Scottish Covid-19 Inquiry

Day 43

May 7, 2024

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Tuesday, 7 May 2024

(9.45 am)

THE CHAIR: Good morning, Ms Bahrami. Good morning, Mr McDonald.

When you're ready, Ms Bahrami.

MR DUNCAN MCDONALD (called)

MS BAHRAMI: Thank you, my Lord. Our first witness is Duncan McDonald from Erskine Care Home in Bishopton. Mr McDonald has provided a witness statement. The reference number for that for the record is SCI—WT0421—000001.

Questions by MS BAHRAMI

MS BAHRAMI: Mr McDonald, you're a house manager at Erskine Care Home in Bishopton; is that correct?

A. I was a house manager during the pandemic.

Q. Thank you. Erskine is a charity for veterans which, among other things, has two care homes, one in Bishopton and one in Gilmerton in Edinburgh; is that correct?

A. Yes.

Q. And Bishopton has a capacity of 180 residents ——

A. Yes.

Q. —— while Gilmerton has a capacity of 40 residents?

A. Yeah, that's correct.

Q. Can spouses also move in with their partners?

A. Yes, they can.

Q. And each care home has a number of houses within it; is that right?

A. Yes, so Erskine Care Home, the largest, had 180 residents split into six different houses of 30 residents in each house.

Q. Thank you. You were the manager for Haig House?

A. Yes, I was.

Q. And the residents of Haig House had dementia to varying degrees?

A. Yeah.

Q. At the onset of the pandemic, there were around 30 residents in Haig House ——

A. Yes.

Q. —— as set out. You had responsibility for around 40 staff members in Haig House?

A. Yes.

Q. What were some of the activities and services that Haig House provided or Erskine provided for the residents prior to the onset of the pandemic?

A. So prior to the onset of the pandemic we had activity staff on site. So we would have concerts out within the home; we had a large activity area that all the residents could attend, so large concerts, football matches that were on; we had religious services for different faiths; we had in—house concerts as well; we

brought in petting zoos; we had donkeys, horses, visiting; plus also trips out as well. So we would use —— like, you know, go to different areas. We had coaches or minibuses on site as well we could use. We did that for a lot of trips. Pretty much every single day there was activities on for the residents, so whether it was in group activities or whether it was individual activities.

Q. Thank you. That all stopped when the pandemic started?

A. Yes.

Q. Did Erskine decide to stop those activities prior to the official commencement of lockdown on 23 March or was it on that date?

A. It was four years ago, my recollection is a bit hazy of the exact times, but I know that right up until we had to lock down we still, as much as possible, had activities. We more sort of segregated the house activities rather than having different houses mixing, but we still had activities for the residents within Haig.

Q. Did you allow visitation up until ——

A. Yes.

Q. —— you weren't allowed?

A. Yes.

Q. At paragraph 12 of your statement you say that the

layout of Haig House made it easy for you to distance the residents. You say there that you could separate them for dining in small groups and using the lounge in small groups. Was that after the restrictions were put in place?

A. No. The layout of Haig House is sort of —— it's like a hub with spokes, so each corridor had ten bedrooms but they had their own dining area and lounge area within those ten bedrooms. Other houses had a communal dining room for the 30 residents. So we could very easily in Haig —— and it was just because of the layout, because it had been designed as a dementia house —— we could very easily sort of segregate people into just ten residents in a small area rather than having the 30 residents together, so it made that easier for us.

Q. And they were kept separate to the residents of other houses?

A. Yes.

Q. You also suspended the admission of new residents at that point; is that correct?

A. Yes, we did.

Q. You talk in your statement about updating guidance as soon as changes were made. How were you able to do that? We've heard from some care homes that they had to have their plans approved by people within their

organisation and some by external organisations. Was that not a requirement for Erskine?
A. Yes, so we had an internal quality improvement team that 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 what we were doing that was different from the guidance and then they would very quickly either put out posters or put out information telling us what house managers had to have in place to keep up with the guidance then.
Q. Was that quality improvement team set up prior to the onset of the pandemic?
A. Yes, it was.
Q. Were they based in one of the two care homes or were they ——
A. They were based in the main care home at Erskine and they'd been there for years before —— years prior to that, but very quickly their real focus became IPC.
Q. That seems to have made quite a difference for Erskine.
A. Yes, it meant that, as house managers, we didn't have to go through the guidance. We had it given to us very quickly.
Q. So you were able to focus on ——
A. On the residents, aha, and making sure that we were following everything that should be getting followed.

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 residents of Haig House died throughout the duration of the pandemic and a number of other residents in other houses. Were those five all COVID deaths or were they ——
A. They were put down as COVID deaths. You can never tell, you know. We have a population of residents who are elderly, a lot of comorbidities, some had been actively dying before the pandemic even started. It would be difficult to say that COVID was the reason but it could have been a contributing factor.
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 —— you know, with the restrictions that were in place that were changing all the time, it became more of —— we always tried at Erskine to make it person—centred care, you know, it was all about the residents, but very quickly it became all about the tasks, the cleaning, making sure we were following IPC guidelines, making sure that everything was cleaned and it was recorded, because the recording was so important as well for

proof. And very quickly the focus went away from the residents to everything else that we had to do to make sure we were following guidance.
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 ——
A. Yes.
Q. —— and that treatment had been stopped for that.
A. It was a scary time. I didn't know —— one, I didn't know if I was taking COVID into work with me for my residents, who are obviously all quite susceptible, or if I was taking COVID home to my wife, who had been told that her treatment had stopped because, if she caught COVID, it was a serious problem for her illness. So either way —— but it's the job that we do, so you still turn up every day and you did it. But it was just hard and it was a 24/7 job. It didn't stop. It didn't go away. You went to work, you came home and you went back to work the next day, and it just took over your entire life.
Q. Can I ask, how long was your wife's treatment stopped?
A. So it was stopped from —— she was due to get chemotherapy in February. We went to the hospital and she was told, no, she couldn't get it because that was right —— just as the hospital was locking down. So she

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 ——
Q. I'm glad to hear that.
A. —— but at that time it was quite a difficult time.
Q. Yes, thank you. How were your staffing levels affected by the pandemic?
A. It was up and down. You know, we couldn't get agency staff because we couldn't bring people in from other places, so it was only like Erskine staff. They did a lot of extra shifts but a lot of people —— at that time there was no testing so if you had any symptom at all then you had to isolate. So staff were going off if they just felt unwell, you know, had a sore head, were having a cough. We couldn't take that chance so they were going off sick at the time. At that time it was a 14—day isolation so it was a long time for staff to be off. So staffing levels —— we should have had eight staff for 30 residents and some days we had four or five; six if we were lucky.
Q. Did that have an impact on the care that you were able to provide to residents?
A. Yes, it was just less staff, less time with the residents. The time with the residents was cut back to

the bone anyway because we were doing so much cleaning; less staff to deal with everything else. As a manager you lost all your management time so -- you were working on the floor so you lost all that time that you had to do all your management stuff as well so everything else became outwith work. But for staff it was tough. You know, they knew they were going to be short-staffed pretty much every day.

Q. Were staff able to gather in a staffroom or to speak to each other and support each other or was that very much stopped as well?

A. Within Erskine we had -- they had a cafe that we could all attend to before COVID. Once COVID started and that closed, you could only -- you went into your house in the morning, you stayed in the house for the rest of your shift -- so that was 12 and a half hours you stayed in that house. We at the start didn't have a break room within Haig so we ended up having to use residents' bedrooms as they became available, but again we had to cut that back. Because of the distance requirements, we had like two members of staff in each break room and that was it, so you and someone else.

Q. You say in paragraph 21 that by the end of February and into March -- that's before the start of the official lockdown -- you had a couple of residents with

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

A. Yes.

Q. Was Erskine requiring relatives to use PPE before the official guidance required that?

A. Yes, I think it was just our director of care quickly realised that -- you could see on the news it was coming, you know, so it was just a matter of just to keep the residents safe as well and the relatives safe, you know, as much as possible. We didn't really -- we still -- all the way through COVID, at end of life, residents [sic] came to visit, but they had to wear the full PPE just for their safety as well.

Q. Yes, but at that point it was clear to your directors that this is a precaution that should be taken?

A. Yes.

Q. Thank you. We've heard from others that it was difficult for those in the care sector to see the appreciation for those in the NHS, whether it was clapping, special shopping hours, discounts in shops, free coffee and the like, as it made them feel under-appreciated. Was that also the same -- was the same sentiment and feeling experienced by staff at Erskine?

A. Yes. Social care has always been sort of the poor

cousin to care. I've got friends in the NHS and, you know, massive respect to them, especially during what happened, but we felt that, yeah, we were second best again. At the start, PPE had been redirected to the NHS so we were struggling to get PPE. I had all my people in my street out clapping for the NHS every Thursday night and fair play to them, but we had to get letters from our director to say that we worked in social care, could we get into the shops at the same time and even then staff were getting turned away and, you know, it's embarrassing to get turned away from shops. But, yeah, definitely the same sentiment.

Q. We touched on this briefly just before, but at paragraph 26 you mention that at times guidance was changed on a Friday and it was an awkward day as you had to make changes before the weekend to ensure things were up and running quickly for Monday. We've heard that not everyone was able to achieve that. Some care homes had a delay of a week or two --

A. Yeah.

Q. -- because of how things were set up. Do you think the reason you were able to do that was solely down to your quality improvement team or do you think there were other factors that allowed that?

A. I think that was a massive reason. I think, yeah, the

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

The other thing we had within Erskine was that managers didn't just work Monday to Friday, we worked internal rotation, so we were sometimes available at weekends as well to make sure that that was getting in place before the Monday and we never really wanted for any equipment. Erskine always provided what we needed to make sure that we were following everything.

Q. Thank you. In paragraph 30 you state your "management guidance was clear but just changed quite a lot". By that do you mean Erskine issued its own guidance for management purposes and did that seek to implement Government guidance or was it in addition to Government guidance?

A. I think what I mean by that is like -- so for stuff like cleaning charts, we would attach cleaning charts just to, say, equipment so that staff could very quickly sign

off that it had been cleaned, but then we would have guidance that would say, no, they shouldn't be attached to the equipment, they should be kept in a folder, so we 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 that. I mean, it was hard also to cascade that to staff.

As I say, I had 40 staff. Not all of them were on Workplace, not all of them had emails. Trying to put 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.

Q. So that was internal guidance rather than --

A. Yes, aha.

Q. -- anything else from the Government?

A. It might well have came from Government guidance and we've cascaded it down and made it Erskine guidance then.

Q. Thank you. We've heard from others that they found NHS assurance team inspections and requirements to be inappropriate for care homes and to treat care homes

like hospitals. Was this also the experience at Erskine?

A. Yes.

Q. Can you tell us about the requirements that were considered to be inappropriate?

A. Very much so. So Erskine and any care home who considered the care home as the residents' home, they were asking for very clinical set-ups, so they were asking for yellow waste bins in every resident's room, they were asking for separation of PPE, they were asking for PPE to come out of rooms, and it was sort of requirements that we couldn't always put in place for the residents. We had residents with advanced dementia. We couldn't police that. We couldn't -- you can't tell a resident not to touch something all the time, and it's a giant yellow bin, they're going to be attracted towards it. So it was very difficult -- it was difficult to explain to the assurance team that we were someone's home -- I wouldn't expect that in my home so why should I expect that in a resident's home -- but they were quite inflexible.

Q. At points did your directors have to get involved and speak to them about it?

A. Yeah, so there was also differences between what the Care Inspectorate guidance was when they visited and the

assurance teams'. We were getting different messages and we had to go back and question them a lot about what exactly -- who was telling us what to do and, you know, could we get a consensus on it. It could be quite difficult at times.

Q. So the dual inspection regime was causing more difficulty?

A. Yes. Yeah.

Q. In paragraph 43, referring to residents, you state:

"Some of them forgot who their families were, lost social interaction, dining together and activities. Access to outside people, such as dentists, podiatrists, dieticians was only available by telephone contact not 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 were. We had families who visited every single day and they had like large families. To start with there was no visiting at all and it was done either through like tablet or online and the residents couldn't always cope with that. They couldn't understand what was happening. We did start doing outdoor visits, they had to be booked in, it was one person at a time and again the residents

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 when you have a resident with dementia, eating and drinking is quite a social thing, they will copy each other. So they will eat better in a group sometimes, 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 skills.

We were all wearing masks, which made communication difficult with the residents as well by that point. They weren't understanding us, they were scared, they didn't understand it. And also -- yeah, so we had no GP contact, we had no dental contact for two years, dieticians, anybody else. It was by phone only. It was very, very difficult for -- we were lucky -- Erskine is lucky, they have advanced nurse practitioners employed by Erskine who can prescribe and could see the residents on site, but apart from that we had no other allied health professionals that could see them.

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

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

time. A lot of our residents —— and it's just at that stage of life —— either they have dentures or very few teeth by the time —— you know, people are living at home 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 dentures so they were having to get like maybe a different—textured diet, which isn't always the nicest thing when you're —— you know, the only thing maybe you've got left is your food in your life. You know, everything —— family has been taken away, recreation has been taken away, you know, so the thing you've got left is food and that's changed as well.

Q. You mentioned the on—site advanced nurse practitioners. As you might already be aware, not all care homes are fortunate enough to have that.

A. No.

Q. Do you think that having advanced nurse practitioners on site helped lighten the workload on your staff and improve the situation for residents? Were they able to get better care?

A. Yes, without a doubt. It was a massive bonus we had. We had two advanced nurse practitioners on site that worked all through the pandemic. They would come and

they would see residents. If residents became unwell, 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 available to see if the residents had COVID or not. They were the ones who decided who was isolating. They could prescribe for us. They could prescribe just—in—case meds for end—of—life medication for us. They could have syringe drivers for people who became really unwell. They did all of that and they were on site all the way through.

They had contact with GPs, through the local GP surgery. We didn't want for anything from a medical —— a nursing prescription point of view all the way through COVID. It was a massive bonus.

Q. Thank you. You also mention in paragraph 46 that you had two GPs from Bishopton who did online calls. By that do you mean video calls or were they regular telephone calls?

A. They were either phone calls or —— I think we had a couple of video calls for maybe some condition that they would need to see the resident, but they didn't come in. But they used our ANPs a lot for that so they would liaise with the ANPs and sometimes they would just sort of have that conversation between them.

Q. Once Erskine resumed admission of new residents from hospitals or had residents returning from a stay in hospital, were there strict rules about residents coming in?

A. Yes, so we had to have two negative tests before they were admitted. Even then, we still had to isolate for whatever period it was at that time. So at the start it was 14 days. It did get less and less as the pandemic progressed. But, yeah, so we still had to isolate just to make sure that, after the test, they hadn't sort of contracted COVID.

We had to make sure that —— coming from the hospital, that they were coming from a ward that didn't have COVID on it as well. It had to be like a green ward. And if they were coming from home as well, we had to ask for two tests before they were admitted.

Q. Thank you. We heard from some other care homes that they were being sent patients who hadn't been tested prior to discharge from hospital. Did you have any experiences like that or were your residents ——

A. No.

Q. —— or did your residents all receive two tests?

A. From my recollection everyone in Haig had had tests before they came to us. Our moving—in team were very strict on that. I couldn't tell you overall for the

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

Q. Thank you. You mention in your statement your moving team. Can you tell us a bit about them, whether they existed prior to the pandemic and how they were able to help during the pandemic?

A. So the moving—in team was —— it used to be called the admissions team but our director of care was very keen that you don't get admitted to your home, you move into your home, so they changed it to the moving—in team. The moving—in team were a team of three people who from first contact with Erskine right through to the person moving in on that day, they did all the contacts. They were the ones that made sure that the tests were in place. They would give us the assessments for the residents. We would assess them and then they would sort all the moving arrangements from financial through to the tests, through to making sure they were eligible for Erskine.

But one thing that did change was, before the pandemic, if we assessed a resident, we always went and saw the resident. Once the pandemic started, then we didn't; we had phone call assessments. So it was never the same, you never saw the resident before they were

actually admitted to Erskine.
Q. 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?
A. Yes.
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?
A. No, that's right. We -- I can think of multiple residents who went to hospital for various reasons. 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

hospital staff as well.
Q. You say that in emergency cases you didn't test patients; is that right? You just informed --
A. We didn't. We informed, yeah, the Scottish Ambulance Service if there was any symptoms.
Q. We heard from others that some had an impression that some were given DNACPR decisions so that they wouldn't need to be taken by ambulance or taken to hospital -- treated by paramedics or taken to hospital. Why was it the case that at Erskine it was usually actually those with DNACPR decisions who were transferred out?
A. Because -- I would -- the vast, vast majority of our 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 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 didn't -- we never had anyone who would push to say we should give them all blanket, but most of them already had that anyway.
Q. Thank you. Is there anything we've not -- we of course have your statement and we'll take into account everything that's contained within it. Is there anything we've not covered today that you particularly would like to mention at this point?
A. I can't think so, no. I think we've covered everything. You know, it was just -- staff and care homes did the best they could at the time with the resources they had, with ever-changing guidance, you know, with residents becoming unwell. And again, these residents you maybe looked after for years, they became like family to you so it was difficult for the staff. I saw other managers who had seen half their residents pass away and sat at the bedside of every single one of them and looked shell-shocked.
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

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 each other that other people didn't have. So maybe "lucky" is the wrong word, but we had that social contact that other people didn't and it made that camaraderie, which maybe got us through it. But no, apart from that.
MS BAHRAMI: Thank you very much.
A. Thank you.
THE CHAIR: Thank you very much indeed, Mr McDonald.
A. Thank you, my Lord.
THE CHAIR: We've finished early. I think that was anticipated so there's no problem there. I'm not sure if the next witness is available. They're not. So maybe -- it was anticipated at 11.15 -- we may be able to start a bit earlier than that. Apologies I can't be more definite than that. We'll do what we can. Thank you.
(10.16 am)
(A short break)
(11.18 am)
THE CHAIR: Good morning, Mr Caskie.
MR CASKIE: Good morning, my Lord.
THE CHAIR: When you're both ready, thank you.

MS WENDY BATES (called)

Questions by MR CASKIE

MR CASKIE: Would you tell the Inquiry your full name, please?

A. My name is Wendy Bates.

Q. Which organisation are you here representing?

A. Health in Mind.

Q. What's your position in that organisation?

A. I'm the chief executive.

Q. How long have you been there?

A. I've worked with Health in Mind since 2001 and in my current position since March 2019.

Q. Can you tell us the nature of Health in Mind as an organisation?

A. Health in Mind is a charity promoting mental health and well-being. Most of our services are based in Edinburgh, the Lothians and the Scottish Borders but we do also have a number of national services covering all of Scotland and we offer a range of support to people who have mental health difficulties.

Q. Tell me about what it is that you do outside your core geographic area, what are your national programmes?

A. So we offer a telephone counselling service for people who have experienced trauma in childhood and we offer training to organisations who are supporting people

who've experienced trauma. We're part of an alliance providing two services, Future Pathways and Redress Support. Future Pathways offer support to people who were abused or neglected in care in Scotland and Redress Support supports people throughout their redress journey.

Q. Okay. In advance of giving evidence today, you provided the Inquiry with a witness statement. Part of the witness statement is on screen and it's known by a reference number which I'll just read into the record, which is SCI-WT0433-000001. The witness statement that's on the screen, do you recognise that?

A. Yes.

Q. And are you satisfied the content of that witness statement is true?

A. Yes.

Q. And do you want to adopt that witness statement as part of your evidence to the Inquiry?

A. Yes.

Q. Okay. At this stage I'm going to jump back and forward a little bit in the witness statement. Can I take you to paragraph 12? You tell us there that you have a staff of around 140.

A. That's right.

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

an idea of the scale of the organisation?

A. Sure. Our annual turnover is around 8.5 million.

Q. Okay. Going back now to paragraph 8, you talk about the history of the organisation and you talk about the number of people that you support each year and the number of volunteers that you have. Can you just give us those figures?

A. Sure. So every year we support around 4,000 people with their mental health and we involve 150 people as volunteers.

Q. At paragraph 9 -- and I hate this phrase and I'm sure Lord Brailsford will hate this phrase as well -- but you provide in effect a mission statement for the organisation. Can you just tell us about that?

A. Yes, so we provide -- our organisation is a unique organisation because of the breadth of the work that we do and we offer a unique pathway of support for people and we also are committed to working in partnership with others as well to make sure that people who receive support get the best support available to them.

Q. At paragraph 10 you provide us with a kind of definition of the focus of the types of work that your organisation does. Can you just tell us about that, the types of work that you do?

A. So we offer trauma support, which is practical support

with housing, budgets, relationships, as well as emotional support for people who have experienced trauma. We also offer a range of counselling, peer support, guided self-help, art psychotherapy, well-being groups, art, nature and physical activity, and the basis of a lot of our work is supporting people to build natural connections within their own community.

Q. Moving on again to paragraph 18, you talk about another part of your work. I'll come back to the earlier paragraphs in a second, but at paragraph 18 you talk about your fundraising activities and trauma training. Can you tell us about that?

A. Sure. So 83% of our funding comes from contracts or service-level agreements --

Q. Is that with health and social care partnerships?

A. That's right, and the Scottish Government, and 7% of our funding comes from trusts, grants, fundraising and generating income. So one of the offers we have is trauma training, where we use the trauma training framework to deliver training to other organisations who might be supporting people who have experienced trauma in their childhood.

Q. Right. We know about that because almost all of the staff in the Inquiry have undergone trauma training but not with your organisation.

A. No.
Q. At paragraph 14 you talk about the pre—pandemic situation and I get the impression —— and please correct me if I'm wrong —— I get the impression from that that most of the work that you did at that stage was in person.
A. That's right. Only a small proportion, our Trauma Counselling Line, was delivered by telephone. All of our other support was offered in person and staff worked from office bases.
Q. At paragraph 15 you give us an idea of the number of people that you provide support to. Again, can you just tell us about that?
A. Sure. So at the end of March 2020 we'd supported just under 4,000 people, and Future Pathways, which is one of the services we deliver through the In—Care Alliance, supported a further 1,117 people.
Q. Although it's not in your statement, do you have an idea of how those numbers changed during the pandemic period?
A. They increased slightly.
Q. Increased? And how were you able to deal with that in terms of staffing and so on?
A. It was quite difficult because a lot of our staff and ourselves within the leadership team and our trustees were really aware of the unmet needs of people within

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 changed the way we were delivering services to offer more group support rather than one—to—one support, which meant we were able to support more people.
Q. At paragraph 16 —— and this is not something that we've seen from many other organisations —— you identify a danger in the type of work that you're involved in. Can you just explain that?
A. So it's really important that people we support don't become too dependent on our organisation or our staff, so all of the time we speak to people about when our support will end in order to really focus them and making their time with us count so that we can have the biggest impact on them. That's why a lot of our focus is on supporting people to make natural connections within their local community or to use local resources, communities groups. Some of that focus is on supporting people to be able to develop relationships with others because we know a lot of people, especially people who have been abused in childhood, can struggle to make trusting relationships with others. So that's one of the focuses of our work and it's really important that

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

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

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 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 didn't have the IT equipment to enable us to do that. Only a few of our team had laptops. The majority of our team worked from desktop computers. Some of our staff were able to take those computers home; others weren't able to. So some -- in the initial days, some of our staff were working from a smartphone or their home computer until we were able to purchase laptops for everyone.
Q. I'll come back to that later because there's a story about the laptops --
A. Yes.
Q. -- but essentially you moved from -- in client dealings, you moved from one-to-one contact or group work into online work; is that correct?
A. That's right. So one of the first things the staff team did was to contact everyone they were supporting by telephone to let them know that we were still here, even though we weren't working from our office bases, and to offer support, offer people the opportunity to link in

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

a strength-based approach within the organisation rather than everything having to flow through myself or others 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 from everything from making sure people had like a blurred background or a virtual background when they were speaking to people to -- yeah, just how to support someone online and how different it is to supporting somebody in person.
Q. And within the organisation itself, how did the organisation switch into using technology?
A. So, for example, our board meetings moved to meeting online and --
Q. How quickly did that happen?
A. It happened really quickly. Most of our trustees had access to laptops. One of our trustees used to dial in to our Zoom meetings via a telephone, so it worked really quickly.
Q. Right. At paragraph 27 you talk about your leadership team meeting daily. Can you tell us about that?
A. It was important to meet daily to have -- to keep a sense of connection and to make sure that we were sharing the same information across the organisation.

It was important for managers to be able to check in to let us know about the progress they were making in pre-designing services and to give us a report on the well-being of their staff and also any concerns that there might be for people accessing services or our volunteers.
Q. Now, at paragraph 28 you talk about something that happened on 19 March. Can you tell us about that?
A. Yes, on 19 March our funders asked us to report to them how we would be delivering services for people.
Q. This was before lockdown happened?
A. Yeah.
Q. And how were you able to respond to those requests for information?
A. Because of our daily leadership team meetings, we had all that information to hand so we were able to give a swift response to that.
Q. At paragraph 31 you talk about starting a weekly email update for the volunteer team. Now, before I ask you about that -- that was 24 March -- had you already set up some means of passing out information to your paid staff?
A. That's right. I -- from the day that we started to work from home, I wrote a daily update to all staff and, on 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.
A. That's right.
Q. Tell me, what type of information would that contain?
A. So that included information about how we were developing our services in relation to how they might be 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.
Q. You talk about, at paragraph 32, again a difference in approach in the initial stages where people didn't know if the lockdown was going to happen for a month or however long. Can you tell us about that?
A. Yeah, particularly within our counselling services, people let us know that they didn't necessarily want to move to being supported online or by telephone; they

thought the pandemic might last a couple of weeks and so they wanted to just wait and then pick up support in person again after the pandemic. We kept in regular contact with those people because, as we got more information about the length and the duration that the pandemic might take, we didn't want people to feel that, because they'd said "No" once, that they wouldn't be able to reconsider.
Q. You talk at paragraph 34 about your relationship with Volunteer Midlothian.
A. Yeah.
Q. Again, can you tell us about that and what that organisation is?
A. So we were successful in our partnership bid to the Supporting Communities Fund with Volunteer Midlothian. Volunteer Midlothian is the volunteer hub within Midlothian and we work together to train volunteers 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 into that was to offer mental health training to those volunteers.
Q. And did that result in an upturn in the number of people who were volunteering as far as you're aware?
A. Yes.

Q. At paragraph 34 you say that there were 150 new volunteers across the area. Was that just for Health in Mind or was it for other organisations?
A. That was for other organisations.
Q. And then you also talk at 33 about accessing additional funding, yes, and then at 35 you talk about the outcome of that additional funding. Those two paragraphs are obviously related to one another. Can you just tell us about that?
A. So we were able to access a number of different grants from funding that was made available to support people. For example, the Community Response, Recovery and Resilience Fund, we used funding from that to purchase Zoom —— additional Zoom licences for staff and volunteers to use and we also used it to deliver wellness recovery action planning groups. Those groups focused on supporting people to identify daily and weekly well—being tools that they could use to keep well during the pandemic and also early warning signs that they might be starting to feel unwell or experience distress, and we were able to offer, for a short time, a well—being line for young people in the Lothians and Scottish Borders.
Q. And why did that come to an end, as you indicated it did?

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

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

A. That's right. So, in addition to sending out a weekly 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 space, just a chance to get together, have a cup of tea 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 people to spend time together with people that they knew and new people as well, and some ongoing friendships were developed.
Q. Was that a positive aspect for the organisation?
A. Yes, it was really positive.
Q. Okay. At paragraph 46 you talk about furloughing staff. How many staff did you furlough?
A. We furloughed four staff out of 140 staff. That was our —— two of our fundraising team and two people that we employed as office cleaners.
Q. We've heard from a number of third sector organisations who spoke of redeploying rather than furloughing. Why was the decision taken in your organisation to furlough a small number of staff?
A. The staff that we furloughed didn't have the skills or experience to be able to offer support. That wasn't the

reason why we employed them. They had different skills that weren't required at that time.
Q. Right. At paragraph 47 you talk about lending bikes. Tell us about that. That's just an interesting story from the pandemic.
A. So, within Midlothian, one of the support activities that we offer is a cycling group, and we had five bikes that we lent to NHS key workers to support them to be able to get to and from their work when there was limited other ways for them to get there. So, yeah, we lent out the bikes to allow key workers to use them.
Q. But you had to be conscious of a danger for the organisation in that?
A. Yes. We didn't want to inadvertently put the organisation at risk if something happened to one of the key workers when they were on our bikes. So, for example, if like a wheel fell off and they injured themselves, we didn't want to be liable for that so we had to get that checked out.
Q. At paragraph 50 you talk about assisting staff and others with —— "coping with the new normal" is the phrase that you use.
A. That's right.
Q. Tell me what you did in relation to that.
A. So when the lockdown measures began to lift and we were

able to have a little bit more freedom and we were able to support people in person and in groups, one of the things we noticed was that people were feeling really scared about being back out and in areas with large 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 started to feel anxious when they were out. Having a face covering, a mask, was difficult for a number of people that we supported so it was also —— that was really helpful to help with that feeling of panic, having the mask on.
Q. Now, at paragraph 52 you talk about the first 100 days of lockdown and your web activity as an organisation. Can you tell us a bit about that? That I think became quite an important part of what the organisation did.
A. That's right. So Health in Mind have our own website and social media channels and, in addition to that, we have four information websites covering Edinburgh and then each of the Lothians. Our information websites include information about local services as well as more general mental health and well—being information and both our own website and our information website became

hubs, a one—stop shop, if you like, for people during the pandemic, where they knew they could access the 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, 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.

Q. So you were providing information. Were you also passing people on to other organisations via the web? I don't mean in person.

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.

Q. And you talk about, at paragraph 52, the number of posts that you put up as an organisation: 434 social media posts.

A. That's right, focusing on well—being and resources. So that was —— for example, around our information that we developed around the five ways to well—being, so supporting people with practical tools and techniques to be able to support their well—being during COVID.

Q. You talk at 53 to 55 about changes over time in relation to the guidance you were receiving, that early guidance was black and white and later it became more nuanced. Can you tell me how, as an organisation, you coped with that?

A. It was really quite challenging. We had to be really careful to understand where and how guidance should be applied. Sometimes that involved checking our understanding with peers, colleagues and at times the 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

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

Q. Please don't name that person.

A. I won't.

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 personal support, that we were able to offer each other during that time. We had a daily phone call to make sure that we were both on the same page, that we were both okay and to highlight any issues or challenges that we were facing.

Q. Now, you talked earlier about the shift from in—person to online and the use of laptops. Tell me about that.

A. Yeah. So we worked out —— of course the price of laptops just skyrocketed at the early weeks of the 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 would take that money from organisational reserves.

Q. So you were going to eat into your reserves to meet that £30,000 ——

A. That's right because ——

Q. —— outlay?

A. Yeah, because it was a non—negotiable. We needed that equipment to be able to support people. But we were really fortunate in that we actually received a donation from someone who wanted to cover the cost of those

laptops for us so we didn't have to use reserves in the end.
Q. Now, you say in the statement that that person doesn't 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 laptops"?
A. It was someone who had a connection to the organisation already and was really wanting to help and had asked, "What's the best way that I can help you?".
Q. And that person doesn't want identified?
A. No.
Q. At paragraph 56 you talk about facilities for staff, particularly those working in their own home. Tell us a bit about that.
A. Asking staff to work from home was really challenging, especially for a number of our staff who lived in shared accommodation so the only private space that they had was their bedrooms. We were asking people to support others, hear and hold pain, the pain of others, within their own private personal space and it was really challenging. Other staff maybe had a bit more space but then had home-schooling on the go. Others had other caring responsibilities. Altogether it was a real juggling act for our staff team. We are normally really

clear about the boundaries between work and home and 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.
Q. And how as a management team did you respond to that?
A. Where we could, we were able to help in practical ways, so, for example, purchasing desks or chairs for people if they needed it, but also, in terms of emotional 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 data protection.
A. That's right. Information security is really important 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 make sure that they were taking necessary steps to protect the personal information of people we were supporting. That included everything from purchasing headsets so other people within their home wouldn't hear what was being said to making sure security patches were

updated on laptops, making sure that there was no names used if people were writing notes before they uploaded them on to the cloud, things like that.
Q. Okay. 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?
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 staff had given so much of themselves, we didn't want to cause any feelings of not being valued or not being recognised for what had -- what people had given. So our trustees decided, again from charity reserves, that we would offer the -- or give the £250 payment to all staff within the organisation rather than just those who were working within services that were registered with the Care Inspectorate.
Q. So those who weren't getting it from the Scottish Government got it from the organisation?
A. That's right.
Q. So everyone got £250?
A. Yeah.
Q. You then talk about several of your staff testing positive for COVID. What impact did that have --
A. We were fortunate in --

Q. -- on the organisation?
A. On the organisation. We were fortunate in that we didn't have large numbers of staff being infected at the same time. We were able to cover support. But what that did mean was that other staff within the team had to do more in order to cover for people who were off sick.
Q. And at 65 you talk about providing additional support to staff.
A. Following -- yeah, following the -- well, I was going to say the "end of the pandemic". I'm not sure if I would necessarily call it that, but we offered reflective sessions for our staff to just have a safe space -- it 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 staff, all staff.
Q. Unusually, your organisation is slightly self-critical about the reflective period that you've given to staff. Can you tell us about that self-criticism?
A. Yeah, it's my view that we did the reflective practice sessions too quickly. People were still -- our team were still kind of in the throes of what they had

experienced and, if we had waited three/four months to offer the reflective practice sessions, I think it would have been more beneficial, when people had more space to really consider the impact that working through the pandemic had had for them.

Q. And you talk about, at 66:

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

Tell me about that.

A. So every day we were getting telephone calls from people that were looking for support, people in distress. We were receiving referrals for people from third parties on behalf of people who were looking for support. Knowing that waiting lists were growing while staff were working as hard as they could and to full capacity was really distressing for staff and it was just this feeling of never doing enough. I think that was particularly evident within our Future Pathways service, which was for in-care survivors, where we just were never able to meet the needs of everyone who wanted to access support. It was really difficult.

Q. At 67 you talk about "additional support for our team". Tell me about that and the longer-term impact of the pandemic on your team.

A. Hmm. So two people have left the organisation because 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 working. We also noticed that we've lost more staff -- we've had a higher turnover than usual since the pandemic. It's not a significant number but we have noticed an increase in turnover of our staff.

Q. Prior to the pandemic were you an organisation with low staff turnover?

A. Yeah, our turnover has always been under the national average.

Q. Aha, and now?

A. And now we're still slightly under but it has grown.

Q. Okay. You tell a strange story at paragraph 68 regarding PPE and testing kits. You say there were no problems with PPE.

A. Yeah, there was no problems with PPE and there was certainly no problems with testing kits because we received huge boxes of testing kits and they just kept coming and kept coming and kept coming.

Q. Where from?

A. We don't know.

THE CHAIR: They just arrived out of the blue?

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 we could have ever used, and so what -- we were encouraging all of our staff to use them obviously. The staff could share them with people accessing our services, volunteers. We work in a shared building, we offered other organisations, and it's a shame because actually some of the test kits went past their expiry dates and we had to just, well, recycle what we could and throw out the rest. To this day we still don't know where they came from.

THE CHAIR: It's very strange, isn't it?

A. Yeah.

MR CASKIE: At paragraph 70 you talk about the impact on volunteers and we've heard from a number of sources that the desire to be a volunteer increased during the pandemic. Can you reflect on that for us?

A. We did have some increased interest in volunteering with us, but, because of the nature of the work that we do,

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 Protection of Vulnerable Groups scheme in which Police Scotland -- Disclosure Scotland undertake police checks to help us decide if someone is suitable to work with vulnerable people.

Q. You describe that, and then did that have an impact on your -- well, that must have had an impact on your requirement to conduct training.

A. Actually, because we need to have all of those checks in place ideally before we start training, and the same is the case for our staff team, staff -- in terms of people becoming PVG members, staff in key roles were being prioritised by Disclosure Scotland and so volunteers were slightly further back in the queue so it meant there was quite a long gap in getting PVGs back. The Care Inspectorate published some advice on risk assessments where PVGs weren't available and we did follow that guidance, although I felt really uncomfortable not having that final piece in the recruitment puzzle and having a PVG police check back 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 there. Could you read from the quote to the end of that paragraph, please?
A. Sure. So:
"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."
Q. Was that an important thing for you to hear and for the management team to hear?
A. That's right. All feedback was really welcomed during that time; things that we were doing well, things that we could do better, things that we should really stop doing, things that we should start doing. All of that feedback was really helpful.
Q. At 73 and 74 you provide figures, and I think you've already provided many of those figures so I don't need to get you to repeat them. But you do talk about problems with referrals at 75.
A. That's right. So the pathways into our services are different. Some of our services people can self-refer, so they just get in touch with us, but other services

require a third party referral, so that's a referral 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, personal information. So, for example, any referrals that came from the NHS had to come by letter, but letters were being sent to our offices and there was no one in the office to receive the letter. We did start to go in on a semi-regular basis to pick up post, but then, when restrictions eased, we were able to be there to get the referrals. But I guess it's another example just where we were able to work a bit more agilely -- agilely? --
THE CHAIR: With more agility?
A. -- with more agility -- thank you -- than some of our statutory sector colleagues.
MR CASKIE: Thank you. Could you read paragraph 76 aloud please?
A. "As was said during the pandemic, although we were all in the same storm, we were all in different boats and this was especially true for people accessing mental health support. Mental health issues were compounded by the fear of COVID-19, issues of isolation and being cut off from essential connections and underlying issues of 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 time with people with whom they had relationship difficulties. This too significantly impacted mental health and wellbeing."
Q. At paragraph 78 you revert to talking about BAME clients. Again, can you tell us about that and what you're saying there?
A. So, as I mentioned previously, there are a number of barriers to people from black and minority ethnic communities accessing support and these were heightened during COVID and they felt really insurmountable for some people. What made it more difficult was there was a lot of media coverage around at the time about increased risks for people from BAME communities, which also added additional concerns and worries on top of the concerns around the pandemic more generally.
Q. I'll move on. You talk about additional challenges and at paragraph 82 you talk about a feeling of discomfort arising from something. Can you tell us about that?
A. So, because of my role, I was able to work from home

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, who were travelling to the office to check on post and answer phone calls. So there was some sense of, yeah, discomfort and the lack of equity around that.
Q. Could you read paragraph 85, please?
A. "It was 'easier' [and I've put that in inverted commas] to manage the organisation when there were clear boundaries and restrictions in place. As directives allowed for more individual choice and organisational discretion, it became more challenging to balance the needs of people accessing support, staff, volunteers and other stakeholders such as funders."
Q. And at 87 you indicate that there were really, amongst your staff and volunteers, two different types of attitude towards coming out of lockdown. Can you tell us what those were?
A. That's right. So some of our team were really raring to get going, couldn't wait to get back out to support people in person, felt that at times our approach was being too cautious; and there was another group of staff who were really frightened and scared that they might become ill if we went too quickly and we returned to in-person support too fast without appropriate measures

in place; and then we had a group in the middle who were kind of, "Well, I don't know". But I would say most of the staff fell into those two groups.
Q. The extreme ends of the spectrum?
A. Yeah.
Q. At 88 you talk about effectively altering job descriptions for your staff. Tell us about that and why you did that.
A. That's right. So we -- by April 2022 we'd amended role-specific risk assessments for all of our staff, and that was to make sure that, as we returned to in-person working, that we had the proper -- we'd identified and managed the risks appropriately. We'd also opened back up our offices at that point, but with reduced capacity, so we had to develop new systems for planning ahead who would be in the office when to make sure that that was well managed and we weren't too close together.
Q. At paragraph 90 you talk about the changes that the pandemic has had on the organisation overall. Again, can you just tell us about that?
A. So there has been a really positive change in that we're now able to offer people support in a range of different ways, either in person, online or by telephone. Some people want to be supported by all three of those ways at different times during their support journey with us,

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

staff. Again, can you tell us of that?
A. At the beginning of the pandemic we were kind of working on adrenaline. It was new, it was different, we were 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 within it for us as an organisation.
But, as time went on, where people didn't have a real break, there's a real sense of exhaustion, of tiredness. I think the impact of Brexit, the cost of living crisis, increased inflation, the war in Ukraine, the climate crisis, it just all feels really heavy for our staff team just now and just this real -- a real sense of tiredness.
Q. You then talk about "Lessons Learned". All of those will be read carefully by Lord Brailsford and he will take account of your suggestion for "Lessons Learned", but you highlight a couple of points -- or I want to highlight a couple of the points. The first one you've already told us about in some detail. It's at paragraph 97 and the difficulty with the £250 payment and the inequality from Scottish Government in relation to that. Do you want to say anything else about that?
A. No, I think I've covered everything.
Q. Okay. Could you read paragraph 98 aloud, please?

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, they changed. This added a great deal of pressure whilst also managing day to day operations within the organisation. Staff felt the impact of working within an environment of constant change -- this became draining on their energy and resilience levels."
Q. Okay. You state some hopes for the Inquiry. Can I just ask, again, that you read aloud paragraph 105?
A. "I hope the Inquiry is a space where we can recognise all that individuals and groups gave during the pandemic."
Q. And then 104.
A. "It is important that we do not only view through the timeline of the ..."
Sorry, I've just ...
"It is important that we do not only view the timeline of the pandemic through the lens of what we know now, but also based on the information we knew at the time. However, it is ... important that the inquiry is clear about mistakes that were made to ensure they do not happen [again] in the future."
Q. I think those are all the questions I have for you.

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

MS TRACY NICHOLLS (called)
Evidence given via video—link
THE CHAIR: Good afternoon, Ms Bahrami, and good afternoon, Ms Nicholls. Can you hear me?
A. I can do, my Lord, thank you.
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.
Ms Bahrami.
MS BAHRAMI: Thank you, my Lord.
Questions by MS BAHRAMI
MS BAHRAMI: Good afternoon, Ms Nicholls.
A. Good afternoon.
Q. You have provided a statement for the Inquiry. For the record the statement number is SCI—WT0367—000001. I want to reiterate that everything in your statement will be considered as part of our investigations alongside your oral evidence today.
A. Thank you.
Q. Could you tell us briefly about your background and about the College of Paramedics?
A. Certainly. So I'm a paramedic myself, still registered with the Health and Care Professions Council. I've spent most of my working career within an ambulance service in England and I progressed my way to becoming a director of clinical quality and improvement with an

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

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

in the back, where you're treating patients, both patients and crew are very, very close to one another, and there was a real concern from our members that they 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 ambulance work is such that you come on shift at the beginning and you're out for 8/10/12 hours, depending on your shift, and you may never see any of your colleagues or managers, for example, in that time. So it's quite a unique environment and I think the college really felt that that consideration wasn't really given. It's not just community work. It's more than community work. It's an emergency service piece where you're dealing with the health of the Scottish public. So we didn't feel that was really closely recognised.

Q. At paragraph 32 of your statement you talk about IPC Cell guidance and, again, you didn't consider that that was appropriate for the ambulance environment. Could you firstly tell us, what is IPC Cell guidance?

A. So the IPC Cell, from our understanding, was set up in England to take the evidence that was available from a number of -- various sources to try and determine what levels of guidance should be issued across certainly

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 it had and then update guidance around infection prevention and control in most areas of health and care. So it was under NHS England, as far as we were aware. We never knew who were in the IPC Cell or who was making those decisions, but I think they worked closely with NERVTAG and a number of other bodies that were trying to decipher the evidence to provide the guidance at that time.

Q. Was their guidance used by your members in Scotland as well, to your knowledge?

A. My honest answer is I think it was inconsistent, so it seemed like there was slightly different guidance in Scotland than there was in England, and that was -- where our members reported that was a problem was sometimes you do cross-border work where -- people who live right on the borders of England and Scotland, there would be inconsistencies in how crews, depending on which country they came from, would understand what the guidance should be mean for them. But predominantly the IPC Cell's guidance for ambulance staff was the fluid-resistant surgical masks, apron and gloves.

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.

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

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 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

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

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.

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

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 forms and, you know, legislation around that with patients. What our members were finding during COVID is sometimes people had deteriorated so rapidly that none of those conversations had happened so that there was no documentation or paperwork in place. But I couldn't say definitively whether we saw more of those than not. I can find out for the Inquiry after this session.

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

and then the paramedics and the clinicians have to make a really difficult decision about taking people into hospital, given the fact that there is this virus that 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 our members had ever seen before. But if there was ever any doubt about resuscitation, paramedics would absolutely resuscitate and take to hospital.

Q. Thank you. I wonder, can you tell us, can paramedics access a system that has a record of DNACPR decisions or are they reliant on a note being visible within someone's home or a family member telling them about it?

A. It can be inconsistent. Sometimes the access of information, certainly in remote or rural areas, is tricky and it's not consistent, so the proof normally is to see something that's normally left with the patient through a number of healthcare professionals —— it could be the GP or the community nursing team —— and there would be evidence there that the crew could find easily. Electronic access to information isn't always consistent.

Q. Okay. Thank you. You state in the last sentence of paragraph 40:

"We understood from our members that they felt very

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

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

A. We found that there was a minority of our members who gave some quite harrowing accounts that, if they had made a judgment on scene to use higher levels of respiratory protective equipment, that when they returned to a station —— it may not be their own but to a place where they could restock —— they were often challenged around why they had —— what was the job that they'd been on that required them to use the higher level of respiratory protective equipment and sometimes the members told us that the equipment was actually locked away. So they couldn't access it unless they had given a rationale as to why they'd used higher RPE when the guidance said that you should be okay using 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.

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 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?
A. Yes.
Q. Did your members feel under-appreciated?
A. Certainly in the -- we did two surveys with our Scottish members and that came out as a common theme in both. We did one survey very soon after the pandemic -- the lockdowns finished and one relatively recently, and they did feel that the -- they were undervalued, and that certainly left many people -- the members who we have lost certainly seemed to be in -- they're not even at retirement age. You know, these are people who may have been in -- for 10 or 20 years within paramedicine and who, through COVID, have just decided that this is no longer for them. And there may be a number of factors that add to that, but certainly just that feeling of being under-appreciated and not well cared for and, you know, having managers that showed that compassion, you know, in areas did affect our members. They told us that very clearly.
Q. Can you tell us about the wider impacts of low morale

and the decline in paramedic numbers?
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.
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 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

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

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

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

patients that do need to go in probably need risk-stratifying with all involved in their care to say, "Is hospital the right place?", and if it is, then 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 the ED.
Q. Thank you. What were the consequences for paramedics of such prolonged handovers?
A. So initially there was obviously the fear of the virus itself. So, you know, paramedics would be sitting with a patient for hours on end and what their concern would be is -- of course that the virus, you know, had its own anxiety, but the ambulances are not built for a comfortable, prolonged time in them and patients do not anticipate sitting in the back of an ambulance for hours on end. So there is a health and well-being aspect for both parties in that sense, and certainly for newly qualified paramedics, you would anticipate seeing a number of patients per shift and sometimes crews were seeing one patient and sitting with that one patient from the start of their shift to the end of their shift and, in really extreme cases, crews were being sent to relieve the first crew at the end of their shift and another crew would take over so that that crew could go

home. So we were dealing with situations we had never encountered before, certainly from a member perspective.
Q. And do you think that issue impacted the time that people had to wait for ambulances to arrive with them?
A. Undoubtedly, because if the ambulance -- if the mode of transportation is tied up, then, you know, you're very much reliant on speaking to someone on the phone or trying to use technology to access that patient if they have the option to do so. And I absolutely understand patients were, you know, frustrated, anxious, frightened and sometimes downright furious that they had expected an ambulance to come quickly and sometimes patients were waiting for hours for ambulances and the next crew that were available to go to that patient may well have faced sort of verbal and sometimes unfortunately physical abuse as a consequence, but it's understandable that patients are calling for an ambulance with absolute expectation that one will arrive in a timely way, and that couldn't happen.
Q. In paragraph 54 you state that during the pandemic it became common practice for hospital staff to check on patients in the back of an ambulance to see if there was any deterioration. You state that at times they would even have diagnostic tests done, then be returned to the ambulance to wait for results. Again, did this apply

both in adult and paediatric cases?
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 could happen and did happen on very rare occasions, but most of the time this was for adult patients.
Q. Was this down to a shortage of beds within a particular hospital, when they were then being taken back out, or lack of waiting areas even ——
A. Yes ——
Q. —— and were paediatric hospitals better resourced in terms of those areas?
A. I think sometimes it was both. Again, the normalisation 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 with the patient and monitoring them for any deterioration, that's the least worse scenario. But the children certainly seemed to have a quicker ability to be able to be placed somewhere in the hospital, you know. I think it's —— you know, whether it's right or not, I think children and young people certainly stick

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 a medical emergency but they do need to rule out a fracture, for example, and then they might just need to wait a short time until they can get x—ray available and some space. So it was a complex situation.
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 compromised as a result of these delays?
A. I couldn't say anything different, I don't think. I think they absolutely were compromised despite 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 a space there where they would be cared for. I don't 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 on patient care.

Q. Thank you. We've heard from some that they were told or had an impression that ambulances were told not to take care home residents or people who had COVID to hospital or to take them in their ambulance. Is this something that your members reported to you, being told not to take people in either of those categories in their ambulances?
A. No, not —— from my recollection, there was one or two members who had difficulty around care homes, but it certainly wasn't —— normally from the college perspective, when you hear things multiple times across 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 homes, but coming in, what our members told us was that they invariably had time to put on their PPE and, you know, unless it was a medical emergency, they were able to take their time and go specifically to that patient. But certainly from a college perspective, we didn't hear anything other than that.
Q. Thank you. In paragraphs 58 to 78 you talk about communication and guidance. How much of a role did the college play in interpreting and adapting guidance, Scottish Government guidance, for paramedics?

A. Yeah, so I think the college recognised that we were a smaller voice during COVID and it's understandable. You know, I'm sure from a Government or an arm's length body perspective, during this time there was a lot of noise coming at them from a number of organisations. So the college joined with an alliance of members, including the British Medical Association, the Royal College of Nursing, et cetera, and we were just trying 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 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 resuscitation and the fact that, as new variants came through COVID, we were seeing sickness rates ebb and 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.
Q. Yes. When you contacted individuals in the

Scottish Government to raise issues specific to paramedics, what sort of responses did you receive?
A. I think there were only two responses that the alliance received. That was it as far as I was aware. I think everything has been shared with the college that was received back. There was nothing we received.
Q. How well do you think the college was listened to by the Scottish Government and Government organisations?
A. I think on our own I would dare to say we weren't listened to at all. As part of the alliance, I think there was a consideration that there were professions out there that, you know, perhaps needed some closer scrutiny. But, you know, when you're dealing with a pandemic, I have no doubt that it's incredibly difficult to try and juggle everything at the same time. But, you know, we felt unheard and our profession felt unheard and, you know, what we could see was our members living through this every single day, worried about their families, you know, losing family members, losing colleagues, and it just felt the imperative was so great but we clearly didn't land our message in the way we needed to.
Q. Where members in the college considered that their interests and welfare wasn't being adequately considered, did the college issue its own guidance to

members, for example, in relation to appropriate PPE 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 saying 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

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

the research and evidence and we felt we couldn't do anything but that, recognising it would make people anxious.
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?
A. Yes, I think the case mix of what paramedics were seeing certainly changed and some of the -- what would be traditionally primary care work, including things like, you know, repeat prescriptions, for example, or trying to access a particular service by default became something for the ambulance sector, and I think -- you know, the Scottish Ambulance Service I know tried really hard to triage those calls out to try and -- you know, didn't want to send an ambulance to those calls necessarily because it wasn't ambulance-related and didn't require an ambulance. However, sometimes -- you know, people get very confused and will call because they're not really sure what else to do and it's very difficult to unpick that sometimes in a call. So some of our members did end up going to calls that were really not for ambulance transportation to hospital or indeed ambulance related but ended up trying to be

conduits to services and sometimes spent a long time on scene trying to access services that were very difficult .

Q. Thank you. What impact has all of that —— encountering these cases and working in these situations , what impact has that had on the mental and physical health of the profession?

A. Again, I think it's multi—factorial. So there is —— I think sometimes some of our members felt that this was not within their skill set , not within their gift , to be able to help a patient with some of these queries. There was frustration that the system seemed to be putting everything onto the ambulance sector and them particularly . And sometimes people were very anxious —— we saw right across the UK that some patients left it much longer than they would have done before they sought help for specific conditions, which often made them much sicker by the time that the crew had got to them.

But it's that frustration of not —— you know, if the patient doesn't know where to go, the ambulance crew aren't necessarily going to know how to access some of those services or get a repeat prescription , for example and, despite the best signposting you can give, if the services are running, you know, really thinly because of their own workforce absences, for example, then it makes

it very, very difficult .

So there is a sort of psychosocial element to this in that paramedics want to go out and do ambulance work, they want to do the very best they can for patients who are —— you know, have limb or life—threatening conditions who are requiring of their skills , and quite often now we see it's more around sort of primary or urgent care conditions because I think the patient population has changed in the way it wants to access its health and care.

Q. Thank you. Now, I'm aware from your statement and you've mentioned that the college carried out two surveys of Scottish members to gather their thoughts on issues such as mental well—being, PPE and guidance, and we'll consider the results of those surveys alongside the entirety of your written statement and your oral evidence today. Is there anything we haven't covered today that you would like to highlight?

A. I think I would just pay —— like this opportunity to pay tribute —— you know, we lost paramedics, they lost their lives through COVID doing a job they love, and I think this is —— this seems an opportune moment to just pay tribute to those, some of whom came out of retirement to support the work that was required. And paramedics feel very strongly that they're there in patients' times of

need. You know, when, during lockdown, patients were anxious and frightened and lonely in some cases and concerned, paramedics didn't stop providing that care and, you know, I would really want the Scottish public to know that paramedics will remain with them now and in the future despite whatever happens.

But I guess for me I would really strongly recommend that the Inquiry considers the mental health and well—being impact on our profession. You know, we're starting to see a reduction in those coming through the pipeline for paramedicine and, as I say, people leaving, and the retention of paramedics is going to become more challenging. So just to address that mental health and well—being of our members would be really important to me. But other than that, no, just thank you for the opportunity to come and talk to you today.

MS BAHRAMI: Thank you very much for your time.

THE CHAIR: Yes, thank you, Ms Nicholls. Thank you very much indeed.

Good. Again we're a bit early. I don't know if the next witness is here. Do you by any chance know?

(Pause)

It may be possible to start at quarter to but I can't promise. I'm sorry. It would be good if we could, but it depends on the witness being here. In the

meantime, thank you very much. Quarter to, but if not, 3 o'clock.

(2.25 pm)

(A short break)

(3.00 pm)

MR EWING HOPE (called)

THE CHAIR: Good afternoon, Mr Edwards. Good afternoon, Mr Hope.

MR EDWARDS: Good afternoon, my Lord.

THE CHAIR: When you're ready, Mr Edwards.

MR EDWARDS: Thank you, my Lord. The Inquiry will now hear the evidence of Mr Ewing Hope, who is currently the Chair of the Scottish Unite Health Committee.

Questions by MR EDWARDS

MR EDWARDS: Good afternoon, Mr Hope.

A. Good afternoon.

Q. Can you give the Inquiry your full name?

A. Ewing Hope.

Q. You have before you a witness statement, I hope?

A. Yes.

Q. Can you confirm that that is your witness statement ——

A. Yes.

Q. —— and you've had an opportunity to read through it?

A. Yes.

Q. Yes. Thank you.

You agree to your witness statement being published ——
A. Yes, I do.
Q. —— and also to your evidence today being recorded?
A. Yes.
Q. Yes, thank you very much.
My Lord, the witness statement of Mr Hope has the reference SCI—WT0443—000001.
Mr Hope, you have provided quite a substantial statement for the Inquiry and I thank you for that. There are a number of matters which have headings, the first of which is in relation to PPE and the second of which is in relation to infection control. The Inquiry has heard quite a lot of evidence about various difficulties with PPE around matters such as the availability or lack of PPE, what you describe as the "sporadic" allocation of it once it was available and then issues associated with the effectiveness of PPE. Now, although I understand that this is very important, because the Inquiry has heard quite a lot about PPE problems, I'm going to take that part of your statement quite quickly.
So in relation to the lack of PPE, what you say in I think paragraph 9 of your statement is that things changed from the start of the pandemic as the pandemic

progressed. What you identify in paragraph 9 is a lack of PPE and then, as it started to become available, what you say in paragraph 10 is confusion over PPE. Do you want to say a little bit more about that? What do you mean by the "confusion" around PPE?
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

was falling on deaf ears initially, but it got to the stage —— and I make the point in the statement —— that 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 providing services until they were in a safe position. And that's when that changed in relation to the organisation's priorities becoming the need to get PPE because without that you werenae going to have services.
Q. Now, you were in a position to know about this because you are the chair of the Scottish Unite Health Committee.
A. Yes.
Q. Can you say something about the Health Committee and your responsibilities with it?
A. So the Health Committee meets in a normal process about four times a year, which was every quarter, and it's always in person. When the pandemic hit, I was the vice chair at that particular time, but the chair wasnae very well so I chaired most of the pandemic meetings. But because we were using Zoom and media platforms, it was far, far easier to get meetings. So during the pandemic we were meeting on a regular basis. Our Health Committee is made up of representatives from

every health board and every special health board, so you've got that and, because of the nature of Unite, the diversity amongst the committee, you can go from —— our membership rather —— you can go from a domestic to 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 got a rich dialogue about what was taking place and what was really missing.
Q. Now, the Health Committee is a national body ——
A. It's a Scottish body.
Q. —— a Scottish body, yes, but you have particular responsibility and specific knowledge in relation to the Ayrshire and Arran Health Board ——
A. Yeah, so within the NHS structure, Ayrshire and Arran, we've got 15 different trade unions. Every four years we elect a staff—side chair, who then gets appointed to the board through cabinet secretary, and you assume the mantle of employee director, which gives that individual more access to more senior management team meetings and dialogues. So the range from a normal rep to where I was sitting at was far, far different.
But the other part and my role during the pandemic was to make sure that I had regular meetings with collective staff side within Ayrshire to provide

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

Q. Was that something that was particular to Ayrshire and Arran?
A. I think initially it was but that was rolled out to the rest of the country.
Q. And what was the main purpose of the PPE champion?
A. Certain groups of staff within a health setting will have used PPE on a regular basis. The majority of staff will use certain parts of PPE, like the gloves or aprons, but the masks, gloves and aprons have to be donned and doffed in a particular way to prevent infections for the individual so that training for staff on how to don and doff PPE was really, really important because that again reduced the risk of transmission of COVID.
Q. In paragraph 15 of your statement you use an interesting expression, which is that, "Staff became PPE exhausted". Do you want to say more about that?
A. If you go back to the original statement I just made, the majority of staff will use certain parts of PPE, but not on a regular basis. So staff were getting -- when I say like they became "PPE exhausted", what I mean is that the donning and doffing would probably slip, with the inappropriate(?) use of PPE, doubling up of gloves, et cetera, so staff were -- the guidance was changing so often that it made it difficult for staff to follow the

guidance every time. But the longer the pandemic went on, staff became more and more -- and I will use the word "exhausted" by the use of PPE because it was a strain on them.
Q. Later in your statement you talk about problems with training during the pandemic.
A. Yes.
Q. Were these problems also -- did they also exist in relation to the use of PPE?
A. Initially they did but we -- and I go back to that statement about the infection protection and control teams, so they were primarily our PPE champions, so we were taking them away from one part of the organisation where they were needed to undertake training for staff in the wards and in the clinics.
Q. Yes. Then, in relation to masks, like many other witnesses you identify various problems with availability of masks and then the effectiveness of masks and expiry dates.
A. Yeah.
Q. Anything more that you want to add about that in relation to masks in particular?
A. The masks thing -- and, again, if you take the FFP3 masks, which were face-fitted, and you have to go through a certain process and it's timely, but to make

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

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

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.

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

A. Yes.

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

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

there's still very ill patients, but again it's the skills they have for ICU which is slightly different or considerably different from the skills in the ward-based unit.

Q. Is it fair to say, then, that some of these PPE problems led to staff being deployed not necessarily according to their skills?

A. Yes.

Q. Is that right?

A. Yes, absolutely. That's the point I'm making because again it's providing the staff with a safe environment from which to deliver their services.

Q. As I'll say at the end -- of course the Inquiry will have the benefit of your whole statement -- but before we leave PPE, is there anything else you would want to say about PPE and the issues that arose during the pandemic?

A. We weren't prepared as a country for COVID and we certainly werenae prepared as a health service. So if you watched what happened in Wuhan -- and we could see it on a daily basis on our TV sets -- and what happened in North Italy, we knew it was coming in our direction, but that preparation to ensure staff safety never crossed our leaders' minds effectively. And it wasnae until the staff side raised issues about staff safety

that they then became a priority because the reality is 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 downfalls. We knew it was coming but we were not prepared.

Q. Thank you. The next two sections of your statement begin at paragraph 21 and the first one of them is about infection control or infection prevention and control, as you call it --

A. Yes.

Q. -- and the second is about RIDDOR. Just to be clear, "RIDDOR" stands for the "Reporting of Infectious [sic] Diseases and Dangerous Occurrence Regulations".

A. Yeah.

Q. So we will refer to that as "RIDDOR". If we begin with issues around infection prevention and control, in paragraph 21 of your statement you focus in on what you refer to as the "Proper Assessment Group".

A. Yeah.

Q. Yes. Now, can you say something more about that?

A. So if you get an outbreak within a hospital setting, then we set up a PAG -- the Proper Assessment Group -- or the other word -- terminology would be an "incident management team", which brings together senior

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 hospital, and you can tell what room they've been in, who their nurses were, where they were at a particular time, so you can follow the patient's journey. What that allows you to see is where the transmission would take place because then your second cases and third cases would go on respectively where you could see the spread.

Because infection rates were so high and outbreaks were so high, we initially were running IMTs, but it became so busy that we were unable to and therefore that learning of how the virus spread through a health setting, we lost that opportunity. So rather than investigating it, we were getting it reported twice a week through our COVID Oversight Group.

Q. So the first distinguishing feature of a PAG, a Proper Assessment Group, is that it focuses on when a patient comes into the hospital with an infectious disease and the exercise allows the hospital to identify where they've been --

A. Yeah.

Q. -- and who may have been in contact with them. So what you're saying in paragraph 22 of your statement is that,

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

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

pandemic —— well, at the beginning, the start, of the pandemic?
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 RIDDOR as a result of it being in the workplace, which made little sense considering, as soon as you brought the community into the workplace and our setting, in a healthcare setting, then that became the transmission zone. But that was never rescinded.
Q. Just so I understand, what you're saying is that a RIDDOR exercise was about identifying contamination, for want of a better word, in the workplace ——
A. Yeah.
Q. —— but, as you recollect it, according to paragraph 25 of your statement, the Health and Safety Executive issued guidance that RIDDORs were not to take place ——
A. Yes.
Q. —— in relation to workplace spread?
A. They didn't expect it because it was a community—based transmission and not a workplace issue.
I believe, having looked back historically, that probably was based on the very first cases within the UK back in January 2020, where Public Health England published —— their finding was that this was very low

risk to healthcare staff and it was a community—based 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.
Q. To use a word you've used previously —— I think it emerges from about the middle of paragraph 25 of your statement, which is quite a long paragraph —— that some RIDDORs were sporadically carried out.
A. Yes. So if you have a staff death, then it's an automatic RIDDOR within the workplace. When you had some more high—profile cases and we had —— one or two of them was within the NHS Ayrshire and Arran —— then that drove the need for a further investigation and therefore that then uncovered the need to make a RIDDOR report. So there are one or two.
NHS Ayrshire and Arran were probably the highest health board in the country to submit a RIDDOR during the COVID pandemic and, again, I think that was due to staff side, who were constantly arguing about the need for RIDDORs and the need for staff side to be involved in these investigations, which we weren't, but we continually made the argument about the need for RIDDORs.
Q. So although the Health and Safety Executive, as you recollect it, indicated that there were not to be

RIDDORs, still some took place?
A. Yes.
Q. And that would be when there was a death; is that right?
A. That's an automatic RIDDOR or ——
Q. Death of a staff member?
A. Death of a staff member. So RIDDOR is purely about staff, so —— and again it's about that —— forcing the issue by staff side in general about the need for RIDDORs, that we did win some of the arguments and some of them we didn't unfortunately.
Q. It's also true —— in paragraph 26 of your statement, you say that, as you remember it, the first RIDDOR that was submitted in Ayrshire and Arran was where there were multiple deaths in a coronary care ward in one hospital. That was patient deaths, was it?
A. That was patient deaths.
Q. So what prompted the RIDDOR in that case?
A. That was one of the high—profile cases, plus all staff who care for patients are really protective and care deeply about their patients, and the staff in this instance who —— unless we did that deep—dive RIDDOR, that focus of that potentially it was the staff who infected the patients and therefore they caused the deaths and therefore we needed to have a proper investigation, which then uncovered that the staff were

contracting in the ward as opposed to bringing it into the ward. So it was high profile, there was a lot of discussion about it and they needed a proper investigation, and that was a result.
Q. Can you remember when that was —— when that RIDDOR was?
A. That would probably be April/May. It was quite early on.
Q. Of 2020?
A. Yes. I could be wrong with the dates, but it was fairly on in that phase of the pandemic.
Q. And a RIDDOR results in a report, does it?
A. Yes.
Q. Is that published?
A. No, it goes to the Health and Safety Executive and that's then recorded where it needs to be recorded that there's a workplace injury or infection.
Q. Now, in paragraph 29 —— excuse me, in paragraph —— yes, in paragraphs 29 and 30, you indicate your view —— you state your view as to why RIDDORs were not done.
A. Yeah.
Q. Which is what?
A. Purely because, one, the Health and Safety Executive made a decision it was community—based but I also think there's an element in relation to liability thereafter, workplace infections and personal claims. So I think ——

I've got no doubt there was a financial part to that decision—making process.
Q. At paragraph 29 of your statement you discussed some alternatives that were considered at the time to identifying the source of transmission in hospitals. So do you want to say ——
A. So this was round about 2021, just after the Christmas period and the second lockdown, and infection rates were getting higher and higher and higher and Government had, for some unknown reason, decided that, in their opinion, it was because staff were infecting patients and therefore they set up a Compliance Taskforce Group at the request, I'm led to believe, by the Cabinet Secretary, who was Humza Yousaf at that particular time, to look at how we could identify either staff to staff or staff to patient transmissions. And there was a clear inference that there was staff who were transmitting the virus within the hospital setting.
When they came and had —— and again I was there representing actual staff side —— when we first met, I asked to show what evidence they had, what information they had, to suggest this is how it was taking place because, if there was a lack of investigations that we we'd been calling for for the best part of a year that had never taken place, how did the Government have that

level of data. We asked to see the data, but they clearly couldn't provide it so it was purely on a hunch.
Q. This is data about ——
A. Staff.
Q. —— the level of staff infection?
A. Yes. They didn't have that data so their response or one of the responses were —— apart from communications, et cetera, was that staff would be more compliant if they knew they were being watched, and there was a suggestion that we put body cams on to nurses to make sure they're complying with regulations or with guidance, which I found —— I was astonished initially but then I was deeply offended by the suggestion that that's where Government went. So in their eyes our staff went from being superheroes to supervillains overnight without any evidence.
Q. What happened to that proposal?
A. It came to that group —— it came to myself and I made it perfectly clear that staff side would never accept that as being an appropriate use of —— and an invasion of our staff's privacy, and if they wanted to go fishing, I suggested they get a fishing rod.
Q. What is the current position in relation to RIDDOR or, rather, when did RIDDORs recommence?
A. RIDDORs, they always —— they were always there but they

were never there for COVID. So if you had an industrial injury or industrial accident, then a RIDDOR would still be put in. But in relation to COVID, that guidance is 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 COVID outbreaks. In relation to PAGs, they still don't take place and, again, because we've still got the guidance in situ from the Health and Safety Executive, that hasn't changed either, so you're still not getting RIDDORs for COVID outbreaks.

Q. If we can turn to the next section of your witness statement, which deals with various aspects of the impact of the pandemic on staffing, and here there are a number of themes that you identify. The first arises from absence rates.

A. Yeah.

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

say that, not surprisingly, absence rates increased dramatically.

A. Yeah.

Q. And what was the consequence of that for people who 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 services.

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

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.

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 non-COVID.

Q. I see. Right.

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

A. Yes.

Q. -- irrespective of exposure to the virus?

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

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

A. Yeah, because staff -- staff who worked in a ward were fully aware of their patients and built up that rapport with patients and they worked as a fairly close team within a ward. As soon as you start disrupting that and staff were coming in not knowing whether they were going to be on their own ward or on a separate ward or in a separate specialty, then staff became really stressed because they didnae know what their daily day was going to be involving and therefore staff were coming to work with that level of anxiety about, "What's going to

happen to me today and where am I going to be put?". So it wasnae always comfortable for staff to be moved around about the hospitals.

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 well-being hubs.

A. Yes.

Q. Yes. Can you remember when that began?

A. That began, I would say, probably early April/May 2020.

Q. Right, so early on?

A. Very, very, very early on, and it was about creating spaces for staff to get out the ward and relax in an environment where it's fairly safe to do so, where they could get a cup of tea, a cup of coffee, whatever they needed, and it was about that chill-out time, which was really important for staff. We also had quiet areas at the same time. These were drawn up fairly quickly in the early days of the pandemic. Within NHS Ayrshire and Arran we then moved to develop that on a more permanent basis and we've got well-being hubs in our three main hospitals.

Q. Now, going back to paragraphs 42 and 44 of your statement, you discuss at some length issues around the testing of staff --

A. Yeah.

Q. -- during the pandemic. Was there guidance on this matter?

A. Yes, so when we moved to daily testing of staff or random testing of staff, whatever it was going to be, the guidance that came out is we would issue the LFTs, the lateral flow tests, and staff would undertake these at home to make sure they're negative before they came into the workplace. Where they became positive, then we would wait to get a PCR, then they would start their 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

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 at home rather than coming into the workplace positive and, again, it goes back to the money situation.

Q. How long did that continue, that staff were to test at work rather than at home?

A. Not very long once we got wind of it because we made the point that that was a useless exercise because the whole purposes of staff testing at home was to ensure that we didnae bring it into the workplace or into a patient environment. So it probably did last two or three weeks, I'll be honest, but once we got wind of it and we knew it, then we got the guidance reaffirmed and sent back with clear notice that that was unacceptable practice.

Q. Yes. Now, you also mention issues around vaccine hesitancy and the implications of compulsory vaccines, but, again, the Inquiry has heard quite a lot about that. Is there anything specific you want to say about the implications of compulsory vaccines and vaccine hesitancy?

A. Vaccine hesitancy was -- and again, because staff have that level of knowledge about how long a vaccine takes to actually be developed, the effectiveness -- and there

was a bit of concern that it was so quick that we were unsure about what potential side effects there were going to be, and therefore that was a slow burner to win the staff side and the staff's confidence that the vaccines were the right place to go. From a staff side perspective, we always encouraged all of our members to take the vaccine when it was offered because it provided them with protection, their patients with protection but also the families with protection. So we did win that argument with our own members, who then started taking the vaccine on a more regular basis, but there was that 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 that same level of protection.

Now, I made the point and will continually make the point that anybody who works within the Health Service is there to provide a service for the patients. Certainly from entering to exit we've all got a role to play in a patient's recovery or a patient's treatment and therefore I don't see one as being more important

than the other because the reality is —— and I hear this constantly about front—line staff —— the first person you meet when you get into hospital is the receptionist, 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 strongly and we won eventually, but it took a long time.

Q. When you say "a long time", by when was the argument resolved and you ——

A. Well, I couldn't tell you when it was resolved, but it probably took three or four weeks, yeah.

Q. Right. Now, my Lord, if I could turn to one issue in Mr Hope's evidence that is particularly significant. It concerns what he has to say about mental health nursing. This is at paragraphs 59 to 60 of your statement. Now, if you could just briefly describe what you mean by "mental health nursing", is it the staff that work in that area?

A. So staff who work in a mental health facility, and in Ayrshire and Arran it would be Woodland View, which was our mental health facility. So the staff in there —— and again it's a different clientele because your staff in there are probably physically —— a lot more physically fit than they will be in an acute setting and therefore they're more transient within a mental health

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 do.

Q. You say that some patients, in paragraph 59 —— so there's two issues. There's patients wearing PPE and then there's patients with mental health conditions reacting to staff wearing PPE. In relation to patients wearing PPE ——

A. No, patients —— I think that's a mistake —— patients never wore PPE. They werenae tolerating their carers wearing the PPE, and it became challenging within that

particular setting because this was about individuals.

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

A. Yeah.

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

A. Yeah, absolutely.

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

A. Like I said, staff would probably do as much as they possibly can to make that process of getting patients calm, getting the patients to understand the needs for why they were wearing masks, and I could probably say anecdotally that staff would probably remove their mask at some point just to —— and again it was to appease patients. But it wasnae through malice. It was through trying to provide the best care they can for their patients, which was understandable.

Q. So one of the particular challenges in relation to mental health nursing, then, for the staff involved was the reaction of patients to wearing PPE?

A. Yeah.

Q. But another challenge you cover is that mental health patients are more mobile.

A. Yeah.

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

the country more?

A. No, just round about that particular facility. So I think it's Woodland View that —— they'd be in corridors and going in and out of each other's rooms because that's what normally happened prior to the pandemic hit, and therefore to change that routine for mental health patients is really, really challenging for the patient and therefore patient care dictated that we had to minimise impact as much as possible but they still had that freedom of movement.

Q. In paragraph 60, however, you do relate one incident ——

A. Yeah.

Q. —— where a mental health patient was moved elsewhere and that eventually led to I think what you say is the only case of a staff member contracting COVID and dying.

A. Yeah.

Q. Is that right? Can you say a bit more about that?

A. My understanding is that the particular patient was moved up to a Glasgow facility. For whatever reason that didnae work for the patient and they were brought back into Ayrshire and Arran, but they were brought back in without the proper test being done and by the time they got back into the workplace, that individual was COVID—positive and the member of staff who was treating that particular patient contracted COVID and sadly died

some time later. And again it was about that lack of testing during the movements between Glasgow and Ayrshire and Arran.

Q. Are there any differences in the impact of COVID on staff who worked in mental health nursing compared to other healthcare staff?

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

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 required.

Q. What about staff working conditions and attendance at work, was there any difference there or was that much the same?

A. So pre—pandemic, if we get breakdowns of staff absences and the cause of staff absences —— and at that particular time mental—health—related illnesses would equate to somewhere between 23/24% of all absences. Post pandemic, whatever wave —— first, second wave —— it may have been —— you saw that increase in mental—health—related illnesses and now we're up at 34/35/36% of all absences. So staff are still reliving what they experienced during the pandemic and they're still trying to understand it and to deal with it and 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.

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 earlier, about shuffling staff round about hospitals to make sure we had proper cover.

Q. Turning to another matter briefly, which is the impact on restrictions on visitation in hospitals. You deal with that in paragraphs 61 and 62 of your statement.

A. Yeah.

Q. I think what you're suggesting there is that dealing with relations and visitors was also disruptive and had an effect on working conditions and the mental health of healthcare staff.

A. Yeah, very much so because initially we —— there was no patient visiting. We then relaxed some of those guidances and then it was appointments —— visitation by appointments. It was only one at a time, at a particular time, and anybody coming into hospital clearly had to wear the appropriate PPE and masks, and that's how it should have run naturally.

But patients' loved ones, visitors, they were 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

individuals. But, again, that was a real confrontational point. But again staff were looking for their own safety but also the safety of other patients and visitors werenae always aware of them.

Q. Now, you have a section in your statement about long COVID and again this is a matter which the Inquiry has heard about from other witnesses, including the fact that the impact of long COVID or the incidence of long COVID amongst healthcare staff is higher than the general population. Is there anything specific you want to draw out from these paragraphs in your statement, which begin at 63, about long COVID?

A. I think the most important part about staff who then went on to develop long COVID —— and I go back to those initial —— the missing investigations, whether that be RIDDOR or whether that be PAGs, which would have identified if that unfortunate individual contracted the virus in the workplace because, once they then leave the organisation as a result of long COVID, they don't have that financial security that they should have had in relation to personal liability —— personal claims and industrial injuries benefit. That whole opportunity was missed.

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

staff who have had to leave work as a result of long COVID. I'm no naive enough to think every one of them contracted it in the workplace but I am well aware that the majority probably did. But they're now leaving with that lack of financial security or that financial safety net and therefore their lives have changed forever, and I think they were at the expense of, "Let's save a few pounds", at the beginning of this process.

Q. You say in paragraph 63 of your statement that, in your view, at least, for some in the NHS, management and the employer are less sympathetic and you say that some people regard long COVID as the new sore back.

A. Yeah, and I've heard that expression within the workplace because -- and again, because long COVID isn't one particular sign or symptom and it's made up of a whole host of different problems that individuals can be left with, some are more debilitating than others -- but even the minor long COVID, so -- and I take myself. As a result of COVID, I've got constant sinus infections, which is a problem for me -- but if you take that to the workplace, it's like, "Oh, he's got long COVID again", and it's the reality of people are suffering as a result of -- whether it be work or whether it be COVID or whether it's that combination of contracting it in the workplace but the employer is

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.

Q. Before we come to lessons to be learned, there is one matter I would like to ask you about, although chronologically I suppose it goes back to the beginning of the pandemic, which is the section of your statement where you're talking about working from home.

A. Yes.

Q. This is at paragraphs 70 to 72 of your -- or I suppose 70 to 74 of your statement. This concerns staff who were able to work at home, of course, so that would mainly be administrative staff; yes?

A. Yeah.

Q. What you say in paragraph 71 is people -- well, they were sent home to work at home basically with their laptop and there was no other support -- "Staff were sent home with a laptop and a phone [and] that was it", is what you say in paragraph 71. And there was no -- and that led, of course, if they were working at home, for example, to sitting at desks and you giving other examples, including I think you say people sitting at ironing boards and so on. You indicate that there were musculoskeletal issues with people's neck and back because of sitting for long periods in inappropriate

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

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

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 example, if they had a therapeutic chair at work before

the pandemic, would they not take it home or be provided with it?

A. Not everybody did. The majority still haven't, to be honest. And I only know that from the team that I manage, that the majority of them are still using a work laptop and a phone.

Q. So they didn't have the chair they might have had at work, for example?

A. Yeah, because everybody that works in their own office has got their own chairs and their own screens, et cetera.

Q. Are you aware of an increasing prevalence of these repetitive strain injuries or bad postures --

A. Yeah, you see it, and again you go back to that absent supporting that the organisation undertakes. You see that increase in the musculoskeletal problems on a recurring basis and, again, it's that referral into occupational health, looking for physiotherapy treatments, et cetera, or occupational therapy treatments and how to conduct, et cetera. So we have seen an increase and I think we will continue to see that increase until we bottom out proper work spaces for staff in their own homes that are secure and safe.

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

that seclusion. They didn't have that interaction with their colleagues and that, again, caused their own -- individuals to feel that stress and anxiety because of isolation syndrome. And that's still something that we're working through and, again, through our well-being hubs we're tackling it but it's a major issue.

Q. Thank you, Mr Hope.

The last part of your statement is a substantial one about lessons to be learned from the pandemic in light of your experiences. If you were to identify two lessons to be learned, what might you say they were?

A. The first one has to be applied not just through a pandemic but really life, that unless you can ensure your staff's safety, you will never be able to provide patient safety because they're both in the same environment. And unless they're in balance, then one of the two are going to be at risk. Therefore, by failing to provide staff with that initial PPE and that -- and again I go back to the investigations of outbreaks, we never put staff in a safe place so we need to go back and reflect on that. And going forward we need to make sure that staff safety is our number one priority because, without that, you'll never ensure patient safety. So I think that's the first learning.

The other one, and I keep coming back to it, is we

knew COVID was coming because we'd seen it for three months on our TV sets every night, we still weren't prepared. So that preparation for what's coming over the horizon is real and rather than waiting till it gets here and we look like rabbits in the headlights, we need to have our preparation and plans in place for an outbreak, whether it be COVID or flu or whatever. Because we know there's going to be another one, unless we take the lessons learned from here and make sure we're ready and we're prepared and we've got a plan, then I think we'll always get into the same pickle.

I remember asking a senior clinician before the first case came to Scotland about what our COVID plans were, how we're going to deal with them. The response was, "We don't need a plan, we've got a flu pandemic plan, that will do". Clearly it didnae. So that glib answer to me was really, really damning because the reality is we knew what was coming because we'd seen it in North Italy and we were still not prepared. And therefore we have to take every opportunity to provide safety for staff and patients in a hospital setting and our community setting, because it's really important.

Q. Mr Hope, your witness statement as a whole and your evidence today will stand together as your evidence to the Inquiry. Is there anything else you would like to

say in conclusion?

A. No, I don't think so. I think we've covered the main points. Thank you.

MR EDWARDS: Well, I'm very grateful to you for your statement and your evidence today.

My Lord, that completes Mr Hope's evidence.

THE CHAIR: Thank you. Thank you, Mr Hope.

A. Thank you, my Lord.

THE CHAIR: Very good. Tomorrow morning.

MR EDWARDS: Thank you.

(3.57 pm)

(The hearing adjourned until Wednesday, 8 May 2024 at 9.45 am)

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