
- 6 prepared.
- 7 Q. Thank you. The next two sections of your statement
- 8 begin at paragraph 21 and the first one of them is about
- 9 infection control or infection prevention and control, 10 as you call it --
- 11 A. Yes.
- 12 Q. -- and the second is about RIDDOR. Just to be clear,
- "RIDDOR" stands for the "Reporting of Infectious [sic] 13
- 14 Diseases and Dangerous Occurrence Regulations".
- 15 A. Yeah.
- Q. So we will refer to that as "RIDDOR". If we begin with 16
- 17 issues around infection prevention and control, in
- 18 paragraph 21 of your statement you focus in on what you
- refer to as the "Proper Assessment Group". 19
- 20 A. Yeah.

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- 21 Q. Yes. Now, can you say something more about that?
- 22 A. So if you get an outbreak within a hospital setting,
- 23 then we set up a PAG -- the Proper Assessment Group --
- 2.4 or the other word -- terminology would be an "incident
- 25 management team", which brings together senior

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- 1 clinicians staff side, nurses, doctors, infection
 - control, large estates. So we look at the primary case
- first and then we follow that individual through the
- 4 hospital, and you can tell what room they've been in,
- 5 who their nurses were, where they were at a particular
- 6 time, so you can follow the patient's journey. What
- that allows you to see is where the transmission would
- 8 take place because then your second cases and third
- cases would go on respectively where you could see the
- 10
- 11 Because infection rates were so high and outbreaks 12
- were so high, we initially were running IMTs, but it 13 became so busy that we were unable to and therefore that
- 14 learning of how the virus spread through a health
- 15 setting, we lost that opportunity. So rather than
- 16 investigating it, we were getting it reported twice
- 17 a week through our COVID Oversight Group.
- 18 Q. So the first distinguishing feature of a PAG, a Proper
- 19 Assessment Group, is that it focuses on when a patient
- 20 comes into the hospital with an infectious disease and
- 21 the exercise allows the hospital to identify where
- 22 they've been --
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- 24 Q. -- and who may have been in contact with them. So what

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25 you're saying in paragraph 22 of your statement is that,

in the early stages of the COVID pandemic -- and in this 2 regard you're only speaking about Ayrshire and Arran 3 Health Board -- they did carry out the PAG exercise? 4 A Yes 5 Q. -- but that fell apart? A. Fell apart, because there were just so many. So outbreaks became normalised and it was reporting of 8 outbreaks rather than investigation of outbreaks. 9 Q. And then in paragraph 23 you refer to what substituted 10 PAG; yes? 11 A. That was the Oversight Group, which was effectively 12 infection prevention and control teams collated the 13 numbers and the dates, et cetera, and brought them to 14 the Oversight Group so as you could see where each 15 outbreak was, in which ward, which hospital, et cetera, and how many staff were infected and how many patients 16 17 were infected. But that deep-dive investigation into 18 how it took place or how it was created, we lost that 19 ability, but I think that weakened our fight-back or our 20 responses to the COVID infections. 21 Q. The weakening being that --22 A. We were fire—fighting rather than being preventative. 23 Q. Well, you weren't able to identify where in the 2.4 hospital -25 A. Yeah.

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- Q. -- it was located, yes. 1 2
 - What do you say should have been done then?
- 3 A. I think we should have had a dedicated team who looked purely at COVID outbreaks and did that deep dive and 5 followed the patient's journey so as we got an
- 6 understanding of where the transmissions took place
- within the hospital setting not only for the patient but 8 also for staff because, again, it's about that staff
- interaction with COVID-positive patients, and you could
- 10 follow the journey but you could also break the spread 11 if you knew where it was taking place.
- 12 Q. Now, turning to RIDDOR then, which you begin talking 13 about I think at paragraph 24 of your published
- 14 statement, the contrast with a Proper Assessment Group
- 15 exercise and a RIDDOR exercise is what?
- 16 A. So the PAG would look at the infection within the
- 17 department, the ward, and it's patient-based. RIDDOR is
- 18 looking at the impacts on staff and where staff
- 19 contracted or came into contact with COVID; two
- 20 completely -- although they're joined, they're two 21 separate investigation purposes.
- 22 Q. Right. So the focus of the RIDDOR exercise is to
- 23 identify staff who have been exposed?
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- 25 Q. And what happened to RIDDOR exercises during the

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pandemic -- well, at the beginning, the start, of the pandemic?

- 3 A. My understanding is that the Health and Safety Executive
 - made the decision that COVID-19 was a community-based
- transmission and therefore they did not expect to see 6 RIDDOR as a result of it being in the workplace, which
- 7 made little sense considering, as soon as you brought
- 8 the community into the workplace and our setting, in
- 9 a healthcare setting, then that became the transmission
- 1.0 zone. But that was never rescinded. 11
- Q. Just so I understand, what you're saying is that 12 a RIDDOR exercise was about identifying contamination,
- 13 for want of a better word, in the workplace -
- 14 A. Yeah.
- 15 Q. $\,--$ but, as you recollect it, according to paragraph 25
- of your statement, the Health and Safety Executive 16
 - issued guidance that RIDDORs were not to take place --
- 18 A Yes

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- 19 Q. -- in relation to workplace spread?
- 20 A. They didn't expect it because it was a community-based 21 transmission and not a workplace issue.
- 2.2 I believe, having looked back historically, that
- 23 probably was based on the very first cases within the UK
- back in January 2020, where Public Health England
- 25 published -- their finding was that this was very low

- 1 risk to healthcare staff and it was a community-based 2
 - and it was a moderate risk within the communities. So
- that early findings I think swayed one or two other
 - outcomes as we moved through.
- 5 Q. To use a word you've used previously -- I think it 6
 - emerges from about the middle of paragraph 25 of your
- 7 8
 - RIDDORs were sporadically carried out.
- 9 A. Yes. So if you have a staff death, then it's an
- 10 automatic RIDDOR within the workplace. When you had
- 11 some more high-profile cases and we had -- one or two of
- 12 them was within the NHS Ayrshire and Arran -- then that drove the need for a further investigation and therefore 13
- 14 that then uncovered the need to make a RIDDOR report.
 - So there are one or two.
- 16 NHS Ayrshire and Arran were probably the highest
- 17 health board in the country to submit a RIDDOR during
- the COVID pandemic and, again, I think that was due to 19 staff side, who were constantly arguing about the need
- 20 for RIDDORs and the need for staff side to be involved
- in these investigations, which we weren't, but we
- 22 continually made the argument about the need for
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- 24 Q. So although the Health and Safety Executive, as you

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25 recollect it, indicated that there were not to be

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I've got no doubt there was a financial part to that RIDDORs, still some took place? 2 A. Yes 2 decision—making process. Q. And that would be when there was a death; is that right? 3 Q. At paragraph 29 of your statement you discussed some A That's an automatic RIDDOR or -alternatives that were considered at the time to Q. Death of a staff member? identifying the source of transmission in hospitals. So A. Death of a staff member. So RIDDOR is purely about 6 do you want to say --A. So this was round about 2021, just after the Christmas staff , so -- and again it's about that -- forcing the 7 8 issue by staff side in general about the need for period and the second lockdown, and infection rates were 8 9 RIDDORs, that we did win some of the arguments and some 9 getting higher and higher and higher and Government had, 10 1.0 of them we didn't unfortunately. for some unknown reason, decided that, in their opinion, 11 Q. It's also true —— in paragraph 26 of your statement, you it was because staff were infecting patients and 11 12 say that, as you remember it, the first RIDDOR that was 12 therefore they set up a Compliance Taskforce Group at 13 submitted in Ayrshire and Arran was where there were 13 the request, I'm led to believe, by the 14 multiple deaths in a coronary care ward in one hospital. 14 Cabinet Secretary, who was Humza Yousaf at that 15 That was patient deaths, was it? 15 particular time, to look at how we could identify either A. That was patient deaths. 16 staff to staff or staff to patient transmissions. And 16 17 Q. So what prompted the RIDDOR in that case? 17 there was a clear inference that there was staff who 18 A. That was one of the high-profile cases, plus all staff 18 were transmitting the virus within the hospital setting. 19 who care for patients are really protective and care 19 When they came and had -- and again I was there 20 deeply about their patients, and the staff in this 20 representing actual staff side -- when we first met, 21 instance who -- unless we did that deep-dive RIDDOR, 21 I asked to show what evidence they had, what information 22 that focus of that potentially it was the staff who 2.2 they had, to suggest this is how it was taking place 23 infected the patients and therefore they caused the 23 because, if there was a lack of investigations that we deaths and therefore we needed to have a proper we'd been calling for for the best part of a year that 25 25 investigation, which then uncovered that the staff were had never taken place, how did the Government have that 117 119 1 1 contracting in the ward as opposed to bringing it into level of data. We asked to see the data, but they clearly couldn't provide it so it was purely on a hunch. the ward. So it was high profile, there was a lot of 2 discussion about it and they needed a proper Q. This is data about -investigation, and that was a result. 4 5 Q. Can you remember when that was -- when that RIDDOR was? 5 Q. -- the level of staff infection? 6 A. That would probably be April/May. It was quite early 6 A. Yes. They didn't have that data so their response or on. one of the responses were -- apart from communications, 8 Q. Of 2020? 8 et cetera, was that staff would be more compliant if A. Yes. I could be wrong with the dates, but it was fairly they knew they were being watched, and there was 10 on in that phase of the pandemic. 10 a suggestion that we put body cams on to nurses to make Q. And a RIDDOR results in a report, does it? 11 11 sure they're complying with regulations or with 12 A. Yes. 12 guidance, which I found -- I was astonished initially Q. Is that published? 13 13 but then I was deeply offended by the suggestion that A. No. it goes to the Health and Safety Executive and 14 14 that's where Government went. So in their eyes our 15 that's then recorded where it needs to be recorded that 15 staff went from being superheroes to supervillains 16 there's a workplace injury or infection. 16 overnight without any evidence. 17 Q. Now, in paragraph 29 -- excuse me, in paragraph -- yes, 17 Q. What happened to that proposal? 18 in paragraphs 29 and 30, you indicate your view -- you 18 A. It came to that group -- it came to myself and I made it 19 state your view as to why RIDDORs were not done. 19 perfectly clear that staff side would never accept that 20 as being an appropriate use of -- and an invasion of our 20 A. Yeah. 21 Q. Which is what? 21 staff's privacy, and if they wanted to go fishing. A. Purely because, one, the Health and Safety Executive 22 I suggested they get a fishing rod. 23 made a decision it was community-based but I also think 23 Q. What is the current position in relation to RIDDOR or,

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rather, when did RIDDORs recommence?

A. RIDDORs, they always -- they were always there but they

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there's an element in relation to liability thereafter,

workplace infections and personal claims. So I think --

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2 injury or industrial accident, then a RIDDOR would still 3 be put in. But in relation to COVID, that guidance is 4 still in place, so individuals who are contracting COVID in the workplace now will still not see a RIDDOR and they're still not doing proper deep dives in relation to 7 COVID outbreaks. In relation to PAGs, they still don't 8 take place and, again, because we've still got the 9 guidance in situ from the Health and Safety Executive, 1.0 that hasn't changed either, so you're still not getting 11 RIDDORs for COVID outbreaks. 12 Q. If we can turn to the next section of your witness 13 statement, which deals with various aspects of the 14 impact of the pandemic on staffing, and here there are 15 a number of themes that you identify. The first arises 16 from absence rates A Yeah

were never there for COVID. So if you had an industrial

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18 Q. Then a matter you've already touched on, which is deployment. We've already talked about deployment 19 20 problems and where people were working arising from PPE 21 issues and you go on to discuss deployment issues 22 arising from absences. You also discuss the cumulative 23 impact of all of this on the mental health of staff in 2.4 hospitals. So if we could just briefly talk about 25 absence rates. In paragraph 32 of your statement, you

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1 say that, not surprisingly, absence rates increased dramatically.

A. Yeah

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4 Q. And what was the consequence of that for people who 5 continued at work?

A. So the majority of our admin staff who could work from home were sent home with the bare essentials, and we'll come to that later. So in the hospitals it was primarily your operational staff, your acute nursing staff, your labs, diagnostics, domestics, catering, portering. So that was the main workforce that was in the hospital setting. The majority of your admin staff had been sent home, apart from one or two small pockets. And therefore, because they were very much patient-facing and very much because we were slow in relation to providing them with PPE, therefore the infection rates went up significantly . But at the same time our infection rates in the community were going up significantly because we were getting more and more people into hospital and therefore hospitals became really, really busy and probably overstretched, with a reduction in the workforce to be able to provide those

So when I say it was 160 to 180 staff per day, that was purely in acute settings. That wasnae including

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anybody else. Therefore the result of that was wards were short of staff and the phrase that I heard constantly at that particular time was, "We will shuffle staff round about the hospital". Now, we had an agreement and there was clear guidance that staff who worked in a red ward didnae work anywhere else. Staff who worked in a green ward, they were fine, but as soon as they went into that red ward, then you couldnae go back to the green wards. So the fact that they shuffled staff round about wards just to cover gaps in service, we didnae have that detail of where staff were being sent to and where they had came from.

I asked for it on several occasions and I made the point I could tell you where staff had been on a Saturday night because, if there was an outbreak and it was related to a wedding or to a birthday party, I could tell which staff were there, but I couldnae tell you where they had been Monday to Friday in the wards because we didnae keep that level of detail. And that caused me a worry because that way -- and I go back to the PAGs -- if we're doing proper PAGs and proper IMTs, we would be able to know which staff was in what ward. The fact they were shuffling them about purely to cover gaps in the services, we werenae recording that appropriately.

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1 Q. And the distinction between red zones and green zones. is that something to do with the care required?

A. So your red zone is a COVID zone; your green zone is 4 non-COVID.

5 Q. I see. Right.

6 Yes, so just to bottom that out, in paragraphs 34 7 and 35 you're indicating that staff were being moved 8 around between the zones --

9 A. Yes

10 — irrespective of exposure to the virus?

11 A. Yeah. It was who could cover it and who was available, 12 how we could spread that staff complement across the 13 hospital settings.

14 Q. Then at paragraph 36 you indicate that this further 15 contributed to increases in anxiety.

16 A. Yeah, because staff -- staff who worked in a ward were 17 fully aware of their patients and built up that rapport 18 with patients and they worked as a fairly close team 19 within a ward. As soon as you start disrupting that and 20 staff were coming in not knowing whether they were going 21 to be on their own ward or on a separate ward or in 22 a separate specialty, then staff became really stressed 23 because they didnae know what their daily day was going 24 to be involving and therefore staff were coming to work

25 with that level of anxiety about, "What's going to

2 it wasnae always comfortable for staff to be moved 3 around about the hospitals. 4 Q. You do say, to be fair, in paragraph 54 of your statement that certainly NHS Scotland did respond to the mental health difficulties by starting running 7 well-being hubs.

happen to me today and where am I going to be put?". So

- 8 A. Yes.
- 9 Q. Yes. Can you remember when that began?
- 10 A. That began, I would say, probably early April/May 2020.
- 11 Q. Right, so early on?
- 12 A. Very, very, very early on, and it was about creating 13 spaces for staff to get out the ward and relax in an 14 environment where it's fairly safe to do so, where they 15 could get a cup of tea, a cup of coffee, whatever they needed, and it was about that chill-out time, which was 16 really important for staff. We also had quiet areas at 17 18 the same time. These were drawn up fairly quickly in the early days of the pandemic. Within NHS Ayrshire and 19 20 Arran we then moved to develop that on a more permanent
- 21 basis and we've got well—being hubs in our three main
- 2.2 hospitals.
- 23 Q. Now, going back to paragraphs 42 and 44 of your 2.4 statement, you discuss at some length issues around the 25 testing of staff --

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A Yeah 1

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- 2 Q. $\,--$ during the pandemic. Was there guidance on this matter?
- 4 A. Yes, so when we moved to daily testing of staff or 5 random testing of staff, whatever it was going to be, 6 the guidance that came out is we would issue the LFTs, the lateral flow tests, and staff would undertake these 8 at home to make sure they're negative before they came into the workplace. Where they became positive, then we 10 would wait to get a PCR, then they would start their 11 self-isolation.

The fact that it was a work—related activity, staff side and trade unions in general made the point that therefore staff should be paid because staff had to take time out of their private life to undertake the test but also wait on the results, et cetera, which to us seemed a reasonable position, plus it provided that security that you didnae have positive staff coming into the workplace

Some managers looked at that was an additional cost and therefore, rather than pay the additional cost, bring staff in at the beginning of their shift to undertake the LFTs. What that meant is you were potentially bringing in positive staff. So you're saving a few pennies but the reality is you could

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increase the spread of the virus and therefore I always

deemed that to be not very wise because -- the reality

is we created that guidance so that staff were testing 4

- at home rather than coming into the workplace positive 5 and, again, it goes back to the money situation.
- 6 Q. How long did that continue, that staff were to test at
- 7 work rather than at home? 8 A. Not very long once we got wind of it because we made the
- 9 point that that was a useless exercise because the whole 1.0 purposes of staff testing at home was to ensure that we
- 11 didnae bring it into the workplace or into a patient
- 12 environment. So it probably did last two or three
- 13 weeks, I'll be honest, but once we got wind of it and we
- 14 knew it, then we got the guidance reaffirmed and sent
- 15 back with clear notice that that was unacceptable 16 practice
- 17 Q. Yes. Now, you also mention issues around vaccine
- 18 hesitancy and the implications of compulsory vaccines,
- 19 but, again, the Inquiry has heard quite a lot about
- 2.0 that. Is there anything specific you want to say about
- 21 the implications of compulsory vaccines and vaccine
- 2.2 hesitancy?
- 23 A. Vaccine hesitancy was -- and again, because staff have
- 2.4 that level of knowledge about how long a vaccine takes 25
 - to actually be developed, the effectiveness -- and there

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1 was a bit of concern that it was so quick that we were

unsure about what potential side effects there were 2

going to be, and therefore that was a slow burner to win

4 the staff side and the staff's confidence that the

5 vaccines were the right place to go. From a staff side

6 perspective, we always encouraged all of our members to

take the vaccine when it was offered because it provided

8 them with protection, their patients with protection but

also the families with protection. So we did win that 10 argument with our own members, who then started taking

11 the vaccine on a more regular basis, but there was that

12 hesitancy at the very beginning.

> The other problem with the vaccines, of course, was, when it first became available, who was eligible for the vaccines, and that -- again we created a two-tier workforce because it was patient-facing, it was close to patients, and our admin and clerical staff and people who were not in the wards wouldn't have been afforded

19 that same level of protection.

20 Now, I made the point and will continually make the 21 point that anybody who works within the Health Service 22 is there to provide a service for the patients.

23 Certainly from entering to exit we've all got a role to 2.4

play in a patient's recovery or a patient's treatment and therefore I don't see one as being more important

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4 A Yeah

than the other because the reality is $\,--\,$ and I hear this 2 constantly about front—line staff $\,--\,$ the first person 3 you meet when you get into hospital is the receptionist, 4 but they werenae getting the vaccine. So that argument that every single member of staff was equally as important as the other was one that we argued very 7 strongly and we won eventually, but it took a long time. 8 Q. When you say "a long time", by when was the argument 9 resolved and you --10 A. Well, I couldn't tell you when it was resolved, but it 11 probably took three or four weeks, yeah. 12 Q. Right. Now, my Lord, if I could turn to one issue in 13 Mr Hope's evidence that is particularly significant . It 14 concerns what he has to say about mental health nursing. 15 This is at paragraphs 59 to 60 of your statement. Now, if you could just briefly describe what you mean by 16 17 "mental health nursing", is it the staff that work in 18 that area? 19 A. So staff who work in a mental health facility, and in 20 Ayrshire and Arran it would be Woodland View, which was 21 our mental health facility . So the staff in there --22 and again it's a different clientele because your staff 23 in there are probably physically -- a lot more 2.4 physically fit than they will be in an acute setting and 25 therefore they're more transient within a mental health

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setting and therefore, rather than being able to contain positive patients, the fact that they're transient and therefore going about the hospital made it really, really challenging. And therefore the infection rate amongst staff, because they're coming into contact with a lot more patients who arenae aware of the significance of the virus -- and therefore that caused an increase of absences within the healthcare setting as well.

The other part was -- and this isn't a criticism but a lot of patients had difficulty to understanding why their nurses, who they had known for several years, suddenly had to start wearing masks to come in and treat them and speak to them and that whole scenario, and therefore I don't expect it would be unusual for staff. for the sake of their patients, to make that as comfortable as possible and do whatever they needed to

- 18 Q. You say that some patients, in paragraph 59 -- so 19 there's two issues. There's patients wearing PPE and 20 then there's patients with mental health conditions 21 reacting to staff wearing PPE. In relation to patients 22 wearing PPE --
- 23 A. No, patients — I think that's a mistake — patients 24 never wore PPE. They werenae tolerating their carers 2.5 wearing the PPE, and it became challenging within that

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A. Like I said, staff would probably do as much as they 9 possibly can to make that process of getting patients

Q. What was the response to that, then, from the staff?

particular setting because this was about individuals.

Q. So, as it were, focusing on their reaction to staff

Q. So that's something they weren't used to?

- 1.0 calm, getting the patients to understand the needs for
- 11 why they were wearing masks, and I could probably say
- 12 anecdotally that staff would probably remove their mask
- 13 at some point just to -- and again it was to appease
- 14 patients. But it wasnae through malice. It was through
- 15 trying to provide the best care they can for their
- 16 patients, which was understandable.
- 17 Q. So one of the particular challenges in relation to
- 18 mental health nursing, then, for the staff involved was
- 19 the reaction of patients to wearing PPE?
- 20 A. Yeah.
- $21\,$ $\,$ Q. But another challenge you cover is that mental health
- 22 patients are more mobile.

wearing PPE?

A. Yeah, absolutely.

23 A. Yeah.

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- 2.4 Q. And you indicate that that means sometimes they move
- 25 around within the hospital estate. Do they move around

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- 1 the country more?
 - A. No. just round about that particular facility. So
- 3 I think it's Woodland View that -- they'd be in
- 4 corridors and going in and out of each other's rooms
- 5 because that's what normally happened prior to the
- 6 pandemic hit, and therefore to change that routine for
- mental health patients is really, really challenging for
- 8 the patient and therefore patient care dictated that we
- had to minimise impact as much as possible but they
- 10 still had that freedom of movement.
- 11 Q. In paragraph 60, however, you do relate one incident --
- 12 A. Yeah.
- 13 Q. -- where a mental health patient was moved elsewhere and
- 14 that eventually led to I think what you say is the only
- 15 case of a staff member contracting COVID and dying.
- 16 A. Yeah.
- Q. Is that right? Can you say a bit more about that? 17
- 18 A. My understanding is that the particular patient was
- 19 moved up to a Glasgow facility. For whatever reason
- 20 that didnae work for the patient and they were brought
- 21 back into Avrshire and Arran, but they were brought back 22
- in without the proper test being done and by the time
- 23 they got back into the workplace, that individual was
- 24 COVID-positive and the member of staff who was treating
- 25 that particular patient contracted COVID and sadly died

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- some time later. And again it was about that lack of 2 testing during the movements between Glasgow and 3 Avrshire and Arran.
- 4 Q. Are there any differences in the impact of COVID on 5 staff who worked in mental health nursing compared to other healthcare staff? 6

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A. Probably a different impact because the impact would be the impact -- what COVID did to their patients and the restrictions and how that affected their patients and therefore that created that frustration or anxiety within the staff group.

If you remove that and go back up to an acute setting, it was about that real devastating impact on individuals who were severely ill and dying as a result of COVID, and some of the impacts that had on staff in relation to their mental well—being because they were in it on a daily basis and it would then create that post traumatic stress as a result of -- and I've spoke to several colleagues and staff members. While they were in that setting, their focus was very much on patient survival and patients' well—being.

As soon as we started to come out of that particular part of the pandemic, that scenario, and we were less focused on severely ill patients, the scenes and the thoughts come flooding back to staff and we saw an

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- 1 impact at a later date because that's when staff had time to absorb what they'd actually lived through -because at the time there were too focused on their patients and delivering that high level of care that was 5
- 6 Q. What about staff working conditions and attendance at 7 work, was there any difference there or was that much 8 the same?
- 9 A. So pre-pandemic, if we get breakdowns of staff absences 10 and the cause of staff absences -- and at that particular time mental-health-related illnesses would 11 12 equate to somewhere between 23/24% of all absences. 13 Post pandemic, whatever wave -- first, second wave -- it 14 may have been -- you saw that increase in 15 mental-health-related illnesses and now we're up at 34/35/36% of all absences. So staff are still reliving 17 what they experienced during the pandemic and they're 18 still trying to understand it and to deal with it and 19 it's really challenging.

So part of that well—being structure that we spoke about earlier, we now have a direct line into clinical psychologists, clinical psychiatrists, for staff to go there and get the assistance they require, which I think is really, really important.

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Q. Were staff absences amongst those who were working in

mental health nursing broadly the same or different?

- A. Probably slightly less, but they were still very, very high because we still had that scenario I spoke about 4 earlier, about shuffling staff round about hospitals to make sure we had proper cover.
- Q. Turning to another matter briefly, which is the impact 7 on restrictions on visitation in hospitals. You deal 8 with that in paragraphs 61 and 62 of your statement.
- 9 A. Yeah.

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- 1.0 Q. I think what you're suggesting there is that dealing with relations and visitors was also disruptive and had 11 12 an effect on working conditions and the mental health of 13
- 14 A. Yeah, very much so because initially we -- there was no 15 patient visiting. We then relaxed some of those 16 guidances and then it was appointments — visitation by 17 appointments. It was only one at a time, at 18 a particular time, and anybody coming into hospital 19 clearly had to wear the appropriate PPE and masks, and

that's how it should have run naturally.

21 But patients' loved ones, visitors, they were 2.2 anxious and stressed about their loved one being in that hospital and therefore their anxiety levels were up, and not everybody was complying with the guidance in relation to the masks and staff rightly challenged

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- 1 individuals. But, again, that was a real confrontational point. But again staff were looking for 2 their own safety but also the safety of other patients 4 and visitors werenae always aware of them.
- 5 Q. Now, you have a section in your statement about 6 long COVID and again this is a matter which the Inquiry 7 has heard about from other witnesses, including the fact 8 that the impact of long COVID or the incidence of long COVID amongst healthcare staff is higher than the 10 general population. Is there anything specific you want 11 to draw out from these paragraphs in your statement, 12 which begin at 63, about long COVID?
- 13 A. I think the most important part about staff who then went on to develop long COVID -- and I go back to those 14 15 initial $\,\,--\,\,$ the missing investigations, whether that be 16 RIDDOR or whether that be PAGs, which would have 17 identified if that unfortunate individual contracted the 18 virus in the workplace because, once they then leave the 19 organisation as a result of long COVID, they don't have 20 that financial security that they should have had in 21 relation to personal liability -- personal claims and 22 industrial injuries benefit. That whole opportunity was 23

So if you do the numbers, in Scotland we're probably looking at somewhere between 600 and 650 members of

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2 long COVID. I'm no naive enough to think every one of 3 them contracted it in the workplace but I am well aware that the majority probably did. But they're now leaving 4 with that lack of financial security or that financial safety net and therefore their lives have changed 7 forever, and I think they were at the expense of, "Let's 8 save a few pounds", at the beginning of this process. 9 Q. You say in paragraph 63 of your statement that, in your 10 view, at least, for some in the NHS, management and the 11 employer are less sympathetic and you say that some 12 people regard long COVID as the new sore back. 13 A. Yeah, and I've heard that expression within the 14 workplace because -- and again, because long COVID isn't 15 one particular sign or symptom and it's made up of a whole host of different problems that individuals can 16 17 be left with, some are more debilitating than others — 18 but even the minor long COVID, so -- and I take myself. 19 As a result of COVID, I've got constant sinus 20 infections , which is a problem for me -- but if you take 21 that to the workplace, it's like, "Oh, he's got 22 long COVID again", and it's the reality of people are 23 suffering as a result of -- whether it be work or 2.4 whether it be COVID or whether it's that combination of 25 contracting it in the workplace but the employer is 137

staff who have had to leave work as a result of

- 1 looking at it as a reason for staff being off -- not every employer and not every manager, but we've got the rogue ones who do.
- 4 Q. Before we come to lessons to be learned, there is one 5 matter I would like to ask you about, although
- 6 chronologically I suppose it goes back to the beginning of the pandemic, which is the section of your statement 8
 - where you're talking about working from home.
- 9 A. Yes
- 10 Q. This is at paragraphs 70 to 72 of your -- or I suppose 70 to 74 of your statement. This concerns staff who 11 12 were able to work at home, of course, so that would 13 mainly be administrative staff; yes?

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14 A. Yeah. 15 Q. What you say in paragraph 71 is people -- well, they 16 were sent home to work at home basically with their 17 laptop and there was no other support -- "Staff were 18 sent home with a laptop and a phone [and] that was it", 19 is what you say in paragraph 71. And there was no --20 and that led, of course, if they were working at home, 21 for example, to sitting at desks and you giving other 22 examples, including I think you say people sitting at 23 ironing boards and so on. You indicate that there were 24 musculoskeletal issues with people's neck and back

because of sitting for long periods in inappropriate

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chairs. Is it your evidence that, given the 2 responsibilities that you're aware of, support such as 3 chairs and proper chairs were not provided?

4 A. Absolutely not. People were literally sent home with a laptop and a phone and asked to get on with it and 6 therefore they had to make their own arrangements within 7 the home. The reference to the ironing board and sitting on a sofa is a factual one because a member of 8 9 staff did that for the best part of two years, who then 1.0 developed muscular back problems, neck and shoulder 11 problems. The emphasis should have been on the employer 12 to take a proper risk assessment to see whether that 13 individual needed to work at home, at a proper desk, 14 proper work space, proper screens, DSUs. That whole 15 risk assessment of slips, trips and falls never actually 16 took place and still hasn't took place. 17

As a result of staff being sent home to work, we've now created a home work and flexible work location policy which dictates quite clearly that, if an employer is asking individuals to work from home, then they're to provide them with the appropriate equipment, desks, proper chairs, proper video screens, et cetera, so as the individual has got a proper work space.

Q. What if someone had a chair at work, though -- for 2.4 example, if they had a therapeutic chair at work before

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- 1 the pandemic, would they not take it home or be provided 2
- A. Not everybody did. The majority still haven't, to be 4 honest. And I only know that from the team that
- 5 I manage, that the majority of them are still using 6
- a work laptop and a phone. 7 Q. So they didn't have the chair they might have had at
- 8 work, for example? 9
- A. Yeah, because everybody that works in their own office 10 has got their own chairs and their own screens. 11 et cetera.
- 12 Q. Are you aware of an increasing prevalence of these 13 repetitive strain injuries or bad postures -
- 14 A. Yeah, you see it, and again you go back to that absent 15 supporting that the organisation undertakes. You see 16 that increase in the musculoskeletal problems on 17 a recurring basis and, again, it's that referral into 18 occupational health, looking for physiotherapy 19 treatments, et cetera, or occupational therapy 20 treatments and how to conduct, et cetera. So we have 21 seen an increase and I think we will continue to see 22 that increase until we bottom out proper work spaces for 23 staff in their own homes that are secure and safe.

24 The other issue was when we sent staff home without 25 that proper risk assessment, they often suffered from

1		that seclusion. They didn't have that interaction with	1	say in conclusion?
2		their colleagues and that, again, caused their own $$	2	A. No, I don't think so. I think we've covered the main
3		individuals to feel that stress and anxiety because of	3	points. Thank you.
4		isolation syndrome. And that's still something that	4	MR EDWARDS: Well, I'm very grateful to you for your
5		we're working through and, again, through our well—being	5	statement and your evidence today.
6		hubs we're tackling it but it's a major issue.	6	My Lord, that completes Mr Hope's evidence.
7	Q.	Thank you, Mr Hope.	7	THE CHAIR: Thank you. Thank you, Mr Hope.
8		The last part of your statement is a substantial one	8	A. Thank you, my Lord.
9		about lessons to be learned from the pandemic in light	9	THE CHAIR: Very good. Tomorrow morning.
10		of your experiences. If you were to identify two	10	MR EDWARDS: Thank you.
11		lessons to be learned, what might you say they were?	11	(3.57 pm)
12	Α.	The first one has to be applied not just through	12	(The hearing adjourned until
13		a pandemic but really life, that unless you can ensure	13	Wednesday, 8 May 2024 at 9.45 am)
14		your staff's safety, you will never be able to provide	14	
15		patient safety because they're both in the same	15	
16		environment. And unless they're in balance, then one of	16	
17		the two are going to be at risk. Therefore, by failing	17	
18		to provide staff with that initial PPE and that $$ and	18	
19		again I go back to the investigations of outbreaks, we	19	
20		never put staff in a safe place so we need to go back	20	
21		and reflect on that. And going forward we need to make	21	
22		sure that staff safety is our number one priority	22	
23		because, without that, you'll never ensure patient	23	
24		safety. So I think that's the first learning.	24	
25		The other one, and I keep coming back to it, is we	25	
		141		143
1		knew COVID was coming because we'd seen it for three	1	INDEX
2		months on our TV sets every night, we still weren't	2	MR DUNCAN MCDONALD (called)1
3		prepared. So that preparation for what's coming over		Questions by MS BAHRAMI1
4		the horizon is real and rather than waiting till it gets	3	MS WENDY BATES (called)25
5		here and we look like rabbits in the headlights, we need		Questions by MR CASKIE25
6		to have our preparation and plans in place for an	4	MS TRACY NICHOLLS (called)66
7		outbreak, whether it be COVID or flu or whatever.	_	Questions by MS BAHRAMI66
8		Because we know there's going to be another one, unless	5	MR EWING HOPE (called)100
9		we take the lessons learned from here and make sure		Questions by MR EDWARDS100
10		we're ready and we're prepared and we've got a plan,	6	
11		then I think we'll always get into the same pickle.	7	
12		I remember asking a senior clinician before the	8	
13		first case came to Scotland about what our COVID plans	9	
14		were, how we're going to deal with them. The response	10	
15		was, "We don't need a plan, we've got a flu pandemic	11	
16		plan, that will do". Clearly it didnae. So that glib	12	
17		answer to me was really, really damning because the	13	
18		reality is we knew what was coming because we'd seen it	14	
19		in North Italy and we were still not prepared. And	15	
20		therefore we have to take every opportunity to provide	16	
21		safety for staff and patients in a hospital setting and	17	
22		our community setting, because it's really important.	18	
23	Q.	Mr Hope, your witness statement as a whole and your	19	
24		evidence today will stand together as your evidence to	20	
25		the Inquiry. Is there anything else you would like to	21	
		142	22	
		142	23	
			24	
			25	

appreciate (1) 71:12

60:21

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