SCOTTISH COVID-19 INQUIRY

STUC

OPENING STATEMENT: IMPACT ON HEALTH AND SOCIAL CARE

1. I represent the STUC and Scottish Hazards in this Inquiry and this statement is made on behalf of the STUC. The STUC is the independent body to which individual Trade Unions in Scotland affiliate their Scottish membership. It is the national lobbying and campaigning body for Trade Unions in Scotland and represents over 550,00 trade union members through their affiliate Trade Unions.

2. This Opening Statement is made in line with the Terms of Reference and Scope of this Inquiry.

3. As this is the first substantive hearing in this Scottish Inquiry, it is appropriate that we acknowledge immediately the very great sacrifice made by so many workers and their families in the pandemic.

4. The STUC represents the collective voice of workers in Scotland and campaigns on behalf of workers and their families in Scotland. It is a key civic organisation that has engaged with successive Scottish Governments since 1999. It is uniquely able to gather information, offer advice because its representative structures cover, gather information and disseminate advice throughout the public private and voluntary health care sectors in Scotland. It is able to receive direct reporting and feedback from key workers delivering essential services. It established the Covid Group that met with the Scottish Government. Evidence will be given about the engagement between the STUC and the Scottish Government and about concerns that were communicated to the Scottish Government about the level of consultation and response by employers to the crisis caused by Covid; failures in the provision of PPE to a range of workers in health and social care; failures in the setting up and maintenance of an effective supply chain of PPE and associated equipment; inconsistency in planning and provision to protect workers in high risk groups, such as those with underlying health issues, disabled workers, and black, Asian and minority ethnic workers; and ensuring that the system of testing and protecting was

not hampered by employers failing to support workers to self-isolate without incurring financial loss.

5. Covid Group meetings continued throughout the Pandemic until March 2022 and throughout that time the STUC and its affiliates were able to identify and raise concerns and report issues and potential breaches of guidance and regulation by employers thereby providing government with valuable insight into risks posed to key workers in carrying out their health and social care roles.

6. Workers and their families faced huge challenges in their private and working lives during the pandemic. The working population was significantly impacted either by being forced to work from home, by being deprived of the ability to work and earn, or by finding itself on the frontline of the response in providing health and social care, in transport, in retail (including pharmacies) and education. People were hampered by shortages, access to services, by restrictions placed on travel and social interaction, and by lockdown. Some had to live in their places of work. At every level people found themselves fearful of risk of contracting the disease but were often placed at increased risk from the disease itself, together with the stress and pressure of everyday living, studying and working through a public health crisis of mammoth proportions.

7. Workers in health and social care were in the front line of a national emergency. It is of paramount importance to acknowledge and understand the fear that would have been felt by many as they strived to provide care to patients and clients, disabled people and the elderly despite the known and as yet unknown risks they faced. As death rates surged our frontline health and social care workers who were doing their best to preserve safety and life inevitably sustained a very significant toll on their own lives, health and well -being.

8. We can now see that in addition to the tragic early deaths, there has also been a significant toll on family lives impacted by long term mental health issues, financial issues and relationship breakdowns, the cause of which was exhaustion, disillusionment and burnout. This has been the outcome for many that soldiered on through all the challenges notwithstanding that they had to cope with bereavement

in their own families, among their colleagues and friends, and labour under daily fear that they could be next to lose their lives.

9. It is self evident that Covid 19 is a Public Health issue but it is not only a public health issue. It is an Occupational Health issue that constitutes the single greatest threat to occupational health and wellbeing in Scotland for decades. By the beginning of 2022 there had been well over one million Covid cases in Scotland and over 12,000 deaths following a positive test for the virus. Covid cases and the death toll continue to rise but are mitigated by the vaccine programme. Long Covid is one of many outcomes that is also rising and is, self-evidently, an occupational health issue. It is an issue that impacts on workers in health and social care. It should be recognised as an occupational health issue by Governments, enforcement bodies and employers. Covid and long Covid are not just community-based concerns. Evidence shows that Covid was for a significant portion of the population, contracted and spread within places of work. That phenomenon was not recognised and continues to be ignored. Evidence will demonstrate widespread failure to report workplace related outbreaks, continuing related illness (such as long Covid) and death. Evidence will demonstrate that failures to record such events, inspect suspect workplaces and make targeted interventions increased the risk of exposure to the virus. Evidence will show that unnecessary exposure to risk has resulted in ill health (in many cases long term) for workers, their families and those being cared for; in financial losses for workers and their families. The failure or refusal of governments to recognise the Occupational Health risk that is constituted by Covid has the effect of denying opportunity for practical legal redress.

10. Deficiencies in pandemic planning and resilience continues to have a significant impact on day to day life and work in Scotland. I consider that it is necessary to look at the malign impact of austerity on Scotland's ability to effectively implement planning and readiness for a pandemic during the decade that preceded Covid.

11. Pandemic planning in Scotland (and indeed the UK) was predominantly focused on influenza -type viruses. This is concerning because the existence of coronavirus was already known about. Such outbreaks occurred in 2002 (SARS), 2009 (Swine flu) and 2012 (MERS). Exercise Silver Swan was delivered during the latter part of 2015 as a series of "table top" exercises across Scotland that focussed on "Health

and Social Care, Excess Deaths, Business Continuity and Coordination". The Report was published in April 2016. Key findings can be found on page 9 of the Report. I note the following from those findings:

"1.1 All Health Boards, Local Authorities and Health and Social Care Partnerships should review their pandemic plans, including those for prioritising services in a pandemic. Plans must be scalable for different levels of pressure on services. (See also 1.4) 1.2 The Scottish Government should review national plans to ensure learning from the exercise is incorporated. 1.3 Scottish Government should review internal planning arrangements for influenza pandemics to ensure they are sufficiently robust. 1.4 RRPs should ensure that a comprehensive, multi-agency planning framework is in place to respond to influenza pandemics of varying severities, including overseeing the production of multi-agency pandemic influenza plans, which include Health and Social Care Partnerships. 1.5 In line with existing frameworks, all plans should be subject to regular review and exercising"

12. Evidence will demonstrate that underfunding in health and social care caused by austerity had a significant adverse effect on planning and readiness for the Covid emergency. Preparation requires not only planning, but also the capacity in public services, in health and social care. Public services are greatly diminished and weakened by years of budget cuts that impacted on the ability of our national and local governments to respond quickly and effectively to the sudden and devastating shock of a national emergency that has been Covid 19.

13. The initial response to Covid 19 also failed to consider, and recognise, the potential for aerosol transmission of the virus so that the health measures initially put in place focussed on other precautions such as handwashing rather than on the provision of equipment such as masks for the general public and PPE for front line workers. That was the case notwithstanding recommendations that derived from UK exercises in 2016 and 2018 (in particular Cygnus and Iris) about stockpiling PPE and provision of training in the use thereof.

14. The trade union affiliates that are represented under the banner of the STUC are all able to bear witness to the impact of what can only be described as lack of preparedness in every facet of life and government for the pandemic. The STUC intends to highlight the effects of this lack of preparedness on workers and their families in Scotland.

15. Evidence shows that from the onset of the Covid-19 pandemic, workers in health and social care immediately experienced a number of significant issues in the provision of care and in the impact on them physically, mentally and socially, as a high percentage female workforce providing frontline healthcare during such an extraordinary situation, which the government, national health service, local authorities and private and third sector employers were evidently ill prepared for. That placed a substantial strain on all aspects of family life including, but not limited to, child care and in making provision for child care with relatives at great risk, so that health and social care workers could carry out their critical roles as key workers. Many have not recovered from the stress and strain that this brought them.

16. One very clear example of lack of preparedness has been the substantial number of problems that were associated with provision and access to supplies of PPE and the absence of guidance to workers on how best to protect themselves and others from the exposure and spread of the Covid Virus. It was immediately apparent that the high level of uncertainty and anxiety put immense pressure on all areas of the health and social care workforce to access face masks and other protective clothing and to attempt to adopt social distancing. The practical difficulties associated with that created widespread anxiety and impacted substantially on the ability to avoid contracting and transmitting the virus.

17. At all sectors of the health and social care system, workers encountered delays in receiving adequate supplies. Some PPE had to be reused causing risk to the wearer and others. There were fears about engaging with fellow workers, patients, clients and members of the public who did not have or could not wear any masks or PPE. The inclusion of face shields in PPE provision were thought to provide a higher level of protection but they were less accessible.

18. PPE was rationed and issues arose with accessing or achieving appropriate PPE fittings. Advice and provision were often cost/supply driven as opposed to being based on the highest level of protection. Instructions with some PPE weren't in English, which caused confusion and a lack of confidence about correct use, and some PPE supplied to workers was out of date. The quality of supplies was variable. Guidance associated with the use of PPE was mostly focused on providing care in

acute hospital settings, and health and social care workers outwith that setting and those in the community were vulnerable due to lack of clear advice and equipment to protect themselves.

19. Health and social care workers had to work in uncontrolled settings in homes, where there was no control over ventilation, access to washing facilities, numbers of people present and overall conditions. Workers providing homecare services did not have guaranteed access to appropriate rest areas or the ability to prepare food/drinks, for prolonged periods of work.

20. The vast majority of health and social care workers wash their uniforms at home; however, the unknown cross infection risks created worry about the risk that might ensue from taking work clothes home, and being able to launder clothing without putting others in the home at risk. The absence of guidance on this among other things added further to the stress that workers experienced.

21. Evidence about experiences in almost all areas of working lives can be demonstrated in the impact summaries and statements that have been prepared by the STUC and its affiliates. I give below some examples and references to some of the evidence that will be offered at the Inquiry.

22. Attempts at controlling infection in residential care homes often meant that a "bubble" was created. That had the effect of limiting staff members that were available to work and stay in house so that workers were separated from their families and loved ones often for long periods of time. It is unfortunate that the continuing low pay conditions has resulted in workers leaving the sector because they feel undervalued.

23. Other workers had to cope with transport issues that left them exposed to greater expense and risk of contracting the disease. The stress that has been associated with working under pressures at home at work and during travel contributed to long term stress related issues.

24. Evidence will show that workers that were in occupations in unavoidable close proximity to others had higher death rates and that this is also true in relation to ethnicity, low pay poverty, insecure work, poor housing conditions and those in poor health.

25. Evidence will demonstrate that there has been a disproportionate impact on ethnic minority groups within the health and social care sector. This should have been avoidable but failures to recognise and provide guidance about higher potential risk to groups such as those with co-morbid health issues and BAME workers left them exposed.

26. While most other parts of the NHS locked down and minimised direct contact with patients, most workers in health and social care had to be in daily contact with the public whether that was in travelling to work, delivering care across the sector, transferring people to hospitals or securing the supply of medicines, and providing access to advice and treatments. For example, many GP patients that would have otherwise presented at GP practice or A&E transferred to the local pharmacies. The increased workload pharmacists faced was unprecedented, with large surges in patients accessing pharmacies at the onset of the pandemic and throughout the series of lockdowns. There was a lack of supply of PPE; social distancing was often impossible to observe and many staff became ill, due to Covid-19 and other illnesses, so that the remaining staff found themselves working longer and more hours than normal. This was a contributory factor to the scale of burnout recorded by several surveys amongst these and other key workers in health and social care.

27. Evidence will be given about an astonishing lack of support in training, security and finance of protective measures for workers. Contractor owners of care homes and home services and other health services such as physiotherapy and private nursing care and the like as well as pharmacies in Scotland were funded to provide training to their staff to enable them to cope with the new reality but very few staff themselves saw any benefit in the form of protected or paid learning time.

28. The above is but a few examples of shortcomings in the private sector support for key workers. The adverse impact on all sectors of health and social care has been substantial overall.

29. This adverse impact is also true in relation to the training and education of students within health and social care, by delays encountered in obtaining qualifications due to inability to gain necessary practical experience through workplace placements and interruption to study that was encountered due to lockdown. Evidence will show that not only was there was an adverse impact on the progression of studies but also on the finances of students and their families and on relationships such that many sought employment in other areas with less stress and better pay.

30. The shortage of workers has resulted in delays, shortages and limitations in the provision of care that is continuing. Those issues cannot be addressed in the short term. They have been exacerbated by the departure of workers back to Europe following the departure of the UK from the EU as also by continuing austerity and consequent underfunding and low wage structure of many parts of the health and social care system.

31. The legacy of the impact of Covid and disputes regarding pay and working conditions in the private and third care sectors are a major contributory factor in the current shortage of workers (leading to, in some cases, the care home closures.).

32. Another legacy is the complex situation faced by those experiencing Long Covid conditions. Workers in many sectors who experience Long Covid face reduced earnings, absence discipline hearings and dismissal on grounds of capability. Long Covid also represents a significant challenge for workers continuing their employment. With the revocation of Covid-related absence provisions employees suffering from long Covid who remain unfit to work are now managed via the Once for Scotland Attendance Policy. Those who are unable to work face ill-health dismissal and, given the uncertainty surrounding diagnosis, treatment and prognosis for those with long Covid, it is far from settled or certain that they will qualify for ill-health retirement. Therefore, anyone with Long Covid,

whose absence has continued since the revocation of the Covid-related absence provisions is rapidly exhausting their occupational sick pay and facing a financially parlous situation. The medical uncertainty regarding prognosis and the subsequent uncertainty regarding ill-health retirement, mitigates against fair, just and compassionate outcomes for long Covid's victims.

33. The STUC has worked tirelessly to bring together evidence in combination with its affiliates and it will provide witnesses who will attempt to cover all the experiences that have been encountered in the course of the pandemic and its aftermath. It is accepted that, in general, the imposition of lockdowns was initially seen as the only effective tool in the box of limited options that were available. The delay in implementing a lockdown strategy may now be seen with other decisions as having caused or at least contributed to more deaths than might have been anticipated by better planning. However, the effect of lockdowns was not entirely beneficial to everyone. This is especially obvious in the case of students' abilities to attend lectures interact and gain practical on the ground experience. Dentistry is but one of many examples.

34. The STUC will give a more detailed overview of Impact. What I have set out above is but a brief introduction to the evidence and submissions that will be given by and through the STUC as this Inquiry progresses.

35. The STUC acknowledges that the Scottish Government proactively engaged with the STUC throughout the pandemic. However there remain certain issues over which the STUC have serious concerns and reservations. The attempts that were made by government to create effective lines of communications were good and that process was of benefit to the extent that issues at ground level could be better communicated. The outcome of that process informed policy and improved some levels of guidance.

36. The STUC was able to provide a better understanding of the real issues relating to PPE and how urgently it was needed across many sectors. It also emphasised the need to support testing at all levels.

37. Social care workers faced a reduction in their income when sick or self-isolating because many had limited access to sick pay. The provision of the Social Care Staff Support Fund supported workers to be tested and self-isolate when necessary, thereby assisting in limiting the spread of the disease among vulnerable people.

38. Additional safety guidance was promoted by STUC and adopted by the Scottish Government. The Fair Work coronavirus statement set out important key standards that, inter alia, assisted at least for a time those that were absent due to Long Covid.

39. Prominent encouragement was given to those that could promote and encourage people to use the testing facilities that were provided. That in turn assisted and improved track and trace.

40. Some challenges arose in relation to response times (often less than 24 hours) that the Scottish Government gave when distributing draft guidance that was produced and shared with STUC for comment, so it was often difficult for the STUC to respond fully with engagement from relevant affiliated trade unions in the time provided.

41. The STUC maintains that the reserved status of employment law and health and safety legislation in Scotland has made it impossible to avoid the UK regulatory failures in relation to Covid-19 in the working environment especially in relation to the duty of employers to protect workers. The STUC considers that the Scottish Inquiry should address this when considering the evidence that will be heard of experiences of health and social care workers throughout the pandemic and its overall impact in relation to health and social care especially in the private sector,

42. This opening statement provides only a brief overview of the level of experience, interest and involvement that the STUC brings to this Inquiry in relation to health and social care. The STUC has input to make in response to the full scope of the Inquiry under all of the headings set out in part 2.1.

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