OPUS 2

Scottish Covid-19 Inquiry

Day 45

May 9, 2024

Opus 2 - Official Court Reporters

Phone: 020 4518 8448
Email: transcripts@opus2.com
Website: https://www.opus2.com

Thursday, 9 May 2024

(9.45 am)

THE CHAIR: Good morning, Mr Caskie.

MR CASKIE: Good morning, my Lord. Our witness this morning is Susanne Napier.

MS SUSANNE NAPIER (called)

THE CHAIR: Good morning, Ms Napier.

A. Good morning, my Lord.

MR CASKIE: Shall I begin?

THE CHAIR: Please.

Questions by MR CASKIE

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

A. Susanne Anderson Napier.

Q. I believe in relation to the Inquiry you've provided a witness statement; is that correct?

A. Yes, it is.

Q. The top of the witness statement will appear on the screen. You've signed this witness statement and before you signed it, had you read through it?

A. Yes.

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

A. Yes.

Q. And do you wish to adopt all of that statement as part

of your evidence today?

A. Yes, I do.

Q. For our records, the witness statement number is SCI-WT0472-000001.

I'll ask you this: from which organisations are you appearing this morning?

A. Turning Point Scotland and Unite the Union -- it's for Unite the Union.

Q. Is it correct to say that effectively you had two roles during the pandemic? One was your employment with Turning Point -- and I'll ask you to explain that in a bit of detail later -- and, secondly, for Unite the Union?

A. Yes, that's correct.

Q. And tell me about your role within Unite.

A. My role within Unite is -- I'm a workplace rep. I'm also the treasurer and the secretary for the branch, which is SC38/415.

Q. Yours is an organisation which loves acronyms as well.

In terms of Turning Point, do you know how many staff, how many employees, it had?

A. Yes, it's approximately 1,600.

Q. Okay. And over what range of roles does that organisation operate?

A. Do you mean in terms of the individuals they support or

do you mean --

Q. No, what do they do?

A. What do they do? They support vulnerable individuals in society.

Q. And your role, what was it you specifically did?

A. My role as lead practitioner means that I supported individuals in the service -- known as "Time Out/218 Service" -- it was to support individuals in the criminal justice system, women who had offending behaviour.

Q. And in what venue did you provide that support?

A. That was 218 Bath Street, the service known as "Time Out" or "218", as it's -- you know, more people know it as the "218 Service" in criminal justice.

Q. I understand that that service no longer operates; is that correct?

A. Yes.

Q. Okay, I'll ask you about how it came to an end, if I can put it that way. But whilst it was operating, what function did you carry out? You said you were a lead practitioner. When did you work?

A. When I first started there, for about a year I worked in the day service, the dayshift team, and quite quickly -- it was about a year in. That would be about 2014 -- I started working nightshifts. So I was the lead

practitioner on nightshift. There were two staff on nightshift, myself and a support worker, and basically it was to, you know, support the women throughout the night.

It was a 24-hour service --

Q. Was it a residential service?

A. It was a residential service at that particular point. There would be 12 beds, so there would be 12 women -- we were generally pretty often full -- there would be 12 women with -- as I say, they had offending behaviour, offending histories, but most of them -- and I would say 90%-plus -- also had issues with substance misuse, both alcohol and other substances. So when they came in, they would be undergoing detox and at night I would be supporting individuals through that process; you know, emotional support, homely remedies. We had nurses on board, but not throughout the night. Really all aspects of supporting folks emotionally and physically.

Q. And was Turning Point viewed as an alternative to custody?

A. Yes. This service in particular came about as a result of an increase in suicides in Cornton Vale Prison and, following a review, it was decided that we needed something different, we needed a more holistic approach, something that was less punitive. So 218 was, you know,

basically conceptualised to do that, providing, you know, holistic support, counselling, cognitive behaviour therapy, detox from alcohol and other substances, group work, emotional support —— just a more holistic and just a better way of supporting folks because most of the women there were really victims and had been since, you know, their younger years.

Q. Okay. Are you able to tell us what the budget for the 218 was when it was up and running?

A. Yes, prior to COVID, it was 2 million, was actually the budget. Shortly after COVID they reduced that by —— I think —— at that point I think they reduced it by 200,000 and that took away the day service.

In addition to the residential service, the 12—bedded unit, we had a day service that supported around 60 women in the community from Glasgow and Greater Glasgow, but that budget at that point was slashed. And the reason for that was that we weren't getting the same footfall. However, considering we had just gone through COVID, which had an impact on who was presenting at the service, that's why that budget at that point was reduced to 18 —— 1.8 million.

Q. We've heard from a number of different sources that third sector organisations often have to bid for funding from Government agencies, health and social care

partnerships or from Scottish Government. Did 218 go through a requirement to bid?

A. They did just last year, rather —— no, this year. Prior to that, no, our funding was —— came from a different budget. I think it was from the justice budget, central Government. We didn't need to put out tender. The money was there pretty consistently until this year, when, you know, we had to put it out to tender.

Q. Having said the budget previously was £2 million, how much would the bid have paid a successful bidder?

A. How much did —— how much were they —— I'm not quite sure what you mean by that, but if I could —— what I will say is what happened was there was a review of services carried out in —— I can't remember the exact date. There was a review of services carried out and we were asked to put in a bid for it.

Q. Can I take you to paragraph 7 ——

A. Yeah, please do.

Q. —— in your witness statement.

A. Yeah, right. Okay.

Q. You say there about the cut in funding and then:

"The decision is very controversial ... Funding for the facility was put out to tender with the outrageously low budget of 600,000 ..."

A. Yes, that's right.

Q. Having put it out to tender with that as the budget, did anybody bid?

A. No, no, and as I've said in the statement —— I sort of had to backtrack on that there —— it was —— they originally said our budget would be —— I think they were saying it was going to be 12 and then just immediately they came out and slashed it to 600,000, which is a completely unworkable sum. When you consider it had been 2 million reduced to 1,800 [sic], so that's when we took away the day service —— so 1,800 [sic] was the amount of money we required to run the 12—bedded unit, and when you consider that the tender that was offered was 600,000, it's completely unworkable. You know, it was one—third of the money that we had after the initial cut back in 2020.

Q. And what was the impact of that on the service?

A. Well, the service had to close because nobody bid. Turning Point knew that they could not even dream of running that service on that amount of money. It would —— actually, if they'd run it on 600,000, it would have been a hostel with no support. They wouldn't have had all the support. I mean, we had doctors, nurses ——

Q. But that decision was taken, and was that decision taken independently of COVID or did COVID impact on that?

A. Well, I suppose that's a matter of conjecture, isn't it,

because, you know, we have different ideas why they were trying to claw back finance. A lot of people might have said that, because funds were so long following COVID —— the costs of COVID, they were trying to get money back in whatever way they ——

Q. And now that 218 has closed ——

A. It's gone.

Q. —— what are you doing?

A. At this point in time I'm just in between jobs, although I still work as what's known as a "companion" for Unite. I'm due to start another job shortly but at this point in time I was made officially redundant on 31 March.

Q. And what's your new job?

A. I'm a stand—down officer with Unite the Union.

Q. So a full—time official?

A. Well, a part—time full—time official.

Q. A part—time full—time official, okay.

Now, at the start of COVID, the lockdowns, I understand you were off work; is that correct?

A. Yeah.

Q. And I understand the reason for that is because you personally suffered two bereavements in quick succession.

A. Yes.

Q. I don't want to go into the details of those, but the

consequence of that was that you were off work, as I understand it, until —— when did you go back?
A. August —— beginning of August ——
Q. Okay.
A. —— 2020.
Q. Right. So you were unable to work. Did you carry on any duties or functions in your capacity as a union rep?
A. Yes, I did. I continued to take calls from colleagues.
Q. And what did you do with those calls when you were receiving them?
A. Some of the calls I was able to just deal with at source by allaying people's anxieties or, you know, point them in the direction of policies that had been put out by Turning Point Scotland. I was privy to them still ——
Q. I also understand that you would refer quite a lot of people on to a particular individual ——
A. Yes.
Q. —— within the organisation. Now, please don't name that person, but can you tell me what their role was?
A. The health and safety officer for Turning Point Scotland.
Q. And how were they dealing with enquiries they were receiving?
A. It's my understanding they would be gleaning the information from the same —— you know, from what

Government was putting out and they would then be passing that information back on to their, you know, colleagues, people that they were supporting.
Q. Right. Can I take you to paragraph 17? You talk there about what the calls were about and you indicate they weren't really about PPE.
A. Hmm—hmm.
Q. Was that because, within the organisation, PPE was pretty widely available?
A. Yes, it was.
Q. Then at 18 you talk about most calls from people working in the learning disabilities sector. Can you tell me about that?
A. Yeah. Really, as I said, most of the calls I received was from that particular sector because they had less —— they felt they had less control over the hygiene and who was coming in next to the project or who was leaving, whether they had cleaned it properly. Also there would be at times relatives visiting. You know, I know that there had been a restriction on that, but their anxieties were around people coming in, maybe not social distancing, maybe the place was not as clean as they would like it to be —— just a general anxiety around transmission. But most of the enquiries came from that particular area.

Q. And at 19 in the witness statement you talk about people being concerned about going off sick ——
A. Yes.
Q. —— and people approaching you as a union officer in relation to that. Can you tell us about that?
A. Yeah. As I said, folks were concerned that, if they were off sick, would that be a trigger point, would that then mean it would result in formal absence disciplinary procedures, and I was able to tell them that, no, that we had come to an agreement that that would —— that, you know, any COVID sickness absence, although they would receive support to see how they were and whether they were fit to return to work, it wouldn't result in disciplinary action at that particular point in time; that they would be supported and also paid.
Q. You move on at paragraph 20 to talk about changes to the guidance happening all the time. Tell us about that and what impact that had.
A. I suppose that's quite an anxious period of time because there was so much stuff to try and read through to keep abreast with what the current procedures were. You know, it just felt as if there was information just cascading from everywhere, from the union, from Turning Point Scotland, from the Government —— you know, a bit of a whirlwind going on really to try and keep

abreast with the information that then I would have to pass on to others.
Q. Now, you have a heading just before paragraph 22 in the witness statement which is "Daily Routine within the Facility". What you're talking about there is the normal practice prior to COVID happening within the facility and how 218 engaged with residents in particular. I don't need to take you through that kind of daily routine, but you, at 29, talk about having to incorporate social distancing into the daily routine. Just tell us about that, please.
A. Well, it meant changes to the staff team. We had quite a healthy staff team, and healthy in terms of numbers, and that had to be reduced to ensure that, you know, we were not —— there's a narrow corridor. You know, you'd be sliding along the walls to try and maintain social distancing. And also for —— you know, when the shifts changed, there was also a change to that, where the handovers were different, and also how we engaged with like nursing staff. Normally, I would go in with the nursing staff and —— with the women and sit and chat. That no longer happened. We were just given, you know, handover by one person in a room, isolate —— you know, socially distance.
It was difficult because people would forget ——

especially the women that were using the service, they would forget and come right up to you and ask you things, and you were trying to say, you know, "Please, can you maintain a distance?". It was just a very, very, very difficult time. Everybody was so anxious about transmission.

Q. You indicate -- and I don't need to take you to particular bits of it, but from 22 to 28 -- the activities that would normally be involved for women. Tell me about the activities for women residents when COVID happened.

A. Some women chose to self-isolate and they would be in their rooms for most of the time. We had a lounge area, a pretty big lounge area, which folks could access only two at a time and socially distance. Really the main thing that they did was probably watch TV. They had access to -- more access to laptops to allow them to engage with family. Prior to COVID, families would visit regularly, you know, a supported visit with staff there, but they would visit regularly. Folks had children, you know, women who used the service had children, they would visit. They could no longer see their children so they did that through, you know, FaceTime, that sort of thing. They were incredibly bored. That's what I'll say, you know, and isolated.

Part of the thing they needed most was support from other people and really that couldn't be provided in the way it had been prior to COVID.

Q. Okay. Now, you talk about, at 31, the COVID outbreak and lockdown and then you provide personal information as to why it was that you had to take time off work and, as I've said, we don't need to go into that. But at 33 you talk about the facility also doing work in the community. Can you tell us about that, firstly pre-pandemic?

A. Do you mean my role or just the service --

Q. The facility.

A. Oh, the facility, as I said, had a day service which supported women in the community, so it ran groups -- it ran group work, a group work programme, you know, about -- the group work programme would be about offending, about addiction, mental well-being. There would be craft groups. There was acupuncture offered daily, Acu-Detox. All of that ceased, all of that stopped.

Q. Then we know that you had a period of absence until August 2020 and you talk about that at paragraph 35. You talk about some of the changes that you've already made reference to. Is there anything in paragraph 35, particularly the final four or five lines,

that you want to talk about? You're talking about women suffering a relapse whilst they were in. How was that dealt with during the lockdown periods?

A. Some women would just leave the service and that would be that. They would just go back out on to -- you know, some folks had nowhere to go. They would be back out on to the street. But I think just the pressure of being isolated and not really -- although they were still receiving a degree of support, it was not the support -- nothing like the support that they received prior to the pandemic. You know, not only did they not have support from staff, they didn't have the support from their fellow residents. It was no longer available.

And part of the recovery process is building community support, as in the community of 218. That was no longer available to folks. So for some folks that relapsed. It just seemed that the only way that they could cope with their mounting anxiety was to go out and possibly use substances, drink alcohol. It was a very, very difficult time. Very difficult.

Q. How did Turning Point respond to that?

A. There's really not that much that Turning Point could do. We could try and find people once they left -- you know, we always had contact details, mobile numbers. Some folks had no address to go to. But what we would

do is we would contact the police and tell them that such and such individual had left the service or, if someone had been sent there with a court order, you know, through their lawyer, then obviously we would contact the relevant individuals and let them know that, you know, someone had just sort of left. We would hear an alarm sometimes. Folks would just leave in the middle of the night, down the back stairs, gone. It was really difficult because there was nothing out there for folks.

Q. At 37 you talk about health and safety and again you make reference to the health and safety officer and also the chief executive but you also give an indication about another anxiety that staff had in relation to transport.

A. Yeah.

Q. And you would hear -- did you hear about that through your role as a union official or was that something you just picked up?

A. Probably both. People would talk about that in the context of, you know, other calls, in addition to, "This is how I feel about ... I have to travel to work". In fact it was something actually I had to do myself so I can personally relate to that fear of transmission when you were on public transport. You know,

I travelled over an hour to work and an hour back, so sometimes you were in closer proximity than you would have wished to be. So I would say both. Folks were just talking about it generally, staff, and then other folks would be mentioning it as well as, you know, difficulties around their work-related stuff.

Q. You've spoken about the necessary support within the 218 community, if I can put it that way. As a worker, were you also getting support from the wider Turning Point staff? Was there any communication, staff communication, across the organisation?

A. Not that much.

Q. And what about in terms of dealing with guidance? When new guidance came out, how were you, as a staff member and quite a significant staff member, effectively running a shelter during the night -- how were you provided with information regarding updates to guidance?

A. Regular -- very regular contact through email from both the chief executive and the health and safety officer. We were -- they were cascading information very often and, if need be, I could pick up the phone at any point and call the health and safety officer.

Q. Was that guidance always consistent with itself, if I can put it that way? You know, did it change significantly over time?

A. Oh, yeah, yeah, and that's why there were regular updates.

Q. One of the complaints that we've heard from other sources is that the guidance that was being issued was too frequent and too -- and not always consistent with previous guidance. Was that your experience?

A. Yes, there was really a plethora of information and it was pretty hard to keep up with it. And, yes, it was changing often. You know, people were saying, "I've just read such and such but now they're saying this", and it was just a very, very difficult time. It was a pure upheaval to not only our personal lives, lives at home, but in the workplace -- yeah, a very difficult time.

Q. Okay. I'm going to go back -- I just want to clarify something. The funding that you received, was that from the Criminal Justice System within Scottish Government?

A. Yes.

Q. It was?

A. But there was also a ringfenced amount that we had, and I think it might have been £300,000. There was a ringfenced amount that came from the city council which was withdrawn. They said they could no longer afford to do that. That ringfenced amount had been in situ since -- well, that would be -- when did that open?

It would be 20 years this year, so it would have been in 2004 that that amount was available and then it was just withdrawn.

Q. Gone. At 45 you talk about the process for women who -- going through the process, so how women came to end their time at 218. How long typically would a woman be within 218, typically?

A. Well, prior to COVID it would be six months. After COVID and towards the end of the service it was whittled right down to 16 weeks, which is not nearly enough time.

Q. And tell me about the transition. What happened at the end of the period that a woman would be with 218?

A. Towards the end of the period the women would go through a process called "graded exposure". What that would mean is they would be -- there would be a plan, a risk assessment plan, put in place to start the gradual process of people moving back into the community. So that would be in terms of them dealing with how they felt emotionally, being outside the safe environment of the building.

So, as I said, a plan would be put in place and initially we would support individuals to go out, you know, maybe just have a coffee, whatever, return to the service, and that would gradually improve until someone had a plan of action that they would follow; you're

going here, you'll have a coffee here, you've chosen to maybe go to two different shops, you'll go to this shop -- you know, it was quite prescriptive. You stuck to the plan just to enable folks to gently return to society without just saying, "There you go, you're back in Sauchiehall Street" and --

Q. Was that a supported process?

A. Yes.

Q. Who was it that was providing the support?

A. The day service staff, the staff that worked the dayshift. Not the day service, rather -- the dayshift staff would provide the support, carry out the risk assessment, formulate the plan in an agreement with the women.

Q. And at 48 you talk about referrals and how the process for referrals changed over time --

A. Hmm-hmm.

Q. -- in that the geographic area was reduced.

A. That's right.

Q. Can you tell us about that?

A. Prior to COVID and possibly some time -- I can't remember exactly when it changed, some time between COVID and now -- we used to be able -- our catchment would have been Greater Glasgow, Scotland. We'd have women from all over. And then that was reduced down to

City, Glasgow City. So we couldn't take referrals from South Lanarkshire, North Lanarkshire, you know, Renfrewshire, et cetera.
Q. Which you had been taking previously?
A. Oh, absolutely, absolutely.
Q. And was the service that you were providing highly regarded by the users?
A. Absolutely.
Q. Yes?
A. Absolutely.
Q. You talk about that and you talk about something quite surprising in relation to that at paragraph 48, about halfway down, where you say that the criteria for entry was to have a conviction. Tell me about that.
A. Previously we had supported women who were at risk of offending behaviour —— you know, of offending behaviour and also at risk of getting a criminal conviction, so we would support individuals to see where their behaviour was leading them. And then afterwards what we had to do was take women only who had an existing criminal justice history, you know, they already had convictions. And I think I said that some women had actually said that they'd gone out and committed crimes so as that they could get into the service because they knew, if they hadn't actually —— if they hadn't been charged with

something, they didn't have a chance of getting in the service. And I found that was —— you know, we had been proactive and then afterwards it was a reactive service. You know, we were supporting women who had actually a criminal justice history as opposed to be at risk of offending, which is a much better way of dealing with things in my sense.
Q. At paragraph 51 you talk about the number of calls that you received. Presumably these would be calls from furloughed trade union members. Can you just tell us about how that varied over the period of COVID?
A. You've said it would —— yeah. It was not only from trade union members. It would also have been just from —— probably from Turning Point Scotland staff as well, people who —— I was supporting people who weren't members. I'm not going to say to —— I just wasn't going to say to someone, "No, I'm not supporting you, you're not a member". So I was taking calls really from the whole staff team at that point.
Q. And you explain to some extent what the calls were about. Can you tell us about that?
A. Again asking about —— just trying to allay their anxieties around sickness absence, about —— I've already spoken about the learning difficulties service, where it was around the hygiene and it was about transmission,

about folks coming out of —— you know, people who had —— I did say earlier in the statement that Turning Point Scotland doesn't support elderly people but we support elderly people who have learning difficulties.
So they would be in and out of —— they would be more vulnerable through age and also having, you know, Down's syndrome, whatever learning ... it meant that they did get a lot of hospital treatment and may have been in hospital. And quite a few calls were around someone getting out of hospital and coming back into the community to share a house with maybe three other individuals and workers. So folks were at their wits' end, saying, "The hospitals are full of COVID. What happens when they come out? Do they have COVID? Do we test?". There was a lot of anxiety around that.
Q. Did Turning Point take steps to allay those fears?
A. Yes.
Q. Why were people coming to the union rather than to their employers?
A. Probably just because they thought maybe they had more —— not confidence but —— just maybe I'm more approachable or they felt I was more approachable, there to ...
Q. At paragraph 53 —— I'm not going to ask you to read it out —— but you identify that there were particular

problems at particular facilities.
A. Yes.
Q. Again, without going into the specifics of what you refer to at paragraph 53, what was different about the venues from which you were receiving a large number of calls?
A. Those would have been the services which were in people's own homes. So what there would be is maybe a four—apartment house supporting three individuals living in their own home, shared accommodation, and that would have been, as I said previously, about maybe folks being in hospital, coming out, back into the service and also the amount of staff that were going in. So you would have maybe two staff in the morning, two staff in the evening, you might have six staff supporting those three individuals over a 24—hour period. So it was just about the footfall, the amount of people social distancing. They were definitely in much more close proximity so the anxieties were just around transmission.
Q. And you refer at paragraph 55 to you being involved in communication with managers about people going off with COVID. Again, why would you be involved in that rather than someone just going directly to their line manager?
A. Because at times the line managers appeared not to be

aware that there had been an agreement made that folks wouldn't be penalised for it and the letters that were being sent out to individuals who had been off sick with COVID —— the letters at that point still had headings like "Formal absence meeting", and people were saying, "Why is this a formal absence meeting? I've had COVID. It shouldn't be like that". So I was then going back to managers and saying, "Look, can I refer you back to probably the communication that you've had from X, Y and Z because it's clearly saying this shouldn't be a formal —— this is not a formal absence meeting. It might be a supportive meeting. So you need to ..." —— and they did eventually change the wording on that. And that created a lot of anxiety around folks, you know, this formal absence. People thought, "Oh, we'll lose our jobs, we won't get paid", blah blah blah.

Q. At 55 you talk about workers who were off several times with COVID in close succession. Did that link to particular anxieties?

A. Sorry, which paragraph are you referring to?

Q. 55.

A. Oh, 55 again. Yeah, of course, there was an anxiety around it. But although those procedures did change, I know more recently the COVID —— anyone who is off with COVID, it is now just as in sickness absence; at that

particular point in time it wasn't. So I was again just saying to them, "Don't worry about it. Do not worry about your absence through COVID. If you can prove that you had COVID, you'll be supported through that, you'll receive your wage, you won't be penalised, you'll get a supportive meeting, but it's not a formal absence meeting. It should just be a supportive meeting". And it's really down to, I would say, the ineptitude of some of the managers, who maybe weren't reading —— you know, are not getting properly briefed on what they should be doing.

Q. At paragraph 59 you talk about a longer—term impact within not just Turning Point but the health and social care sector in general. Can you tell me about that, please?

A. Yeah, and you see in the first kind of statement in that, I would say a lot of people who were —— definitely worked harder, had more anxiety around their own health and providing support for others with wages that didn't reflect what they were doing, just thought, "We've had enough. We're out, we're out. We're leaving this sector", and we're still feeling the impact of that now.

Q. So did you view that as quite a significant number of people who simply said, "No more"?

A. Yes, yes. And we know in Scotland that there is now ——

you know, the social care sector is on its knees basically. There have been so many people that left and just said, "No, we've had enough", and I know it's probably similar in the NHS. It was such a stressful time for people and they just don't feel they were —— you know, although people were out clapping in the streets, you know, they weren't financially remunerated. They didn't feel —— they felt after it was all sort of dying out that they just went back to being kind of dogs' bodies really. That's what the people would say.

Q. At 62 you talk about what you view as a difficulty that arose from wearing masks.

A. Yeah, without a doubt. I've never in my life ever had sinusitis before and I had it really, really badly and still at times suffer for it because I had to wear a mask —— wear a mask on the bus two hours, wear a mask for a 12—hour shift unless I was sitting on my own. Yeah, I feel that had a real detrimental effect to myself and I know that there are —— even people within my family are suffering from it, regular sinusitis now, and that's what they —— I suppose having a mask on and having the fibres had an impact. My daughter is a nurse and her face would be red raw literally with wearing a mask in a heated environment.

Q. At paragraph 63 you talk about your attitude to the

vaccine. I'll give you the opportunity to explain that.

A. Yeah. I do believe I have long COVID and whether —— I mean, I'm not a microbiologist, I haven't studied it in depth, but I do know and I do feel that the vaccine came out so quickly, and although, of course, there are —— you know, they've done various studies prior to it, you know, COVID—19, on the one hand, they were saying it's so unique, it's so different from other virus —— to think that in jig time they could have managed to get a vaccine that was somehow going to have that impact, you know, to prevent you having it or for it to be less of an impact, I don't know. I'm very sceptical about it.

I know people who have not had the vaccine and have had COVID and it's been slight, and they've had conditions like diabetes or whatever, and I know people who have had all the vaccines and have had COVID which has hit them like a tonne of bricks. Who knows? I certainly —— as I said, I took two vaccines, I wish I had never taken it at all and, if I was offered it again, I wouldn't do it. I think there was an awful lot of pressure. Although I don't believe it was mandatory, certainly there was that feeling of, "Will you be taking the vaccine or you'll no going here or you'll no be going there and you'll no be flying?". There could be

an element of you losing your job. All of this was an undercurrent going on. It's kind of veiled threats towards what would happen if you don't take the vaccine.
Q. That was the next thing I was going to ask you about because you make reference to that at paragraph 66. I think -- I don't need to ask you to repeat what's in paragraph 66.
Those are all the questions I have for you, unless there's anything important that you think I haven't covered.
A. No.
MR CASKIE: Ms Napier, thank you very much.
A. Thank you.
THE CHAIR: Yes, thank you, Ms Napier. Thank you, Mr Caskie.
Mr Caskie, we've finished early again, which is -- this is not a criticism. It's relatively common. I don't know if the next witness is here actually.
MR CASKIE: Nor do I but I'm sure the usual channels will be in touch, if I can put it that way.
THE CHAIR: Yes, if it's possible to start early, we can start at about 10 to or something like that, but, if not, we'll start at 11 o'clock. Thank you very much.
MR CASKIE: And I will see you this afternoon.
THE CHAIR: So I believe. Thanks.

(10.33 am)
(A short break)
(11.17 am)
THE CHAIR: Good morning, Ms Bahrami.
MS BAHRAMI: Good morning, my Lord. Our next witness this morning is Maurice Hickey, who is Scotland head of policy at the Pharmacists' Defence Association, and his statement reference number for the record is SCI-WT0333-000001.
MR MAURICE HICKEY (called)
THE CHAIR: Thank you. Good morning, Mr Hickey.
A. Good morning, my Lord.
THE CHAIR: Right. If we're all ready, Ms Bahrami will have some questions for you.
MS BAHRAMI: Thank you, my Lord.
Questions by MS BAHRAMI
MS BAHRAMI: Mr Hickey, please could you tell us briefly about your own background and about the Pharmacists' Defence Association, please?
A. My own background is that I'm a pharmacist. I've been a pharmacist for 42 years and over that period I've worked in all the sectors of pharmacy and I've worked as an employee, I've worked as a contractor pharmacist and currently I work as a locum for the trade union. I've also been active in pharmacy politics over most of that

time and basically have sat on every board at some time that you can get elected to, including the board of the Royal Pharmaceutical Society of Great Britain.
I work for the PDA partly because of COVID. I just got -- by 2021 I got to a point where I'd had enough basically and wanted out to a certain extent and the PDA had started to restructure as a result of COVID and were sort of changing the way they operated in Scotland.
The PDA is the largest representative body for pharmacists. There's roughly 65,000 registered pharmacists and we represent, as members, 38,000 of them and we're the largest such body in the British Isles at the moment. Roughly 10% of our members are in Scotland and PDA is a trade union, it's also a professional indemnifier and it's a membership organisation. So we try and look after them, and it is only for pharmacists. It's not for other pharmacy staff.
You know, we challenge employers, regulators and Government on behalf of the members and we look after the students from the day they start at university. We offer them free membership. That's it basically.
Q. Thank you. Now, when the pandemic restrictions were put in place, many pharmacies saw a surge in workload while some saw a significant decline in patients and customers. Would you tell us the reasons for this, please?

A. The reason was because of the lockdown. If you worked in a city centre pharmacy -- a lot of cities are not like Edinburgh in the sense that they have a lot of people living in the centre. A lot of cities have business areas or whatever and all these people vanished to home workers as a result of the lockdown. I was doing the odd day very close to here and what we found was our patients changed overnight. It was all the ones that lived nearby that we started seeing where previously they would have gone to pharmacies near where they worked during the day.
I think some of the pharmacies were around railway stations, for example, and in the more business-orientated areas their clientele vanished overnight, and it took a number of the companies that controlled these pharmacies -- they were mainly chains, but they -- I think it took them several months to sort of adapt to that.
The other side of the coin was that in the more outlying areas these pharmacies became busy because of that, but they became much busier as a result of the general lockdown. But this change between city and perhaps the suburbs was quite profound.
Q. Thank you. And that led the busy pharmacies to

implement a one—in/one—out queuing system. Did that lead to issues with some patients, particularly in the winter months?
A. It led to issues with some patients from the word "go", but by and large people accepted it, certainly during the first lockdown. You have to remember that a pharmacy —— when you go into a pharmacy, the patients going to it —— it can be quite a big area and there's a bit behind that the patients are excluded from, and it's much smaller. And in many cases we had to sort of move forward in the shop, and to have two people queuing in the shop, that caused problems and you were —— everything had to be done at the counter, so, for example, if we were dealing with people that wanted to come in for a urinary tract infection or to get the daily supervised methadone, we couldn't take them into our consultation rooms. That had to be done at the counter and these are quite tricky interactions to manage if there's a queue in the shop.
So very quickly it had to be one—in/one—out. So when the patient came in, it was just them and whoever was there, which led to a lot of people thinking that not much happened in pharmacies because they're used to them being quite bustling places, but in actual fact there was a lot going on and, if there would be things

going wrong, patients wouldn't be aware of that.
Q. Thank you. In paragraph 19 you state that:
"A number of GP surgeries were doubling prescriptions to ensure customers/patients would not run out. For example, instead of 4 weeks' worth of prescription, they were issuing prescriptions for 8 or 12 weeks at a time. This also contributed to subsequent shortages of medications, particularly for devices like asthma inhalers."
And later in your statement you also speak about people stockpiling over—the—counter medication, such as paracetamol, which also led to a shortage of that medication, and in time people stockpiling lateral flow tests. Firstly, did that ever result in medication expiring before it could be used and so leading to waste?
A. I don't think anyone could say for certain if it would have. Generally in a pharmacy if you pick up a prescription and it's longer than the expiry, you're given enough until the expiry date and then you're asked to come back. That in itself was —— particularly for some of the COPD inhalers was one of the sort of issues that caused patients to become, shall we say, agitated because they weren't sure if they would get the second one and they were always aware that there were shortages

because it was widely publicised.
In terms of the —— I think the idea of issuing four—week prescriptions, there's quite a lot of evidence that suggests that, if you eight instead of four, there is more wastage, so —— you know, it means more work for some people, but now it's all computerised it's not so difficult. But a 12—week prescription there's considerably more wastage because people don't always need it and people were ordering things they didn't necessarily need because they might need them. You know, that would be medicines for stomach problems and what—not where —— depending how they eat or, you know, different factors. They would not necessarily need a month's worth for a month, but they were coming in, getting as much as they could, and you felt it was always because it was, "What if we run out of things?". So that was an issue.
In terms of the overall waste, I don't think anyone has documented it. But something I've discussed with colleagues and we noticed was that we gave out huge amounts in —— particularly in the first lockdown. This didn't occur in the other ones because the health boards leaned on the doctors to go back to normal prescribing and everything settled down. But in the first lockdown we discussed that with colleagues and we would say,

"Well, that means they don't need it the next time —— in two months' time or three months' time when they're —— because they've had it when it's due", but they would still come in and if —— I looked at a few records myself and I know others did, and it would seem that a lot of that must have gone to waste.
Q. Thank you. It might be that GPs were pressured by patients to double and triple prescriptions, but do you believe that there would have been the same level of shortages if GPs hadn't prescribed in that way and if individuals hadn't chosen to stockpile over—the—counter medications?
A. I mean, sadly shortages are with us all the time. It's a major part of my job —— a major part of any pharmacist's job. But I do think that there was a shortage of paracetamol, for example, and there was a shortage of COPD —— you know, drugs that had an effect on breathing, inhalers and the like. And I think the fact that people were overprescribed probably for about six weeks from the onset of the lockdown, that contributed to it and it took the supply chain several months to settle back down.
Certainly, once we got into the second lockdown and the third lockdown, I would say, yes, there were shortages but not really significantly more than I would

expect at any other time. I mean, if it happens to you, if you're the patient, it's not good news. And the shortages are very often drugs —— you can't say to a diabetic, "Well, I'm sorry, we can't get your insulin". That involves changing the therapy, that involves other practitioners. There's all sorts of things to reinforce it. But generally the shortages that we hear about are the shortages of painkillers, shortages of insulin, shortages of drugs for people that have difficulty breathing, and these are all worrying for patients.

Q. If a patient with diabetes or COPD, health issues like that, wasn't able to get their medication, would there be a risk of them having to be admitted to hospital to be managed in a different way?

A. There's always a risk with every patient. Medicine is not a risk—free supply function. There were difficulties then certainly with communications with the surgeries. We would refer them to minor injuries, minor ailments or to casualty if we thought fit, but generally we would try and get them to make contact with the doctors, and we would contact the doctors and say, "Look, there's a problem with this". There's a process, it's not perfect, but I don't think that particularly failed. I think some patients got quite close —— or

quite stressed by the situation and, you know, I think, if they were admitted to hospital, it was because there really was nothing else that could be done. If it could be managed at home, they were managed at home.

Q. Did the PDA ever try to raise the issue of prescriptions with double and triple the amount of medication or issues of stockpiling by individuals with the Scottish Government?

A. I don't think we raised it in particular but I'm pretty sure some of the other bodies did. It was well known. As soon as it happened, I think a lot of pharmacists complained to the health boards and said, "Look, we can't manage this situation".

Q. Was there a view that either the Government directly or the health boards should have stepped in sooner to prevent this becoming an issue?

A. I don't really know what they could have done because, to be perfectly honest, it happened so quickly and they did act. I mean, perhaps they didn't act as quick as I would have liked or as the working pharmacists would have liked, but they did act. Having said that, there are professionals that will do as and what they please. I mean, that's true for all the professions, not just the medical ones. But, generally, once the health boards sort of were alert to it, I think things

started —— we went back to having normal shortages.

Q. Yes. In paragraph 21 you mention that pharmacists also took on a triaging role during the pandemic.

A. Aha.

Q. Would you tell us about that, please?

A. Well, that was partly because the doctors —— it was very difficult to see a GP. Having said that, some surgeries were better than others. The very worst, I think, would be that the receptionist and not the doctors were just telling everybody —— if you phoned the doctor, you were told go to the pharmacy and we would see them the next day or the same day and basically we had to triage them. A lot of them we could treat, it has to be said, but a lot of them we couldn't. We had to —— you know, there had to be local mechanisms in place to refer them back. Some surgeries were good at handling it and some were bad.

Q. And that also increased your workload further?

A. Oh, it hugely increased our workload because you've got your normal workload that you do —— and we're very busy as a rule. I suppose the best thing about a pharmacy in a sense is that there's no appointment system, anybody can walk in, anybody can access —— you know, ask to speak to the pharmacist. If anything, the queuing helped in one way, but in the other, a lot of the people

we were seeing —— we saw —— all sorts of people would just come in and I —— you know, you almost thought they wanted out the house if it —— you know, it was an excuse to get out the house, and I wouldn't blame them. I didn't know what it was like to be banged up for six months because I had the opposite problem, not being able to be.

But I think the triage system, in some surgeries the receptionists just were told to send everybody to a pharmacy and that considerably sort of increased our workload on top of what was already a huge workload. Many of us —— our surveys, the PDA surveys, the Safer Pharmacies Surveys, were showing in 2017, 2018 and 2019 that there was —— in parts of pharmacies there were instances of burnout in the 80% range and COVID just blew that out the water. Everybody struggled.

THE CHAIR: Can I ask, please, this increase in the use of pharmacies for triage purposes, did that cease, go away, go back to what it was pre—pandemic when the pandemic abated or went away?

A. Well, no. We have a —— you'll have heard of the "Pharmacy First system", where we can supply counter medicines and we get paid —— the consultation —— we get paid three ways. It's the same payment that you get, but we can give the patient advice, we can supply

medicines or we can refer them to the GP surgery. And Pharmacy First was relaunched in 2020. It was meant to be relaunched in April and they postponed it to end of July/beginning of August, which increased the education burden on pharmacists in the midst of the first lockdown. But the Pharmacy First system in many ways is a triage system. So you have three choices, one of which is to send the patient to the doctor.

I think the usage of the system was 2 million patients used it in the first 15 months or so. It was widely popular and it continues to be the same. If anything it's busier as more and more people are aware of it. So that triage system was in place, was heavily used and is still heavily used, but it's structured differently now. It's one of the positives.

THE CHAIR: Thank you.

MS BAHRAMI: Thank you. We've heard from a number of other professionals that there were great feelings of stress, under-appreciation, mental health was severely impacted and there was a lot of burnout and people were leaving their professions early; there was a sense that they were seen as separate to the NHS and not appreciated like NHS staff. Were those range of feelings and actions also true for pharmacists?

A. Widespread, widespread. I -- when I read through the

union -- the PDA did a lot of surveys, including the Safer Pharmacy Survey, and when you read that it just -- it just comes out the page in neon that everybody felt like that. And pharmacies -- a community pharmacy particularly is a bit different in that it's not -- it is part of the NHS and we deliver NHS services, but the pharmacists, the work they're in -- the locums have no access to the NHS pension, they're not on NHS pay scales, they don't have the career structure that you have with band 5, 6, 7, 8 and 9 in the NHS, so everybody feels slightly divorced. I think, particularly in the case of that group, the feeling of being isolated and excluded was -- and there was other things happened, but that feeling was magnified, if anything.

I remember at the beginning of the thing we got -- we were told to stay open and there was a letter coming round, saying, "If you get ill, contact Public Health and they'll tell you if you can go to work". I knew one pharmacist who worked in a pharmacy who -- they were in an area of Edinburgh that had a lot of tourists and there'd been lots of the rugby players come to that area, and he got ill with what in retrospect was obviously COVID, but when he phoned the Public Health, they said, "You've got the wrong symptoms, go to work".

You know, you have to say, on the other hand, I don't think they knew how it was developing, but there was more than one instance like that. It was always a problem.

And then, I think initially, there were difficulties with many of the pharmacists getting the communications that were coming from the Government and coming from the contractors' body, Community Pharmacy Scotland. Both sets of communication was very good but, because of the sort of position as employees of contractors, as subcontractors to contractors, a lot of them didn't see the information coming out initially.

That was made worse by the fact that they changed the operating platform that the NHS email system works on and a lot of people, like myself, who had an old -- I'd had an old nhs.net email since about 2005 and all of a sudden they changed it to nhs.scot, and I couldn't get one because they had problems that meant you had to be fully integrated into the NHS to get one, and they would allow one person in a shop, I think, to have the email initially.

They've got that sorted out now but I know that was -- having spoken to Government officials, that that was a problem also for some of the other professions. Locum dentists, locum optometrists and people who were

peripatetic all had difficulty getting the emails and accessing information.

Q. There was also an issue regarding low-paid pharmacy staff moving to other -- leaving their jobs and moving to other roles that were deemed less stressful; is that right?

A. That's always been an issue. The pharmacy support staff -- I mean, at the moment the Government or the DHSC in England have put through national protocols to allow technicians to take on some of the work in community pharmacy under PCDs, but the employers aren't training as many staff as they can because they pay them so poorly that, as soon as they get them trained, they'll go into the NHS because they can earn a third to half as much and they have a career structure and they get the pension and they have to work less hours and they don't have the stresses that they get in community pharmacies.

That's always an issue. All of us in community would work with support staff who are trained, the technicians, they're regulated, who would leave and get more money stacking shelves or sitting on the till at Lidl. That's something -- that doesn't affect the pharmacist other than in the sense that we don't have properly trained support staff around about, but,

I mean, you can't blame anyone for leaving, especially the way we were getting treated by patients, by management, the way we all felt ignored. I would have done the same.

Q. In paragraph 27 you state that, when people became ill with COVID-19, while larger pharmacies could move staff around, smaller pharmacies at times had to suddenly close the whole pharmacy. In those areas with the smaller pharmacies, did that lead to patients not being able to access medication that they needed?

A. I think there was odd instances, but I don't think that was particularly a big problem. I think initially the larger chains were reluctant to move staff about and then did. I think the case of the smaller chains, there was probably a problem in the sense that, if somebody in a particular pharmacy contracted COVID, then they all had to isolate and that meant there was maybe one or two staff that were normally there who hadn't been exposed who could go back to work. So they would have to move staff from other shops and that would spread COVID around the group. I know a few of them were affected by that.

The single-handed independents, which are vanishingly rare these days, to be perfectly honest, I think they had -- you know, they all had -- everybody

had problems, but it was just dealt with at the time and I think there was a lot of thinking on the foot and maybe minor breaking of the rules because it was the only way we could work.

Q. Thank you. In paragraph 30 you tell us that pharmacy owners in Scotland were paid specific funds to provide training to their staff. Was this payment made by the Scottish Government?

A. Every payment that the pharmacists get is paid for by the Scottish Government. I mean, the average pharmacy -- one or two of the big chains who have large shops might be different -- but the average pharmacy, the split is 90% of the funds or their payments come from the NHS and from the Government, therefore, the other 5% is just counter sales, and it's a diminishing amount, especially with Pharmacy First, when people know, "Well, why would you go and pay for something when you can actually endure a two-minute consultation and get it for nothing and save a tenner?". You would be mad not to.

So all their money comes from the Government. Within that money is included -- the current terms, they get paid for staff training. That's not just for pharmacists. A lot of it is -- it's for all the staff and it's to cover things like Pharmacy First, new PG --

PGDs, that sort of thing.

The Government -- the civil servants tell me that the spirit of it is that that should be spent on the staff, but as a union we survey our members and say, "Do you get protected learning time? Do you get time off?", and the truth is most of them -- and I don't mean like 80% -- but a very high percentage of them do not and they have to do it in their own time.

Now, that was a major problem in 2020, when the Pharmacy First -- the Minor Ailments Scheme was changed to Pharmacy First and there was a lot of training to do with that and there was a subsequent train of PGDs where we would supply antibiotics for skin infections, we could treat herpes, a number of things -- shingles is the word I was looking for -- they all had to be done and people had to do them at the time. And this was at a time when they were going into work and, although we were working less hours as far as the public could see because we wouldn't open till 10, we'd close for lunch and we'd close at 4.30 -- and that would be for cleaning -- most people were just trying to catch up with the day-to-day work. Many people were working longer hours unpaid and then they would have been expected to sort of undertake this burden of training in their own time, often at weekends, and that should have

been family time. The employers by and large did not pass that money on to the staff.

Q. Do you think the organisation that paid each pharmacy should have held them to greater account for the purpose -- to find out what they were spending the money on? So rather than just releasing it, expected them to account for what it had been spent on?

A. I think there could be better audit of how the money is spent and where it goes. The simple truth is, if all the staff do it in their own time, then the contractors can say to the Government, "Everybody has done it so the system works". But the system is working at the expense of the staff and burnout. That's true for all the staff. I mean, that's -- something I would like to see would be better audit. I think there are different ways of doing things, perhaps directing that to the staff, and I think you could see that in COVID it became a particular burden.

Q. Thank you. Now, we've heard from a number of other professionals as well that they couldn't access furlough funds but also couldn't sustain themselves on statutory sick pay so had to work even when they were ill and in some cases professionals were self-employed and so didn't even receive sick pay. Was this also true for pharmacists and pharmacy staff and did this contribute

to people leaving the profession?
A. It must have contributed. It was a major problem. I don't think people necessarily left during COVID but I think there have been quite a lot of people left since, and I think that's a significant issue. If you were a locum, a locum pharmacist, if you didn't work, you don't get paid and they were classed as self-employed business people. They didn't get any furlough and they don't qualify for statutory pay. And I do know pharmacists that worked longer than they should have and -- especially now we know about things like long COVID, and that's acknowledged. People did go back to work sooner -- you know, sooner than they really should have. At the end of the day, people have to feed their kids, they have to pay their mortgages and you can't really blame them for that.
In terms of the staff, I think that's -- I knew pharmacy staff that had been furloughed and they were people that had particular health issues, but the bulk of pharmacy staff did go to work, and for staff who were employees and took ill, they only got statutory sick pay and a lot of employers within the sector don't actually add any more on that; you get it? Now, I couldn't live on £80 a week or whatever it is. They had colleagues who were furloughed right through the lockdowns and the

whole period who were getting 80% of their wages.
The people -- we heard from -- I heard it myself -- staff saying, "I'm not testing myself for the pure and simple reason I can't afford to be ill". If staff had got ill -- because we were very exposed to COVID, everybody got ill at some point. If we'd been able to get equity with people who were furloughed when we were ill, which I think would have been only fair, I think that would have gone a long way to decreasing the sort of incidences of long COVID and people wouldn't be so burned out, wouldn't have been so ill at the time and it probably would have reduced the spread within the shops, because I think people went to work when they knew they had COVID and people certainly went back to work earlier than they should.
Q. Thank you. We've heard from care homes that UK-wide chains, UK-wide care home chains, often attempted to apply English guidance in Scotland and I see from your statement that this was also an issue for pharmacists. You give an example of that, in paragraph 41, as staff being able to go to work if they had COVID asymptomatically in England but in Scotland that wasn't permitted. But UK-wide pharmacy chains were requiring Scottish staff to be at work in accordance with English rules and, when the PDA contacted them about this, they

refused to change anything until Humza Yousaf spoke to them. Did you find a regular need for the PDA to intervene in these situations?
A. Yes, there was -- you know, at certain periods. I mean, the issue of mixed messaging, where the media were reporting things as being in Britain -- and this was more of a problem I think in the first pandemic. Everybody got wise to it and would counteract it when it happened later on -- but the mixed messaging that was coming out -- and that affected patients, not just pharmacy staff. I mean, some of our staff were confused because the higher management, particularly in the chains, were telling them one thing and they were phoning us up and saying, "Is this right?", and we'd say "No, no, that's England only" or "That's England and Wales. This is what you have to do. So we would put out press releases and say "In Scotland ..." or qualify it and say, "This is the situation in England", and then underneath, "and in Scotland and Wales it's different".
The incident you're referring to is one of the larger chains and I think it was in April 2022 the superintendent issued a statement to all his shops, saying, "If you feel well enough -- if you've got COVID but you feel well enough to go to work, go to work". And that didn't apply in Scotland, it only applied in

England. We wrote to them within 24 hours of them releasing it because, as soon as they'd emailed it to the staff, we had people phoning us up and sending us WhatsApps of the actual letter and saying, "Isn't this wrong?". We contacted the company and they just said, "We don't care. You know, we just treat all of Britain the same", and we continued to put pressure on them.
So in the end I contacted the Medicines Division in St Andrew's House and it was escalated to Humza Yousaf's office, and he made a statement saying "It's different" and they had to retract it in Scotland. So it was always an issue that affects pharmacy. They quite often though -- the chains -- and you can't really blame them in a sense. You know, 90% of their pharmacies, this is the model, and then Scotland is 10% and it's a slightly different model, and they work on a one-size-fits-all or they try to work on a one-size-fits-all model. It wouldn't be a problem with the Scottish chains or anything. It was specific to the UK-wide chains.
Q. So essentially the mixed messaging is a result of management making a decision to ignore Scottish guidance and apply English guidance where it shouldn't be applied?
A. I don't think they ignored it. I don't think they were aware. You know, they just -- they look at it from

an Anglo-centric point of view.
Q. Do you think they had the resources to be aware of the different --
A. Oh, they had the resources. I mean, they've got much more resources than we have as a member -- a non-profit organisation which relies on our members to give us their income to represent them, and we could cope with it easily. We had all sorts of checks in place so that -- you know, we knew -- so if something happened in Scotland, I told everybody. My equivalent in Wales did the same. I knew what was going on in Northern Ireland, Wales, Scotland. Sometimes I would see something happen in Wales and I'd be going to -- lobbying the Government and saying, "You should look at this, this works". So if I can do it in three days a week, I'm pretty sure that a large multi-national with, you know, their kind of money could do that, and their staffing levels, they could have done it. They weren't interested.
Q. Thank you. Another significant cause of concern for pharmacists and pharmacy staff was the inability to socially distance in smaller pharmacies, and that was exacerbated by a lack of availability of PPE. Were pharmacies being provided PPE by the NHS or were owners purchasing their own PPE?
A. Three stages, I suppose. I mean, the crammed conditions

in pharmacy, that's something I'd like to go back to, but the problem with PPE, I think there was three stages, possibly four.
Some pharmacies had PPE really just because it provided certain services or because they had a client base that asked for it. I wouldn't say it was widespread, but I certainly worked in one shop who had PPE and it all disappeared overnight in late January -- and we all laughed about all these Chinese people, for want of a better description, coming in and buying all the masks -- and it was because COVID was happening at home and they responded to that, and very quickly we ran out of them, much to our shock, and tried reordering it and couldn't get it.
The first main stage, it was being supplied through the Health Service, the health board, and we just didn't get it or, if we did, it was very, very limited. Some pharmacy owners did obtain it because they were quick off the mark, but they didn't, I think, get very much, and very quickly nobody had any. So we were left sort of out there, hence the fact that in a lot of shops people put screens up as quick as they could -- not all, it has to be said.
So it was coming from the health board and there was very much a feeling amongst our members that we were

last in the queue. That could be -- in the case of community pharmacy, that could be because we were not seen as part of the NHS or a full part of the NHS, but we also had hospital pharmacies reporting to us that they weren't getting as much and they certainly weren't getting, you know, the better PPE. They were just getting the simple mask, if they got anything at all.
That was resolved when the supply -- the Government managed to put the supply through the pharmacy health -- through the pharmacy wholesalers and we were able to order it from them and by the end of the year it was pretty widely available. You didn't always get it. You had to order it every day, so you would order -- you might need a box for a day, so you would order ten, constantly trying to keep ahead because there were -- at times we just couldn't get it even then. And it sort of -- into 2021 it became normal.
But there were three stages. The employers -- some of them tried to supply it, then it went through the health boards and it was very sort of -- you couldn't predict that you would get it, and then it went through the drug wholesalers, so it came with our daily drug deliveries and that solved the problem. I think that's a lesson that was learned quite quickly and I think -- if we were ever in that position again, I can't see that

they would do anything differently.
In terms of PPE, though -- and again this is in the first lockdown -- there was so little in the place. A lot of people would wear throw-away PPE. The Government was saying -- I'd hear on the radio John Swinney or Humza Yousaf or Jeane Freeman said, "There's loads. Everybody's got it. We've got it in place", and I'd be thinking, "I haven't seen any", and there would be people phoning up on Radio Scotland and saying, "I'm phoning from a surgery and we don't have any", and so forth.
People had to reuse it and the guidance was that, if you used it and took it off, you should use another one, a clean piece. I saw drug delivery drivers who were going out into the community and driving round patients and they were using one piece for two weeks. You could tell how long they were wearing it because it bobbles and it looks dirty. People were making home-made covers to put over them, and you would be saying to people, "You really shouldn't be wearing that", you know. It was a non-ideal situation, but I think we were where we were at the beginning and I think by the end it was -- all the problems were ironed out, but it was badly handled.
Q. Yes. And in paragraph 50 you state that, even when PPE

was available, some pharmacy owners discouraged or prevented staff from wearing PPE because, you say, it set the wrong sort of image and was not attractive.
A. Yes, yes. We had people ——
Q. What was the PDA's views about that?
A. Well, we were so concerned about some of the things we were hearing and some of the things that were being said that —— because it's a retail business, I think there was a feeling that some pharmacy owners put commercial imperatives before, if you say, clinical imperatives. That had several impacts. But at the beginning there was —— a lot of them were reluctant to put up screens, a lot of them were reluctant to have their staff put masks on, because they thought it presented the wrong image. It may be that some of the managers making these decisions were not medical staff or medically trained in any way and it may be that they just hadn't quite grasped the seriousness of the condition, but that happened in several places.
We issued —— we produced a risk management book —— I refer to it in the report —— and we sent that out to all our members and said, "This is what your pharmacy should be doing", and they could work through it. And that enabled them to go to employers, but there was nothing came from the Government or —— there was

a certain amount came from the contractors' body, Community Pharmacy Scotland, but nobody, I think, other than us produced a proper risk management tool, so you could say, "If this is happening, you're in danger".
I mean, some of the risks you couldn't eliminate because of the size of pharmacies. I would say in more than half of them, to actually socially distance was impossible. I mean, you're in a small space, small room, and you're having to move around all the time and everybody is moving around. We all joke that at some point in the day everybody in the pharmacy will be standing in the same 1—metre square, you're bumping into people, people are coughing, people are ill. Nobody saw that because they were on the other side of the counter and they didn't see —— necessarily see into the pharmacy space where we were working, and that was a problem.
Q. Did the PDA try to contact pharmacy owners that wouldn't allow their staff to wear PPE?
A. Oh, we do that routinely. You know, people phone us up with —— it could be, "I didn't get paid for my locum", and we would just phone up the office and say, "We're the PDA", and it gets solved very quick. The same goes —— we did that with the large chain that was giving the English guidance in Scotland. We were straight on the phone to them. We do that as a matter of routine.

If a member phones up and they've got that sort of query, we've got people who just get on the phone and say, "Is this right? And if it is, don't do it". And if they don't do it, we pursue them.
Q. In respect of preventing staff from wearing PPE, was there a view that the regulator or NHS Scotland should have stepped in to enforce the requirement to wear a mask or other PPE?
A. I think the regulator would take the view that they couldn't enforce it because it's not within their remit and I think the Government would probably say the same because they can't actually force people to do something unless it's in legislation. It's the same for the regulator and ——
Q. So do you think the Government should have enacted legislation preventing employers from preventing their employees from wearing PPE?
A. It would have to have been emergency legislation and part of the problem was everything that came out was guidance and some people —— and it happens all the time —— some people would push the envelope, as they say, and ignore the guidance, and this was a case. I also think in many cases it was just people who weren't medically trained, who were in charge of medical functions, completely misunderstanding what they were

having to manage. It does beg the question that are these the most appropriate people to manage health professionals, health functions and things that impact on patients.
Q. We've heard from some professionals that they suffered higher levels of verbal and physical abuse. Was this also the case for pharmacists and pharmacy staff at times of shortages and queuing and the like?
A. Absolutely, categorically. It was horrendous. Everyone, if they didn't experience abuse themselves, witnessed it first—hand. I think we did a survey and we found that something like 60/70% had actually experienced it —— that could be verbal —— but 90% —— nearly 100% of our members, when they were surveyed, said that they had witnessed or suffered some abuse.
Now, that could be —— that could range from just people being sarcastic and just generally shitty, for want of a better word, right up to full—scale assault, and that happened; people picking up things in the shop and throwing them around and what—not. The problem with that, from a public perception, was nobody was aware that this sort of thing was going on and it happened all the time.
It's not —— with most patients it didn't because of —— if you say 95% of patients are wonderful, it's

the 5% that cause you all the bother that stick in your mind and affect your mood at the end of the day because it —— you know, your adrenaline gets going, you're in that sort of situation with a confrontation. It's not good to experience.

To get it day on, day out, was particularly bad in terms of everybody's mental health and so forth. You used to dread going to certain places because you knew what they were like. It was just constant. I mean, we've got one of our senior reps, she was held up at knife point. We've also got a lot of members who are black minority ethnic community pharmacists and they suffered a lot of targeted racist abuse, you know. And it can be things as simple as, "We've had to order that in for you especially and it will be here tomorrow", and you're just standing there and there's somebody acting like it's the Texas Chainsaw Massacre and —— you know, and it goes like that [clicks fingers]. That was what I think most people struggled with. You never knew who was going to do it and you never knew when it was going to happen, but it did.

Q. Thank you. You touched on it there, but in paragraphs 84 to 91 you talk about issues for BAME workers and other disproportionate impacts. In paragraph 85 you're referring to BAME and female

pharmacists and you state:

"Both groups were shown to be worse affected in a number of ways during the pandemic."

Can you tell us what some of those issues were and whether you consider anything could have been done, particularly by the Scottish Government, to alleviate those issues?

A. I think we weren't the only people to raise it. The UK Black Pharmacist Association and I think at other times the Royal Pharmaceutical Society raised it as an issue. The factors that affected female pharmacists were —— there's more female pharmacists than male pharmacists and there is a very high proportion of our workforce that is BAME. They had problems at home with their families and so forth and their communities, but in terms of just being at work, they were an easy target for people that were stressed. Somebody that is just freaking out generally, they would be the person they'd pick in the room to unload on because, if they did it to me, I would give them it back. But they would think that, "The little girl in the corner, she's not going to talk back to me", and there was a lot of bullying. It was just sort of —— it just became endemic and constant and it particularly affected them.

And, as a group, the Government was producing —— the

English Government or the Westminster Government, rather, was producing evidence to sort of say that quite early these groups were actually more prone to —— maybe because of the way —— their living conditions or where they lived in cities —— they were more prone to getting COVID. I think that preyed on their minds as well. You know, you don't need to go into work and then be picked on forever when the disease seems to be picking on you.

We certainly raised the issue very quickly with —— I think it was Christine McKelvie MSP who was —— I think it was the Equalities Committee or something like that that she was convenor of, and we followed it up. It was just something that was there. It applied to all pharmacists with protected characteristics. There was a lot of abuse towards all pharmacists.

I mean, myself, I have a hearing disability as a result of a car crash many years ago and I would get it off patients. They would be saying things to you like, "Are you deaf?" and I'd pull out my hearing aid and say, "Yes, can you speak up?", and then they'd start shouting their head off at you. All the screens, that made the situation worse for lots of people. It made it worse for a lot of patients with similar disabilities. But in terms of the BAME pharmacists, I think our surveys and the UK Black Pharmacist Association surveys

would appear to say that they got more of it or they were more likely to get it ——

Q. Okay, thank you.

A. —— and more of them are female, if that answers your question.

Q. Thank you. In paragraph 111 you state that while usually a pharmacy can't dispense medication when the pharmacist is absent, "the regulator permitted [us] ... a specific time–limited dispensation when no penalty would be applied if, in specific circumstances, ready assembled medicines were being collected by patients in the physical absence of a pharmacist", but there was a requirement for a pharmacist to be available by telephone during that short period.

A. Hmm–hmm.

Q. You say, however, that almost immediately corporate pharmacy owners started taking advantage of that relaxation and in paragraph 113 you state that, "These companies attempted to run some pharmacies with no pharmacist present at all", while requiring locums to have to manage multiple pharmacies by telephone. What issues did that create, the lack of a pharmacist being there and locums having to spread their attention across multiple stores?

A. Well, the first factor that increases when the

pharmacist is not there is there is an increased danger to the patient because there is no pharmacist to consult. That by its very nature is the primary danger. This issue arose partly —— and I think the dispensation from the GPhC, the General Pharmaceutical Council, who are the regulator —— I think the situation arose because you did have situations where a pharmacy would have to close and there would be medicines there that were bagged up and ready to go. So it was really to ensure the patients still got their medicines while —— in this space while the pharmacy got sorted out and got cleaned and got re—opened and so forth. So there was that.

But very quickly what we found the employers were doing was they were saying to their staff, "Would you be able to cover two shops?". You can only have one responsible pharmacist per pharmacy. You can't be responsible for another one geographically distant, even if it's 30 yards up the street. What these particular companies were saying was —— they would say to the staff, "Can you cover that other shop? We don't have a pharmacist there". They would say, "There's a shortage of pharmacists", or they would book a locum and say, "But we want you to cover two shops". Now, saving on the pharmacist's salary is a significant salary, if you can do that. That was a commercial

decision because there was in fact no shortage of pharmacists.

The reason I can say that is that in the lockdown people didn't take holidays because who would take a holiday and sit looking at four walls at home when you can at least get out? By and large people just worked, particularly in the lockdowns, and then had their holidays after. So we got —— we had complaints from members who were locums, who were saying, "I'm having all my bookings cancelled", and then we were finding out they were cancelling bookings and the shop wouldn't open and they would operate differently, and they would say —— the companies would say, "There's a shortage of pharmacists". Well, there was this pool of locums who were no longer able to work because their bookings were cancelled and there was also the fact that —— I think they took 3,000 retired pharmacists on to the register. So instantly there was a pool of thousands of pharmacists who could work in all sectors and there was no shortage and these companies were trying to run pharmacies —— two pharmacies on one pharmacist.

So we very quickly —— the union very quickly lobbied the health departments —— they didn't seem so interested, it has to be said —— and the regulator, and the regulator issued a statement, saying, "You can't do

this". I mean, it affected our members, but the major reason was the most dangerous thing you can do with a pharmacy is run it without the pharmacist; all those checks are not there, which is when the patient comes in and you speak to them.

The numbers of times you say, "Have you got any questions?", or they'll come in and present and you look at them and you know something's wrong —— take that away —— or there's nobody to explain how you take your medicine —— they always say in our profession, "If you really want to scare yourself, tell a patient something and then ask them what you've just told them". It is scary.

Q. When the regulator issued that statement, did that put an end to the practice or did some continue?

A. It put an end to that practice, although I mean even to the current day we see instances of it, and again it occurs with the chains, where on a Saturday they'll try and get somebody to cover two pharmacies and they'll cite the fact that they can't get a locum. We have instances then where we've recorded the closed pharmacies and locums had offered to work at reasonable rates and they said, "No, no, we just decided to close", and they still get paid.

Q. Yes, I wanted to ask you about that actually. In

paragraphs 124 and 126 you speak about that, that corporate pharmacies chose to close temporarily rather than pay for locum pharmacists and that they were still reimbursed by the Scottish Government for services they were either unable or unwilling to provide. You contrast that with the situation in Wales, where they would not be reimbursed in that situation.

A. Hmm—hmm.

Q. Is it the view of the PDA that the Scottish Government should consider the Welsh position and consider declining to pay in that situation in the hope that it would lead to a decline in the rate of closure?

A. If I can explain it, the way they get paid —— they negotiate every number of years a different contractual framework for the pharmacies to get paid, pharmacy owners to get paid, and they get paid all sorts of different kinds of payments which loosely can be split into two: activity payments and non—activity payments. An activity payment would be one that you wouldn't get paid for if you're not open. That's dispensing/supplying medicines. But if you close for one day in six, generally you'll displace them into the other five days, so you have five days where you're busier and you get all the activity payments.

The other ones were they get paid for supplying

services, like Public Health services or whatever, but -- and it also includes things like the education payments that we were talking about earlier. There's a whole variety of them. But they get paid them irregardless of whether they don't open and we've estimated they could be worth between £400 and £700 a day. So there's a significant saving that can be made by not opening the pharmacy and displacing the activity work into their other hours.

We have lobbied the Government, the Scottish Government, and been told that it would require legislation to change that and that can only be done when the new -- the next contractual framework is negotiated, which will be in a few years, probably for 2026, so we would hope that we can get something put in place.

The Welsh situation was that, when they negotiated the contract, the Government of Wales slipped it in that, "If you don't open, you won't get paid", and I don't think the contractors thought very much about it at the time because, if they could prove there was a good reason -- your shop had been flooded or you were in a rural area and somebody couldn't -- you had a period when you couldn't open because somebody got ill or whatever, these were fairly rare and you never

thought about it, and then of course COVID happened and there was this knock-on from the contractors or the big chains where they closed.

We were monitoring the situation and finding there was increasing numbers of -- they were abusing the situation in all three mainland British countries, and the Welsh Government turned round and said, "You can't do that, you know. If you do that and you haven't got good reason, we'll not pay you. We'll take the money back. We'll recover the money". And the upshot of it was we had pharmacists from Scotland and England phoning up and saying, "I'm being phoned up by so-and-so and they're saying, 'Can you go and work in Wales?'". So it does work, and it can't work in Scotland because it's on the basis of an already-negotiated contract that's in legislation and to change it they would actually have to bring in legislation in the current Parliament -- emergency legislation -- and I don't think there's a willingness to do that.

Q. Thank you.

THE CHAIR: You're into your last ten minutes, Ms Bahrami.

MS BAHRAMI: Thank you, my Lord.

In paragraphs 130 to 135 you talk about pharmacists' involvement in vaccine sessions and that pharmacists took steps to prepare to contribute to the vaccine

roll-out in anticipation of the vaccine programme commencing but they were subsequently excluded or given much lower rates of pay than previously agreed while pharmacy owners were still paid the higher rates for supplying their employees for the roll-out. Would you please tell us about that, including the perceived role of the CPS in that outcome and the effect on the rate of vaccination in the community?

A. Well, first of all, I don't think it actually affected the rate of vaccination. It was a technical thing and it was something that we felt was very unfair. They asked for people to go and become vaccinators and they were offering a rate of pay of £70 an hour -- I think it was a three-hour session that you did -- and they made it open to dentistry -- dentists, optometrists and pharmacists.

Now, in the case of pharmacy, a lot of pharmacists are very accomplished vaccinators. I learned to -- I've been doing vaccinations since 2005 so I have a lot of experience in it. I'm not untypical. And what happened was they offered this and lots of pharmacists immediately signed up, particularly the locums, who, you know, were able to do it, had done the training and couldn't get work because contractors weren't employing them. Very quickly, they turned round and said, "No,

pharmacists couldn't do it".

Now, bear in mind pharmacists were more experienced than the other groups, so when they started working, they were helping train the others, they'd done additional training in their own time, which costs money, and they had to take out additional insurance because they were doing COVID vaccinations and so forth. So they laid out this money to be able to do it and then all of a sudden they were told that pharmacists would no longer be able to apply for it unless they are -- and they will be paid at the same rate as a band 5 nurse, which is -- I don't know what it is, but it's about £18 an hour.

Q. Yes, I think in your statement you say that the initial rate offered was £69 per hour --

A. 69.

Q. -- and that was reduced to 14.50 per hour.

A. 14.50 at the time, yeah, that would be correct. But what they had agreed with -- I don't think it was Community Pharmacy Scotland, the higher level, it was at the local level, and this affected in particular Greater Glasgow. What the agreement they'd come to with them was that the pharmacy contractors could send a member of staff, and the member of staff, they would get paid 14.50 for the member -- they would get paid 69.

If a locum went, he got paid 14.50. If the owner sent a member of his staff, he would get paid 69 and he could book a locum at a lot less than that and they made a profit on it.

We complained to the Government, we complained to Greater Glasgow, and Greater Glasgow sent a letter to us, which you've got a copy, saying that they had to take account of commercial imperatives and they didn't want to increase the shortage of pharmacists. And they were worried that if all the locums, many of whom couldn't work because they weren't being employed, took on this work, there would be no pharmacists to work in the shops. And you think, this doesn't square up. So it was an abuse of a sort of position and really it was something that was undertaken by people at the health board, I think, who were probably gaslighted in some way, to help —— the contractors made money out of it and our members lost a lot of money out of it.

Q. Thank you.

Now, we have your statement, I'm just conscious of the time as well, and we will consider it in its entirety alongside your oral evidence today. We just have a couple of moments left. Is there anything you would like to highlight at this point that we haven't covered?

A. I think one other thing, very briefly, that we didn't cover was the £500 bonus payment and this goes back to the fact that pharmacies or pharmacists in community aren't really seen as a proper part of the NHS. There's a sort of snobbery about it. First of all, some of the employers weren't willing to pass the payment on to pharmacies, they weren't willing to make the claim for the locums and even, in one case, for their staff because they didn't —— you know, couldn't be bothered. It was in Scotland and they were a national chain, they don't —— you know, they weren't going to take that focus.

We had set up a helpline for all the people that couldn't claim the payment. When it was finally agreed, after we'd lobbied the Government, that it should apply to pharmacists delivering NHS services, most people got the notification that they could claim later than they could make the claim. And in some cases they had —— if you had three days at most, if the employer had already made the claim, they couldn't make the claim on behalf of you. So we had to set up a helpline and get all these people sort of listed. And it took up to eight months after they paid the bonus to everybody else to get it for all staff, including people that were missed out because they were on maternity leave.

And when they set up a portal —— the Government set up a portal to enable us to get in, they set it up and not everybody could get in because they had to give a contractor number where they had worked, which is a four—figure number, and they were checking that you'd worked in all the places you'd claimed, to make sure you weren't making an illegal claim. And if you worked in the health boards or you worked for a hospital or for a GP practice, you couldn't make the claim. So we had to go back, and it went on.

It was a classic example of how, you know, we as a group felt that we were in some way not felt to be part of the NHS and yet we were the group that were open all the time. If there's anything I think I would like to see come out of this, it's maybe that all pharmacists should be employed by the NHS and the NHS can set health—based priorities for them.

It's a bit like The Divine Comedy and Dante arrives outside the gates of hell and he meets Virgil, and Virgil is standing there, he's got all this knowledge and he's the great philosopher and he's got lots to offer. He can't get into hell and he can't get into heaven, he's stuck in the middle. That's a bit how I feel we were, out in purgatory.

MS BAHRAMI: Thank you very much.

A. Thank you.

THE CHAIR: Yes. Thank you, Mr Hickey. Good. 1.30.

(12.31 pm)

(The short adjournment)

(1.30 pm)

THE CHAIR: Good afternoon, Mr Caskie.

MR CASKIE: Good afternoon, my Lord. Our witness this afternoon is Neil Mathers.

MR NEIL MATHERS (called)

THE CHAIR: Very good. Good afternoon, Mr Mathers.

A. Good afternoon, my Lord.

THE CHAIR: Right, when you're ready, Mr Caskie.

MR CASKIE: Thank you, my Lord.

Questions by MR CASKIE

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

A. My name is Neil Mathers.

Q. You've provided helpfully a witness statement for the assistance of the Inquiry. I think the witness statement has just appeared on the screen.

A. It has.

Q. Do you recognise that?

A. I do.

Q. I think you've signed the witness statement at the end. Before you signed it, had you read it?

A. Yes.

Q. And are you content that the content of the witness statement is true?
A. I am.
Q. And do you want the Inquiry to take account of all of the witness statement as part of your evidence to it today?
A. Yes, please do.
Q. For the purposes of our records, the witness statement has a reference number which you don't need to concern yourself with, but it's SCI-WT0481-000001.
Which organisation are you here from? Samaritans?
A. I work at Samaritans. My job role is executive director for Scotland.
Q. Can you tell us a bit about the Samaritans? We probably know what it is but it is probably better to hear it from you.
A. Yes, Samaritans is a suicide prevention and crisis support charity. We've been working in the UK and Ireland for the last 70 years. Our vision is to ensure fewer lives are lost to suicide and we do that by tackling inequality and the risk factors that make it more likely that people might take their lives.
Q. Okay. In terms of your own role as the executive director for operations for Scotland -- you say something about your role in paragraph 7 of the witness

statement and you indicate there what it is that you do, but if you could just tell us what it is that you do?
A. Yeah, I'm responsible for our operations across Scotland, so that includes research, public policy, influencing campaigns, marketing, communications, service programming and partnership development.
Q. And from paragraph 9 of the witness statement I see that you are a UK-wide charity.
A. Yeah, we work across the UK, Republic of Ireland, Channel Isles and Isle of Man.
Q. Don't forget the Isle of Man!
How does the organisation structure itself in terms of the different nations or regions that it's involved with?
A. So the organisation is led by a chief executive and governed by a board of trustees. In Scotland we have a sub-committee of the board of trustees, which is called the "Scotland Committee", and that's made up of some existing listening volunteers within our organisation and some co-opted independent experts that support us with our work. The Scotland Committee is responsible for overseeing and having devolved decision-making for public policy, partnership development and influencing within the wider Samaritans strategy.

Q. At paragraph 11 you say something about the breadth or the geographic spread of the Samaritans in Scotland. Can I just ask you to explain about that and the difference between charities and affiliate branches -- sorry, branches and affiliate branches?
A. Yes, so across the UK and the Republic of Ireland we've got around 200 branches which support the work that we do. Some of those are what we call "central charity branches", so they belong to the main charity of Samaritans, and some are what we call "affiliate charities" which -- affiliate branches -- which are charities in their own right and operate under an agreement with our Samaritans central charity.
So in Scotland we have 19 branches. Seven of those are within the central charity and the remaining are part of -- are affiliate branches and they manage their own affairs and fundraise for their own operational costs.
Q. Okay. Does the organisation have full-time equivalent employees?
A. Yes. So we have 300 -- just over 300 members of staff across the UK and the Republic of Ireland. In Scotland we've got ten members of staff.
Q. Right. Now, having been through the statement, it seems to me that many of the statistics and information that

you provide are UK-wide rather than Scotland-specific, and we're obviously a Scotland-specific inquiry. Is it not possible to disaggregate Scotland out or are you so inextricably linked?
A. Unfortunately it's difficult for us to do that. The main service that we provide is a helpline, which is offered 24/7 all year round and it's serviced by our volunteers, 23,000 volunteers, across UK and Ireland. That service is managed across the broad spectrum of all five nations, so if someone phones the helpline, they could be speaking to any of our trained volunteers anywhere in the country. It's a confidential, anonymous helpline, so we don't record calls, we don't ask people where they're from, so to disaggregate that data would be impossible really.
Q. So people who make contact with the Samaritans from Scotland won't necessarily be speaking to someone in Scotland and vice versa?
A. That's right.
Q. I know that you have a well-known number. I think it's 116 123. Does that -- how is it decided where that telephone call is going? Once I dial that number, what's the internal system for working out who picks up the other end of the phone?
A. So we have a telephone infrastructure that manages all

calls coming through and is able to direct callers to the available listener, wherever they are. So every volunteer, when they go into a branch to start a shift with us, will log into the system, will make themselves known in the system that they're available and then the digital technology that we use enables callers to be directed to the person available. That's how it works across the whole country.

THE CHAIR: I suppose I'm in danger of putting my toe into waters about which I know nothing —— I apologise in advance —— but I suppose that the rationale is that the needs —— no doubt there are many different needs, but the needs or concerns of people that contact Samaritans through the helpline are not geographically distinct, in other words, the same sort of needs are as likely to occur in Dover as they are in Dundee and so forth and so on, and therefore it doesn't really matter where the person to whom the call is directed is located or am I wrong in that?

A. No, you're right, my Lord. The way that we —— the service essentially is a listening service, so we don't provide advice, we don't refer callers to other forms of support, although, if asked, we do signpost callers to support that they might need. But essentially it's a confidential, non—judgmental listening service and

that's the main function.

MR CASKIE: When I phone the Samaritans, as it were, the person I speak to will be a volunteer?

A. That's right.

Q. How many volunteers do you have in Scotland?

A. In Scotland we have around 1,000 volunteers working across the 19 branches, and some of those are also volunteers working within our prison Listener scheme.

Q. Okay, I'll come on to the prisoners' listening scheme shortly. Can you tell me what the Scottish budget is for Samaritans?

A. So to deliver the work that we do across the listening service and through our central charity branches as well as the Scottish operation, I estimate it's about £1.1 million that it costs each year to run that. It is an estimate because, as I've said previously, the listening service is funded and supported across the UK and the Republic of Ireland, so there's a proportionate cost that's included within that figure that I've given you for Scotland.

Q. And how many branches do you have in Scotland?

A. We've got 19 branches.

Q. 19. We know in some detail about the impact on many of lockdown. Tell me about the impact of lockdown on the Samaritans.

A. So for Samaritans, like most organisations, we had to quickly adapt and respond to the restrictions that were brought in at the beginning of the pandemic, so our Samaritans listening volunteers were given key worker status, so that helped enormously in enabling them to be able to go to their branches and provide the listening service and support the shift patterns that we needed to provide.

Obviously the pandemic also affected our volunteer base and for some they may well have had to self—isolate for their own protection or were unable to come into branch, so that did have an impact on our ability to maintain shift patterns as we normally would. We weren't actually, although my statement —— if I can make a quick correction. I've said that all 19 branches did remain open —— actually 17 branches remained open, so there was two branches that did have to close during the restrictions, particularly from April 2020 through that first year of the pandemic.

Q. Was that closure as a consequence of the physical size of the premises?

A. It was a mixture of the physical size and also they were two very small branches in terms of number of volunteers, so maintaining shift patterns was very difficult during that period.

Q. We've heard a lot from what might be called "third sector organisations" about introducing systems to facilitate people working from home. Was that something the Samaritans did on any scale?

A. In Scotland we maintained the support through the branches in the main. Outside of Scotland there was the possibility to do that through the NHS helpline that we ran in partnership with NHS England and Wales ——

Q. Again that's something else ——

A. —— which we'll come back to.

Q. —— that we'll come back to.

So your volunteers were physically going in to your offices. I understand from the statement that, prior to lockdown, you were providing a face—to—face support service. What happened to that?

A. So that had to stop immediately and the impact of that was felt long after really the restrictions were lifted. We're really only in the last year beginning to offer face—to—face support within our branches, but not all branches have been able to undertake that.

Q. Did you increase the amount of work that you were doing online?

A. We introduced ——

Q. —— during the pandemic?

A. We introduced an online chat service as part of our

wider listening service. So the listening service is made up of our 24/7 helpline, which most people know, which is the phone service; we have an email component of that, so people get in touch with us by email and we provide emotional support through written word; and we introduced an online chat service, which -- another written word, but in real-time; and we also have a letter service, so we have a correspondence branch providing emotional support through the written word and through the postal service.

Q. Is the chat function still continuing?

A. The online chat function is still continuing and that will become a primary component of the listening service in the future.

Q. Was that something that was introduced at the time of the pandemic?

A. It was something we were working on before the pandemic but for obvious reasons became vitally important it was made available. We also received some funding from Scottish Government to support the development of online chat.

Q. Okay. I'm looking at paragraph 19 now, where you talk about the fact that when the pandemic started you weren't in post.

A. That's right.

Q. When was it you started?

A. I started in post in September 2022.

Q. So at the time of the pandemic, before you were employed, how many staff did the Samaritans have?

A. At the start of the pandemic there was two members of staff working.

Q. So it moved from two to now ten?

A. That's right.

Q. And how many of those were recruited during the pandemic?

A. I think most of the new members of staff were recruited in 2022. One or two may have started in 2021.

Q. And you were recruited in 2022; is that correct?

A. That's right.

Q. Tell me about -- looking back on it, reflecting back on the recruitment process, how was that handled in terms of employing new people, including yourself, during the pandemic?

A. I think it's difficult to comment about how that was handled during the pandemic. My own experience was that it was a very positive -- by that time I was able to meet face to face with those that were recruiting me into the role, although we have moved to more of a hybrid recruitment model since the pandemic. So we used online tools to be able to interview staff during

the pandemic and appoint them to roles and we continue to do that but mix it with in-person interviews as well.

Q. Okay. You said earlier that two of the branches hadn't functioned during lockdown and you needed to correct part of your statement. I'm looking at paragraph 20. Is that where the correction needs to be made?

A. That's right, yeah.

Q. Okay. At 22 you talk about staff being furloughed -- or "remained working throughout the pandemic". I inserted "furlough" so correct me if I'm wrong. What happened there?

A. We didn't furlough any staff other than those working in shops.

Q. And of the ten staff that you have now, how many of those are shop workers or managers and how many are involved in the core business of the Samaritans?

A. In Scotland, all ten are involved in the core business. We have one Samaritans charity shop in Scotland, based in Edinburgh, and that's run by the Edinburgh branch and by volunteers.

Q. Volunteers, okay. In terms of staffing the organisation and presumably -- and you'll correct me if I'm wrong, I hope -- finance for staffing, the period during and just after the pandemic is a period of significant growth for the Samaritans as, if I can put it this way,

a business rather than as front-line volunteer workers.

A. Yeah.

Q. How was that co-ordinated within the charity?

A. It was a decision before my time, that there was clear opportunities for investment in the Scotland team to take advantage of opportunities to work in partnership, particularly with Government, to make suicide prevention a priority and to increase our visibility and our voice in our campaigning in Scotland to support and encourage help-seeking and help-giving for those who need emotional support.

So there was a decision prior to the pandemic to make that investment, but that was boosted through further work to identify areas such as the West Highlands and Skye, where we developed a project where there was higher risks of suicide and where we didn't have any branch support, so to invest some innovation in programming within that area. So we were boosted with funding from Scottish Government through the COVID transition and the Recovery Fund to make that happen.

Q. That's another thing which I'll ask you about. The way that your statement is structured is you provide general information and then, at the end, you focus on particular projects that the organisation does and

that's basically the way that I'll do it.
A. Okay.
Q. So these are all introductory remarks and we'll come back to the specific projects. One of the things that one might think as a civilian, if I can put it that way, is that calls to the Samaritans during the pandemic might have increased quite significantly. Is that correct or did you see something different?
A. We didn't see an increase in the volume of calls to the listening service during the pandemic. We saw an increase in the volume of calls at particular periods, particularly where there was new restrictions brought in in lockdowns, where there was an increase to the volume of calls, particularly late night/early morning, so (overspeaking — inaudible).
Q. You talk about that at 26 as —— you talk about that being from 2.00 am to 6.00 am ——
A. Yeah.
Q. —— being a particularly heavy period ——
A. Yeah.
Q. —— for calls. I was surprised to read that because I thought it might just have been —— it might have been just after 6 o'clock, when the ministers had just finished speaking to the country, as it were, as happened almost every day, but it was the middle of the

night that you saw —— your organisation saw a significant shift.
Now, in 26 you provide some interesting statistics, 12% increase in calls during that 2.00 am to 6.00 am, and presumably that's compared to pre—pandemic?
A. Indeed, yeah.
THE CHAIR: And for the avoidance of doubt, it's like for like, so it's 12% increase between 2.00 am and 6.00 am compared with 2.00 am and 6.00 am periods before the pandemic?
A. That's right, my Lord.
THE CHAIR: That is interesting.
I suppose I should ask why. Do you have any idea?
MR CASKIE: Do you know why?
A. I would be speculating, but I think that that period of the evening or the morning is when we might receive calls from people in extreme distress, so we're seeing that increase during the most severest of lockdowns in that early part of the pandemic. So it —— we could make a comparison that there was an increase in distress over that period.
Q. Of the day?
A. Yeah.
Q. Because what you seem to be saying —— and again please correct me if I'm wrong —— is that there was

a significant increase in the volume of calls that you were receiving during that period of time but there was no overall increase. You know, you receive a certain number of calls every day and that didn't change, it just shifted within the day?
A. That's right. And over the first year of the pandemic, we answered 2.5 million calls over that period.
Q. UK and Ireland—wide?
A. UK and Ireland—wide.
Q. 2.5 million?
A. Yeah. Last year, just to give you a comparison, we answered 3.3 million calls, so the volume of calls has gone up over the last number of years.
Q. I know you weren't working there at the time but off the top of your head —— we'll find this from other places if we require it —— what was the volume of calls in the year before COVID kicked in?
A. That's a good question which I don't have an answer to right now.
Q. You don't have an answer to. That's fine. One of the places that we might be able to find an answer to that is in the report that you refer to at paragraph 28, where you refer to One Year On.
A. Yeah.
Q. Can you just tell us about the One Year On report ——

A. Sure.
Q. —— without going into necessarily the content of it?
A. So we produced a report one year after the restrictions were brought in and it was a report that did an analysis of the existing caller data that we had, so this is anonymous caller data. We do record some basic information about the types of issues and concerns that callers share with us. We supplemented that with some primary research with our volunteer listeners to get a better sense of what they were hearing on the calls and with the NHS healthcare worker line also and then did some primary research to look more broadly at the other issues that were going on at that time. So we compiled all of that to create the One Year On report.
Q. And you provide us with some information in relation to that kind of information at paragraph 28 and further down, where you integrate references to COVID into your call or response. You said there were some types of calls where COVID came up and other types of calls where it didn't. Can you tell us about the differentiation?
A. Yeah, so we saw a strong association with coronavirus concerns in relation to calls around mental ill health, loneliness and isolation, work and study pressures, physical health. So those are concerns that we hear routinely on the line, but during the pandemic they were

strongly associated with worries and concerns about coronavirus.
Q. I'll come back to that, but at 29 you say there was a 9% increase in issues of loneliness and isolation in 2020/21 compared to the previous year so —— and you've already drawn COVID in as a factor which arose commonly in calls relating to loneliness and isolation; is that correct?
A. [Nods]
Q. You also talk about types of calls where coronavirus didn't arise as an issue. You do that in 28. Again, can you tell us a bit about that?
A. It was something that we observed through the analysis, that there was clear distinction where there was some issues, as I've mentioned, around family, relationship, work, study, health, where coronavirus was a factor, but some of the other areas that can come up in calls around substance misuse, addiction, issues around sexuality or gender concerns, that those weren't strongly associated with concerns around coronavirus at the time.
Q. Okay. And at 31 you talk about a self—help app. Again, tell us about that.
A. So we launched a self—help app across the UK in the early stages of the pandemic. It could be accessed through our main website or downloaded as a mobile app.

The purpose of it really was to provide another accessible way to provide support to people who might have been struggling during the pandemic. So it had a range of tools, techniques and exercises that people could use to support their self—care.
Q. Does that continue to be available?
A. We just made a decision to withdraw the app now, just because of declining usage.
Q. Right. Now, the next part through almost to the end of your —— sorry, the next part of the witness statement through to the end is really about different projects, as I describe them —— I know you don't describe them as "projects" —— and I want to ask you about those in a second.
A. Okay.
Q. But I also want to ask you something about —— before we do that —— about the process by which Samaritans deal with an individual. I'm not asking, you know, what techniques or training and so on that an individual volunteer will receive, but what happens when the volunteer puts the phone down, the call has ended? What follow—up is there? Because you say you don't give advice, you occasionally —— or you, when appropriate, signpost. What happens when you put the phone down?
A. For the listener?

Q. No, for the ——
A. The caller?
Q. —— volunteer.
A. For the volunteer. So when the volunteer listener puts the phone down, they will record some basic information about the call that they've listened to. So we have —— on the system we've got some standard issues and concerns that will come up and will change from time to time over the course of the service running and the volunteer will mark which concerns or issues were raised. The length of the call will be recorded also and that gives us an indication of how long, obviously, a call was needed. That information goes into the system and it's formed the basis of the One Year On COVID report. So we did an analysis of that caller data.
Q. And is there any follow—up for the volunteer in terms of supporting that individual?
A. In terms of supporting the volunteer, every volunteer is encouraged to —— before they take another call —— so if there's any impact on them in terms of what they've listened to, they always work with a peer by their side and there is always a shift leader available. So if there's any distress caused by that, then they would have someone available to be able to listen and to

support them.
At the end of every shift, there's a mandatory debrief session with the two volunteers that have been on shift at that period. That's not optional and that's in order to protect our volunteers, to make sure that anything that they've heard that evening or morning has been processed and they can leave the branch not taking that home with them.
Q. You talk about the volunteers at 33 and onwards and you talk about the training that volunteers get and a move to make that more online. Can you tell us about that, please?
A. So we have quite extensive training in place for our listening volunteers, which includes weekly training which we call "core training", it includes mentoring with an experienced Samaritans listener and then further training before they are able to take calls themselves. It's quite extensive. Pre—pandemic that was all face to face and delivered in branch. When the pandemic came in, all of that training had to stop and it took us about a year to adapt and to provide an online alternative to that.
So we set up support for branches to be able to move online and we also created a training school, which is managed across the UK, which gives us extra capacity to

manage that training. So we can bring volunteers together or prospective volunteers together from all parts of the country and support them through that training in that way as well as providing the training ——

Q. That must have been quite a big change for the organisation because prospective volunteers in Edinburgh would previously be trained by people in Edinburgh and you've now moved so that they might be being trained by someone in Aberystwyth or wherever the college is.

A. We maintain both versions, so, for example, the Edinburgh branch continued to provide training online after that initial pause of a year, but we added to that an additional capacity managed from the centre to be able to support those branches that maybe struggle to provide that online training. So in Scotland we do have a number of smaller branches with lower numbers of volunteers. That means it's more difficult to find volunteer leaders to take on that training role, so this is an additional support to branches who may be in that position.

Q. Okay. At paragraph 32 you talk about one of the specific services that you provide, which is a service, as I understand it, for NHS workers.

A. Yeah.

Q. Can you tell us about that?

A. So in England and Wales we built a partnership with them to offer a listening service for health and social care workers across the NHS, so that was also staffed by our listening volunteers. Some of those volunteers delivered that service remotely from home and indeed some of our volunteers in Scotland contributed to the delivery of that service in England and Wales. So I mentioned earlier in our discussion that some of our Scotland volunteers were unable to go into branch for their own health concerns but we were able to provide an opportunity for some to be able to contribute remotely —— unfortunately, only for England and Wales healthcare workers.

Q. One of the things that we've heard on a number of occasions from volunteer organisations is that the number of volunteers increased during lockdowns. Was that also true for the Samaritans?

A. We had a lot of interest at the beginning of the pandemic and throughout of people who wanted to volunteer and lend support. Due to some of the issues and challenges that I've already mentioned in that first year, it meant we weren't able to capitalise on that flood of interest and support that people wanted to give, primarily because we couldn't train them

immediately. So we've been, since then, working through those people who still want to volunteer with us and try to bring them onboard.

Q. And at that time you will have lost a number of volunteers for the reasons you described; people who said, "No, I don't want to be coming in to do it any longer". Overall, have the new additions filled the gaps?

A. I think overall, yes. We've done well, I think, over the last year or two to be able to bring new people through. All of our branches are operating training programmes now and we've got the additional capacity of the training school that I've mentioned, so we are now able to bring new volunteers through into the service. But it remains a priority for us to extend our recruitment and our promotion and to make our volunteering as accessible as possible to as many groups across Scotland as possible.

Q. I asked about the number of volunteers that you have and you said the number was around 1,000.

A. Hmm—hmm.

Q. Has that altered significantly over recent years?

A. It's remained relatively stable in Scotland. I would say that there is probably a trend slightly downwards in terms of the number of volunteers that we have at branch

level. It is a challenge to be able to attract and support volunteers into the listening service. It's a demanding role, it would require quite a big commitment from people and they're giving their time freely for no reward themselves.

So it is a —— we have a lot of interest in the role itself, we have a lot of applications, we put people through training, but we also have a lot of people pulling out at that stage and not committing to the role itself, partly because of the demands that it has.

Q. And so people will start the training and then say, "No, this isn't for me"?

A. Yeah.

Q. Okay. You then move on to talk about specific —— another specific what I've referred to as "project", which is the prisoner listening service, at 38. Again, without going through this in particular, can you tell us how that works or how that worked?

A. So the prison listener scheme is a scheme operating in Scotland in partnership with the Scottish Prison Service. It's a peer support scheme, so we train people in prison as listeners, they make up part of our volunteer cohort in Scotland and they provide face—to—face emotional support to other people in prison. They're supported by a dedicated branch so each

prison scheme will have a branch that's attached to them and a team of volunteers that provides that training and support to listeners within the prison community.
Q. And how was that impacted by COVID?
A. So the prison Listener scheme stopped immediately as the lockdown restrictions were brought in. Prison movement was no longer possible, face—to—face contact was no longer possible, so that had to stop.
There are two other channels that are provided for for people in prison. The helpline which —— the 116 123 number, which you mentioned, remained available to prisoners and Scottish Prison Service provided mobile phones for ——
Q. And we heard quite a lot about the provision of mobile phones, both from SPS and also from the Prison Officers' Association, so we know about those going in. I take it 116 123 was a number that was pre—programmed into the phone and that prisoners could freely call?
A. So prisoners could freely call. I can't say it was pre—programmed, but the number was heavily promoted across the Prison Service so —— and it was free for prisoners to use.
Q. We heard that the —— right, that's fine.
A. I'd just add that the third channel is the letter service, so prisoners could also use our letter service

to provide emotional support through written word.
Q. Right. At paragraph 43 you talk about a particular relationship with Network Rail. Tell me about that.
A. So that's a UK partnership between Samaritans and Network Rail. It's funded through Network Rail and it provides rail staff and contractors with training and support to be able to recognise and respond to people in distress both within railway stations and in or near railway lines. It also provides what we call "postvention support", so anyone who has witnessed a suicide attempt or a death by suicide, we provide support directly to them to help them with the distress that they may feel as a result.
Q. And do Network Rail fund that?
A. Network Rail fund that and in Scotland we work closely with both Network Rail, ScotRail and British Transport Police to support that service.
Q. And, again, was that impacted by COVID?
A. We were able to continue that service throughout COVID, partly because of the key worker status of our volunteers. The rail services were running as well, so we were able to continue to do that work. We did use online more. In terms of the training it was safer and easier to do so, so we brought in that online technology to support the work.

Q. The next project, as it were, you refer to as "Step by Step". Can you tell us about that one?
A. So Step by Step is again a postvention programme, so it provides support to —— in the main educational establishments, schools, colleges and universities —— directly to senior management teams, who may be in a position of preparing or thinking about how to respond to a potential suicide and supporting them in the event that that happens. So we have a specially trained group of volunteers across the UK. We have some in Scotland as well. Around 70 volunteers make up that group.
Q. In the UK or Scotland?
A. In the UK. I think we have around five or six in Scotland. We moved that service on to online very quickly. So we have a dedicated phone number and email address for that service and can respond within hours in the event of any incident.
Q. Is that a proactive service in the sense that do you contact an educational establishment if you hear or read of a suicide in the venue or do you wait for people to come to you?
A. We wait for people to come to us. So we don't approach schools, colleges or universities in that event. Primarily we don't want to be opportunistic around the service or presumptuous that we're needed. We do

proactive work in what I'd call "preparedness", so we help those institutions with critical incident planning, and that is where we can be a bit more proactive and get in touch and work with those senior management teams. But we wait until they get in touch with us.
Q. And you also talk about Facing the Future.
A. So Facing the Future is another service delivered through specially trained volunteers. It's a bereavement support service for those bereaved by suicide. It's a peer support service. Prior to the pandemic it had been delivered in person, facilitated by our listening volunteers, and has since moved to be an online support service, and actually it will probably remain that way because of the feedback that we've had from those that have engaged with the service that it's working well.
Q. You also talk about, at 49, West Highlands and Skye. Tell me about that.
A. So the West Highlands and Skye project came about partly as a recognition that, in rural and remote areas such as the Highlands, there was a high rate of suicide. It was also an area where Samaritans didn't have any branches so we didn't have any existing volunteers. So we devised a range of interventions, one, to build awareness across those communities in those remote and

rural areas around help—seeking and encouraging people to reach out to Samaritans if they needed help and to make sure that we were building, I suppose, that credibility with people living in that area.

We conducted some research looking at the impact on lone and isolated workers, particularly trying to understand what protected lone and isolated workers working in remote and rural areas and what could we learn from that and share with other organisations and with Government. We delivered training to workplaces and community organisations in helping to build their skills and confidence around conversations with people who may be struggling or in distress, so helping employers understand when somebody might need additional support ——

Q. And you, at paragraph 50, identify a number of worker groups that you particularly focused on ——

A. Yeah.

Q. —— in that geographic region. Can you tell us about that?

A. Yeah. So we focused on people who were physically isolated through the work that they do, so, for example, crofting, aquaculture and so on; those that were working in more transitory seasonal work, so, for example, in hospitality and tourism, where they may feel isolated

within the communities that they live and not have that social network to get the support that they need; and then looking at the high—risk occupations, so particularly blue—light organisations, people working within NHS, where there might be professional expectations on their role of always being there for others that might make it a barrier for them reaching out and getting the support that they need. So those were broadly the three areas that we looked at.

Q. And at 52 you talk about your learning and development programme. Again, I think that's something that you may have referred to previously about training for employers. Tell us about that in a bit more detail.

A. So we delivered around 20 courses and a number of webinars over the last year or so, and that's directed towards small businesses, employers, different workplaces, community organisations that are working to support people within the community, and it was about building skills and confidence, around recognising distress, providing a compassionate listening support and being able to signpost and steer people towards support if they needed that. The feedback from everybody actually on those courses was it was very helpful for them in building their capabilities around that.

Q. Okay. The next part of your report is statistical in the sense of —— can you tell us, was there an increase in suicide rates during the lockdown and pandemic period?

A. We haven't seen an increase in deaths by suicide over the —— during the pandemic. Broadly speaking, over the last ten years, the rates of suicide in Scotland have remained around the 800 figure, so we haven't seen a significant impact on that.

Q. So about 800 a year?

A. Yeah.

Q. You move on to talk about the organisation's relationship with the Scottish Government. Can you tell us a bit about that?

A. So I've mentioned some of the funding that we've received from Scottish Government for both the listening service, our work in the West Highlands and Skye and, in addition to that, we've been key partners in the development of the national Suicide Prevention Strategy, Creating Hope Together. So we were a member of the National Suicide Prevention Leadership Group up until last year, when the new strategy was published. We were then appointed strategic outcome lead for outcome 1 of the strategy, which is focused on ensuring that the environment protects against suicide. So that work is

focused on policy development that tackles inequalities and risk factors that lead to suicide.

Q. And within the organisation, who takes the lead on that?

A. I take the lead on that.

Q. And do you have others who work with you on it directly; yes?

A. Yes. So I take the lead on that alongside our head of policy and policy manager.

Q. Okay. At 61 you talk about your research and reports and you talk about a number of reports that you've produced, including a report which you refer to at paragraph 62 as the "Social Renewal Advisory Board's report". Then you provide us with a useful summary to that. I've read the whole report, but this is a good summary. Can you tell us —— in fact, could you just read 63?

A. Sure. So:

"[The report showed] that the mental health impact of Covid—19 was not being felt equally across the population of the UK and will likely exacerbate existing socio—economic inequalities. The impact could lead to worsening mental health outcomes for at—risk groups including those living in the poorest communities and on the lowest incomes. Our Covid—19 caller research, which was UK—wide and done in 2020, was undertaken in response

to concerns raised among our volunteers that the pandemic was causing similar worries among high-risk groups. The research showed an increase in calls to our helpline from men discussing feelings of fear and uncertainty about the future. Job insecurity, fear of job loss and redundancy were [also] key concerns. Young people experienced a much greater decline in their mental health than others. This was primarily a result of a loss of coping mechanisms, a lack of peer contact, and uncertainty about what the future holds in terms of education and employment. Lockdown has exacerbated existing mental health conditions; people were worried that their conditions would worsen as access to mental health services and community support was significantly limited. Failing to address the mental health impact of Covid-19 could lead to worsening levels of mental health and illness among high-risk groups. In effect this could limit the ability of some groups to participate in the active labour market and hinder Scotland's economic recovery. Poor mental health is a significant barrier to secure employment and, conversely, insecure employment can lead to poor mental health."

Q. Thank you very much for that. That will provide us with assistance in drawing our own conclusions.

At 65 we're into a section headed "Lessons Learned"

and there you have some positive things to say about the Scottish Government in terms of their dealings with you. Do you want to say a bit more about that?

A. I think our experience both in terms of working collaboratively with the Scottish Government on our West Highlands and Skye project has been very constructive and positive. We've worked in a way that was about trying to understand what could be done differently and could be improved and to cascade that learning through that project to influence practice in the future, and Scottish Government wholeheartedly supported and got involved in that area of work.

I think the other element to highlight would be the way in which we've worked with them on influencing the strategy for suicide prevention and the role that we now play in trying to lead the delivery of certainly part of that.

Q. In terms of lessons learned at paragraph 67, you talk about your newly developed email hub. Tell us about that.

A. So I mentioned the email service earlier and indeed during the pandemic we saw an increase of that service by 23%, I think we had around half a million contacts through our email service. Partly as a response to that and to ensure that we were responding timely to those

contacts, we created an email hub. So our branches contribute to the email service but the email hub is a way of being able to recruit volunteers specifically to deliver that service alone rather than also contributing to the helpline. That was a key focus of our West Highlands and Skye project, so recruiting people from that region where we couldn't offer an opportunity to help us with the helpline but where we could provide remote working opportunities to contribute to the email hub.

Q. At paragraph 70 you say:

"We are only now beginning to get the face-to-face part of our service up and running again and had to work out how we were going to do that safely."

Could you tell me a bit about that?

A. So the face to face in branches is now up and running in a lot of branches but we had to make some physical adaptations. We took the opportunity during the pause, where we brought that to a close, to look at our service standards around that, make improvements, particularly around safeguarding and protecting our volunteers who provide that service. It's an ad hoc service, so people don't make an appointment. They can just turn up at the door and ask for that support. So that is now up and running, but not in every branch.

We also provide face-to-face emotional support in community settings. So many of our branches, immediately as we were able to do so, would go out into public spaces and provide that listening support where people are. That's something that we want to see increased over the next few years and indeed my team is looking at how we can target that in West Highlands and Skye particularly, so working alongside community organisations that are trusted by local people and ensuring that that emotional support is provided in a place that they feel safe and trusted.

Q. Now, you said earlier in your evidence, when you were talking about in prisons, that your face-to-face engagement had ended at the time of lockdown. Has that come back?

A. We're almost back to where we were pre-pandemic. So pre-pandemic we had 19 Listener schemes running in Scotland. We now have 17 Listener schemes.

Q. In prisons?

A. In prisons.

Q. And is it the intention that you'll get back to 19?

A. It's our intention to grow it beyond that. We feel it's a really vital service. People in prison are a high-risk group in a high-risk setting, so this year we'll be looking to do a valuation of the Listener

scheme to better understand its value and impact and look at ways in which we can grow that further.
Q. Okay, thank you very much. I have one final thing to say to you in a moment, but those are all the questions that I have for you. I hope that I've covered all of the ground that you indicated you wanted covered in your witness statement. Is there anything else of significance that you want to add that I've not asked you about?
A. No, I think we've covered a great deal.
MR CASKIE: I just wanted to say, to take your organisation from two members of staff to ten members of staff in the short time you've been there is very impressive.
A. Thank you.
THE CHAIR: Yes, thank you, Mr Mathers. And that's all for today.
MR CASKIE: That's all for today, my Lord.
A. Thank you, my Lord.
THE CHAIR: Tomorrow morning at 9.45.
(2.28 pm)
(The hearing adjourned until Friday, 10 May 2024 at 9.45 am)

INDEX

D

E

F