**Scottish COVID-19 Inquiry**

**Witness Statement**

Statement taken at 1000 hours on Thursday, 25 January 2024. Witness Number HSC0185 refers.

Witness interviewed by Witness Statement Taker [Personal Data] Statement noted by Witness Statement Taker [Personal Data]. Witness interviewed via Microsoft Teams.

Legal representative in attendance from Thompson's Solicitors, 285 Bath Street, Glasgow, G2 4HQ.

Statement: **Esther O'HARA:**

## Consent

1. My name is **Esther Marie O'HARA**. I am 60 years of age, and my date of birth is [Irrelevant]. I can be contacted at my work address of John Smith House, 125 – 145 West Regent Street, Glasgow, G2 4RZ.
2. I am currently on secondment to Unite the Union from my substantive role as a Clinical Specialist Speech and Language Therapist (SLT) with Greater Glasgow and Clyde Health board, with my specialist field in cancers of the head and neck.
3. My trades union role during the pandemic was the Convenor for Unite Greater Glasgow and Clyde health branch. This branch covers all Unite members working within NHS GGC. There are around 4000 members within the branch. Some of the job roles within the branch include biomedical scientists, electricians, porters, admin staff, nurses, health visitors, doctors, radiographers, speech and language therapists,

pharmacists, clinical psychologists, school nurses, biomedical engineers, porters, domestics, phlebotomists, play therapists, and chaplains. I worked full time with four days per week being allocated to the role of Unite Convenor, via facility time, and one day carrying out my clinical role. I was in this position for 5 years, until I started my secondment. Branch Convenor is an elected role, in which branch representatives vote to decide who they wish to represent them. Since 20 November 2023, I have been on full time secondment to Unite as a Regional Officer.

4. I am willing to provide a statement, have my information contained within reports and to have my statement published.

5. I am prepared to give evidence at the Inquiry and I'm aware that I can withdraw consent at any time.

6. I have agreed to the recording of my statement today. I have signed the Inquiry consent form showing my agreement to all of this.

7. I would like to provide a statement to the Inquiry about my experience during the pandemic in my capacity as Convenor for Unite Greater Glasgow and Clyde health branch. I can explain the impact on Unite members working with NHS Greater Glasgow and Clyde (GGC). My experience also allows me to offer insights from a clinical perspective.

**Personal Background**

8. I have been employed by NHS GGC for 15 years. Prior to that I was with NHS Lanarkshire for 20 years. Before that I had a research post with NHS GGC. I qualified as a Speech and Language Therapist (SLT) in 1985, after gaining a 1st class honours BSc degree in Speech Pathology and Therapeutics. I also hold a Licence from the Royal College of Speech and Language Therapists and am registered with the Health Care Professions Council. I have been in the profession for 38 years.

9. In my role as convenor, I am the voice of Unite NHS GGC. I am responsible for all representatives (reps) in that health board area. This includes workplace, health & safety, and equality representatives. I am

responsible for and to them. I ensure they are educated properly and have the information and skills they need to carry out their role representing members; I allocate cases, and ensure work is progressed. I am also their dedicated person if they have an issue or require support or advice. I would either provide the required support or arrange for another experienced member of the reps' team to provide this.

**Overview of Unite the Union**

10. Unite the Union, commonly known as Unite, is a British and Irish trade union which was formed on 1 May 2007 by the merger of Amicus and the Transport and General Workers' Union (TGWU). Unite is the largest trade union in the UK and Ireland, with over 1.2 million members in a variety of different sectors.
11. The UK is split into regions of which Scotland is one. There are 20 sectors within Unite including health.
12. All branch representatives, secretaries, stewards, health and safety advisors, chairpersons and treasurers are volunteers.
13. NHS GGC has approximately 40,000 staff of which 2500 – 3000 are Unite members.
14. None of our branch reps are paid by the union. Whilst they do all volunteer to undertake their roles, they are employment and paid by the Health Board for their substantive posts.
15. Our services are offered in different ways, such as face to face, online or telephone. Most of our communications throughout Covid was by telephone or Teams meetings.

**Unite – Pre Pandemic and Post Pandemic**

16. Our role before the pandemic was similar to what it is now in terms of receiving queries from members, attending meetings with, and supporting them, and trying to balance our partnership role with our representation one. If, for example, you have experienced reps who are pulled into all these partnership groups, it reduces the available time to support the members, which is our bread and butter. The partnership groups can be wide and varied relating to things like service changes or recruitment (whether positions should be filled due to the financial restrictions). Some can be strategic, with some short term, whilst others are for the longer term.

17. Demand for our services pre COVID was always constant. Most of the time our reps were flat out. We have less workplace reps now than we did three years ago before the pandemic. Prior to COVID we had about 90 reps. Now we have approximately 60. We lost people to normal resignations and retirement. Post covid we have lost reps to early retirement, in addition, some did not stand for re-election due to pressures in their day roles and others because of the pressures they were under during COVID. Reps were burned out from the pressures of the role during the pandemic.

18. The convenor's role was very busy pre COVID, and still is now. You get involved in the more complicated and demanding cases. I would say there is less time for this now and I spend more time trying to find people to represent us on partnership groups post COVID or attending them myself. A significant number of partnership groups were parked or discontinued during Covid, there is now a tidal wave of demand to re-populate such groups that we are unable to meet. I would summarise and say there is more work now than there was before, but the balance of the work is slightly different.

**Unite – COVID-19**

19. During the pandemic general enquiries went through the roof, in particular with regards to members seeking advice about PPE and new Government guidance and how it impacted on them in their roles. We were working flat out to try and keep on top of the workload.

20. In addition to this, throughout the pandemic reps had an additional workload from liaising between HR, management, and the union. This included discussions in relation to the interpretation of guidance but also discussions such as the impact of deployment on staff.

21. As the convenor, I was getting policy guidance and policy updates from Unite. This was mainly in the form of bulletins that came out nationally across the UK and Scotland. There were regular core briefs which came from the Chief Executive which highlighted things that may be forthcoming as well as the immediate changes. They came thick and fast. Sometimes two or three per day. This was often confusing for people, and they may not have had the time to read all the information.

22. As a sector, we were not consulted before any new guidelines were released. We were not invited to give comment on new guidance before it was finalised. However, we were very vocal if new guidance was released and we did not agree with it. We would challenge this at the area partnership forums (in addition to any other relevant forums) or directly approaching the relevant managers. We were also able to raise concerns directly to the Scottish Government via the Unite regional Officer for Health who was in regular contact with Government Officials via various groups which had been set up.

23. I don't think the guidance fitted every one of the various different professions we represent. It was often confusing and not clear. We would try and comprehend new guidelines then send it out to our members in a way they would understand what it meant for them.

24. From a personal perspective, I keep a TOIL (time of in lieu) sheet for the hours I work beyond my normal times in my union role. At the beginning of the pandemic I had worked, in total, an additional 99.5 hours, by the end of the pandemic I had worked an additional 277 hours. This was similar for so many of my colleagues. Many reps, including myself, were juggling the demands placed on them as a rep in addition to the demands of their day job. The service was under significant pressure and staffing was an issue as a result of shielding and isolation. We carried out many extra hours during the pandemic. Reps were expected and demanded to attend meetings by management in their personal time, to allow the employer to make decisions in partnership and ensure our members were protected and represented. This was during a time where many reps were also going above and beyond to meet the demand in their clinical roles. There was no payment for these additional hours or any acknowledgement of these efforts.

25. Part of my role as Convenor is to ensure the reps are not overworked or overwhelmed. I was worried about the stress levels across the whole team and tried to support people as best I could. Unite did promote mental health and awareness courses for their members.

26. The operational and strategic considerations were how best were we going to represent our members in the time of crisis, and how we were going to do it. In the Greater Glasgow and Clyde area we immediately decided to have weekly instead of monthly meetings on-line for the senior reps. I was also in daily contact with the then branch chair. I also made myself available on request to the Unite reps team. We also created a senior reps WhatsApp group so we could share information and try to find answers to questions quickly.

27. We created a Communications Officer role to ensure bulletins were being disseminated to all our members on a regular basis, so they were being kept aware of how things were developing and changing. They were

receiving information they might not have ordinarily been receiving from their employers.

28. These measures ensured that we approached the situation with more vigour than normal, and our members were hearing from us a lot more than usual. We were more accessible and active than ever before.

29. Some key messages were left to the Trade Unions to communicate effectively. The health boards were releasing core briefs frequently - sometimes more than one during each day. These were so frequent, and involved so many changes in direction, that we, as reps, were left to identify and communicate the current position. There was confusion – it was coming too fast and there were too many changes. Each was usually a response to something from Holyrood or Westminster. Staff struggled to remember what the most recent advice was. Management would give out the key messages as they saw them, but the important stuff could get lost in the volume of information. That is not a criticism as such - they were doing their best, but the result was confusion.

30. There were some confusing posters – some referred to masks, some to masks plus visors and some to just visors. Some even mentioned half-visors which no-one had ever heard of, which caused further confusion.

31. Our members were very grateful for the support we gave them during this time and the feedback we received was very positive.

**PPE**

32. One of the key and initial challenges of the pandemic was the provision of PPE. What PPE was available? Where was it located? What quality was it? Who needed it? How could staff access it? There were less than ideal decisions being made by management in prioritising who got it and who did not. In my opinion, those in lower paid and apparently lower-valued positions were less appreciated in this regard and were not prioritised for

PPE (for example, porters and domestic staff). Porters were not seen as 'front-line' staff. This was foolhardy, unfair, and wrong.

33. Porters had to move patients known to have COVID. For example, at Glasgow Royal Infirmary, porters had to move COVID patients from one building to another along a long corridor. They were told they didn't need masks because they were pushing a patient who was facing away from them. That did not make sense – if the patient coughed, the porter would walk straight into the air the patient had coughed into.

34. The estates and facilities staff met the same 'brick-wall' as porters and domestics when it came to prioritisation of the distribution of PPE.

35. Community health visitors were in and out of patients' homes and there were PPE concerns. Often not enough PPE was provided or the quality of the PPE was questionable. Even if PPE was adequately provided, there were no disposal facilities available. Community health visitor staff were told to bag up their kit and keep it in their car boots untouched for 48 hours, until the pathogen was deemed to have died off, and then to put it in their bins at home. This was not an appropriate solution to disposing PPE used by community staff and put them and their families at riskof infection.

36. There were also problems with sub-standard PPE. Some examples include: fingers going straight through gloves; masks not fitting properly; and difficulty in getting FFP3 masks. There was also a particular issue with the 'double and even triple-dating' of masks. These were masks which were past their use-by date. This date was printed directly onto the boxes. Stickers were put on them to give a new date and sometimes later a second new date; we didn't know who placed these stickers. Unite contacted the manufacturer (3M) who stated that they would not take responsibility for the consequences of the use of expired masks, and that they did not consider expired masks to be safe. (Esther can make these emails available if required).

37. These emails were shown to management, and I challenged the basis upon which the decision was reached by the employer, that these masks were safe and provided adequate protection. Originally, I was informed by management that they were assured of safety by Health Protection Scotland (HPS). It then transpired that Health Protection Scotland were told that by Health Protection England. I challenged GGC to produce evidence of safety from HPS and/or HPE but they could not produce the evidence.

38. GGC eventually stated they had received a report on those masks and after this was, again, requested, the report was provided. Unite engaged an engineer with specific expertise and experienced in testing to British and European standard, and in fact, writing such standards. I asked him to assess that report. His assessment was simple – essentially that it meant we had to be worried; the robustness of testing of the out-of-date masks was weak and the testing threshold was very low. The reports stated they tested only one mask in every box of 100, and if it passed, they assumed the remaining 99 were good. Nor was the level of testing, in his opinion, particularly rigorous.

39. I fed this to senior management who questioned the credentials of the expert. Once supplied action was taken although this was not what Unite would have deemed rapid or stringent action. Unite had requested the masks be taken out of circulation. Management decided that if any staff who were provided with a redated masks asked for an alternative, must get it. They did not, however, take responsibility to communicate that message We communicated it to our members, but as not all staff are Unite members, not all staff got that message. However, we did share it with our sister unions.

40. There was a concerning lack of audit trails. When PPE was distributed, especially early on, there was no record of what was sent and where it was sent. For example, Unite argued that 'Tiger' masks were not appropriate or safe – but we could not ascertain who had been given

them and GGC could not tell us. When I initially questioned senior management about the lack of audit trail they said I had to understand that the health board were dealing with an emergency situation and therefore was unable to provide me with any details.

41. A lesson for the future is to have systems in place to ensure adequate audit trails - to ensure they can locate and replace anything which turns out to be inadequate, but also to link that to any spikes in infection rates related to where particular PPE is deployed.

42. There was also some discussion on whether, when working in labs, you should wear only a visor, only a mask or both mask and visor (which is the safe option). The official line was at one-point visors only. The unions believed both were necessary. I questioned whether this may have been influenced by the employer having lots of visors but few masks. Things like that were a constant challenge.

43. I think decisions on PPE may have been driven in part by the financial aspect. The NHS had paid for certain masks or PPE and the costs were high so they did not want to waste them, even if their use and safety was questionable. The trade unions were crucial in pushing for staff safety above all, and regardless of cost.

44. Also, I questioned whether there was an attitude from employers that these issues being questioned/challenged were just the unions panicking over nothing and just making an unnecessary fuss. This is despite the fact that the unions were only raising the genuine concerns of their members.

45. There is also the question of perspectives. Management wishes to focus on finances and on providing the service and the unions are focussed on the health and safety of their members.

**Staff Redeployment**

46. Another concern for staff was redeployment of resources. There was one occasion where a member of staff approached me regarding a newly

qualified member, who was already working beyond her hours, and there was a patient at the emergency receiving unit who needed examined. The newly qualified staff member was told to attend at the unit, despite her lack of experience, without any consideration given for her lack of confidence and experience in the role. There was no consideration for whether the staff member was able to stay on past their hours. This was an instruction from the manager to get the patient discharged and the bed cleared.

**Home Working**

47. Especially in the early stages of the pandemic there was lack of clarity on whether certain staff were or were not key workers. Within my area some departments accommodated home working well, or arranged rotas to ensure essential clinics and ward work were covered, whilst keeping on site staffing to a minimum, and that the "on site" working was shared around rather than the same staff being on the front line each week. In some areas however, decisions were taken that all staff were essential workers and home working was not supported. One example was the genetics laboratory where everyone was expected to attend work despite a reduction in workload due to genet clinics being paused except for emergency situations. As a result it didn't make sense for every staff member to be in the workplace (given social distancing requirements) when aspects of the work could be carried out at home. This seemed to be left to the discretion of individual managers.

48. The vast majority of admin/clerical staff had to work from home. There were challenges around IT kit, desks, seating etc for home working. Some staff (e.g. radiotherapy physics) were told to buy their own IT kit, at their own expense, including high spec and very expensive computers (which was required for their role), in order to work at home. To the best of my knowledge, these staff have not been reimbursed.

**Staff pressures**

49. Nurses in critical care teams had very difficult times. I recall that in Speech and Language Therapy, certainly in my team, where a patient was known to be COVID positive, they had to wear PPE for 2 to 3 hours at a time which was a challenge. This was compared to critical care, where they required to wear PPE for 12-hour shifts. They were under huge pressure.

50. Many staff worked additional hours that they were not paid for. That is the nature of NHS commitment. Staff did what they had to do and did not ask for or expect payment. However, overtime should have been paid (as per Scottish Government guidance) but for many staff it never was.

51. On occasion nurses would be looking after someone they knew (for example colleagues). This included a well-known and fondly regarded porter, who contracted COVID and was nursed at Queen Elizabeth University Hospital ICU (Intensive Care Unit) by his nursing colleagues who knew him well. Sadly the porter died from COVID while in Hospital. His widow has stated to me that, in her view, this was undoubtedly an occupational infection, as he has been working numerous additional shifts to help out with the COVID situation.

52. HDU (High Dependency Unit) and ICU staff also had to phone around for chairs, tables and water for their rest room – they were not allowed to leave the ICU/CCU (Coronary or Critical Care Unit) area to access rest facilities so had to organise and equip a local rest area for themselves as GGC did not arrange anything at all for staff in their position.

53. Porters were not allowed into the critical care wards, so nurses had to nurse and support patients whose families were not permitted to be with them until they died. Nurses then had to move the body onto a gurney and move it out to the door of the ward. This was normally the duty of the porters, but the porters didn't have the required PPE and so could not enter the area.

54. I saw nurses outside CCU in tears on several occasions. The required infection prevention controls and PPE removed the normal human and supportive side of the nursing role. For example, nurses were unable to hold patients hands as they passed away. This had a huge emotional impact. Nurses then had to lay the patient out, transfer them to a gurney and wheel the body out of the ward to be collected. They were then expected to get straight back to the front line to try and save the next patient. This inevitably has taken its toll.

55. Our members were very stressed, very worried and very tired during COVID. I think this was because it went on so long and the demands being placed on them, as well as feeling as if they were being taken for granted. There was an attitude of 'you must just get on with it' but this was difficult due to the time it lasted.

**Impacts on Speech and Language Therapists**

56. Speech and Language Therapist (SLT) colleagues in the community had a very difficult time. They were working in care homes, patients' homes and in health centres throughout the pandemic. There was a push for SLTs to continue to carry out their extremely important work in the community, to allow patients to be diagnosed and treated early subsequently preventing hospital admission. An example of this is their work with care home residents. When a care home resident has an issue with swallowing it is important they were seen to prevent them developing pneumonia and subsequent admission to hospital, where covid was rife and beds were scarce. Another example is paediatric services, especially for children with swallowing issues which could subsequently lead to chest issues and hospital admission. Despite this, SLTs had extreme difficulty obtaining PPE and especially the highest level of PPE (FFP3 masks etc). These are masks that have to be specially fitted to you to ensure it fits correctly.

57. In Speech and Language Therapy a lot of what we do involves assessing swallowing abilities. Swallowing problems are not uncommon in hospital or community SLT caseloads. Where someone has a swallowing difficulty, they may well cough when they are eating and drinking. When SLTs are assessing and testing for swallowing difficulty, there is a high likelihood that the patient will cough. SLTs are very close to the patient during the assessment, and so when the patient coughs, there will be exposure to pathogens which may be aerosol generated by the cough. This would include Covid.

58. SLT's in all settings were told by the government medical officers that swallowing assessment was not an aerosol generating procedure (AGP) despite the very high incidence of coughing during swallowing assessment, and so full PPE was not required and the employers refused to provide it on that basis.

59. SLT clinicians had to pressure/argue that swallowing assessments were indeed an AGP. They were backed by the professional body, the Royal College of Speech and Language Therapists. Within GGC SLTs were supported by their management who agreed this was a very high risk procedure. However, the official decision of the Chief Medical Officer as that unless suction was used, swallowing assessments were not an aerosol producing procedure. This demonstrated a lack of understanding of the risks when assessing a swallowing issue. SLTs felt they were being deprioritised for appropriate PPE due to shortages. They felt they were valued less than their medical colleagues and that the concerns they were expressing were ignored.

60. The profession managed to exert sufficient pressure, and practice at a local level eventually changed, to allow an individual to self-assess if they needed an FFP3 mask. If individuals assessed they required an FFP3 mask they would receive one. However, the requirement for a personal risk assessment wasn't commonly known and employers did not highlight this. Unite had to inform our members of this. There were occasions where

staff felt PPE was inadequate, such as not being provided with an FFP3 mask, not enough single use PPE for each patient, out of date masks, flimsy gloves. However, SLTs felt a responsibility to the patient, and so they put themselves at risk by carrying on without adequate protection.

61. In addition to this, there was a supply issue; I had community colleagues who had to travel across the city of Glasgow to collect masks before then driving back to their area to carry out assessments. This wasted valuable time and energy. On at least one occasion a colleague was provided with only one FFP3 mask for a full day of visits. A suggestion was made by one SLT manager that perhaps SLTs could look at holding open air sessions e.g. in local parks. This was a well intentioned suggestion to maintain a level of service within the constraints at the time, however, was not realistic. SLT management were generally supportive of staff around PPE.

62. Another similar issue concerned the head and neck cancer SLT team. Some patients have had their larynx removed; they breathe through a stoma (hole) in their neck. SLTs may have to fit/replace a prosthetic valve in the back wall of their trachea, which then allows them to speak. To do this the SLT is working inside the patient's trachea and this almost always causes a lot of coughing. The SLT is extremely close to the breathing hole and right in harm's way when the patient coughs. The vast majority of patients cough profusely and it is an explosive and often persistent cough throughout the procedure which can take anything from 10 minutes to (in extreme cases) over an hour. I have, on occasion, had to change clothing given the explosive coughing, which can include blood. The official line was that this was not an aerosol generating procedure – officially, it was only deemed to be aerosol generating if suction was used. The clinical service managers for SLT nevertheless made a practical, sensible and responsible decision that full PPE should be worn when replacing valves. Staff were appreciative of managers going against official guidance and agreeing that full PPE should be provided. However, resentment was felt

as a result of the official guidance not being changed despite representations on the issue and the full support of the professional body.

63. Local service management also made good decisions about shielding for those with vulnerabilities and those who were pregnant.

64. Following a piece of advice from senior management, local managers were asking SLTs (and other clinicians) to take on personal care tasks. For example, taking patients to the toilet, feeding etc. This was due to a general staffing crisis of health care support workers coupled with pandemic related staffing shortages. Whilst everyone was ready to go the extra mile, they were already under strain with SLT duties. They already had increased pressures, and were working with reduced staffing (absence, shielding etc). When struggling to do their own jobs staff were asked to take on other work.

65. There were concerns as they were not trained for some of the extra duties. If the patient fell on the way to the toilet, they were not trained to prevent or cope with that. SLTs did what they could e.g. If they were there to assess swallowing, they would try to combine that assessment with feeding the patient their meal. Staff in other disciplines were also asked to do extra work like that.

66. In general, everyone just got on with it. It was not uncommon for people to cry. Tempers became frayed more easily due to stress and tiredness.

**Long term impact on Speech and Language Therapists**

67. COVID has also had a longer-term impact. Firstly, a lot of colleagues of my age, a lot of my peers, decided to retire during and after the pandemic. They had had enough. Whilst some of these vacancies have been filled, some were not due to rationalisation of structures. It has caused some staffing and service issues. Staff are burnt out but there is also a feeling that their dedication and good nature is being taken advantage of. It is felt by NHS staff that they are treated as if they should

soldier on for the love of the job despite increasing pressure. There is an attitude of society and from the Government that NHS staff have a vocation and there is no recognition that staff also require to provide for themselves and their families. This feeling of dejection persists post Covid. There is concern that should there be another pandemic, the service is no better prepared and staff would be put in the exact same position. This has resulted in staff leaving and the service losing some of the most experienced clinicians. Where they have been replaced, this is with staff who do not have the same level of expertise and this impacts the service delivered.

68. Secondly, the high pressure felt during the pandemic has not abated. Due to COVID/lockdowns there is a backlog of work, but also issues arising from late presentations. For example, in my field of head and neck cancer, patients are presenting late and so needing more extensive treatment, more challenging rehabilitation, and there are poorer clinical outcomes including palliation. I hope that at some point this pressure/backlog will return to normal, provided that the right resources are in place (which is not currently the case generally within the NHS due to chronic underfunding).

69. SLT's have had to de-prioritise certain activities e.g., assessing and treating language difficulties which would improve quality of life, in favour of assessing and treating swallowing problems, which can cause threat to life from chest complications including pneumonia, and can require or increase hospital stay, and so put the wider NHS under more pressure. There simply aren't enough clinical resources.

70. SLT treat patients at all stages of life. we deal with people from early weeks of life right through to elderly rehab and palliative care. Those in hospital tend to be older - although we have a team covering the RHC as well. We provide services in hospitals, health centres, schools and nurseries, care homes and people's home environments.

## Unite Post COVID-19

71. With regards to how Unite has emerged from COVID, I would suggest there are both positives and negatives. We are much better at utilising IT such as Teams than we were before COVID. We do a lot more work using Teams and Zoom. We have more hybrid meetings than before COVID but we are trying to encourage more people to attend these in person.

72. We are aware of the value of regular and robust communications, which is exemplified by the fact we now have a Communications Officer.

73. On the negative side, we have lost reps. We are playing catch up trying to recruit new reps to ensure our members are represented properly.

74. With regards our membership, our rep numbers reduced but the overall membership numbers actually increased during COVID. The workload has increased as have the demographics.

75. Demand for our services has increased both during COVID and after. This may be down to the fact people who were not members before COVID saw the benefit members got during the pandemic and have since signed up to join us.

## Lessons to be Learned.

76. Regarding lessons to be learned, the major one for me is that staff need to be recognised for the work they did during the pandemic.

77. I feel there has been a serious lack of appreciation and recognition of the role of trade unions during the COVID pandemic.

78. Unite reps, and in fact most NHS reps, have day jobs in the NHS. Unite and sister unions had reps who were doing many additional hours of work – not just in their day jobs, but in fulfilling their union roles in a time of crisis. Many were having to burn the midnight oil helping deliver services, and then having, on top of that, to assist from the union perspective.

79. They were there to sort out difficulties for members; to attend meetings at weekends; take calls in the evening, even very late at night or very early in the morning, and at weekends (often at the request of management and/or HR), and to challenge on behalf of their members, to keep their members and service users safe.

80. Our reps team (across the various roles) were very busy throughout the pandemic with the kind of issues outlined in paragraph 78. However, a significant additional burden fell upon the senior reps team, including our HS lead. Our senior reps were well known to management and were already very involved in partnership working with GGC management pre pandemic. As things ramped up senior reps were expected to lead and support the wider reps team, were regularly approached by management on the many issues that arose and, were most likely to attend the high level meetings and to meet the out of hours demands. Senior reps were also more involved via the regional committee in raising concerns and attempting to resolve situations.

81. Senior reps were places in a position where they were already going the extra mile during their day jobs, whilst additionally being expected to attend out of hours meetings in their staffside roles. These meetings required attendance to ensure members were protected and represented. This additional demand had to come out of personal time. This was a significant additional workload that lasted throughout the pandemic and was not recognised and there was no opportunity to claim this time back.

82. NHS staff generally have had to do (and still do) extra hours for which they are not paid. NHS staff will often finish their day of clinical work and be required to go home (out with working hours) and type up their clinical notes (or prepare treatment plans and resources for the next day etc) if they have the secure facilities to do so. This is common within the NHS and is taken for granted. These efforts, including during the pandemic, have never been meaningfully recognised.

83. There needs to be proper recognition of these issues, more staff need to be recruited and to pay existing staff these extra hours. If staff are paid for it, they will feel less taken for granted.

84. There is also a need to treat people equitably, and I mean staff as well as patients. There were huge inequities with regards payment to staff who were furloughed and being paid a premium rate to vaccinate people, whilst others who were working, could not do so.

**Hopes for the Inquiry**

85. My hope for the future is this never happens again. But history teaches us it will. We were fortunate enough to have an NHS on this occasion. I would urge the government to remember the value the NHS had during the pandemic and make absolutely sure that if it did happen again, we have a fully functioning NHS, which will require significant investment.

86. I would want to see investment in the NHS going forward and be in a state of readiness, so if it did every happen again, we would hit the ground running.

87. I would encourage robust and effective communication. Whilst I appreciate things change, and there may be a need to revise what's been issued, I would beg the powers that be not to be sending out three updates in the one day. It leads to confusion. Make it clear who the information is for and what it means for people.

88. I would also ask that unions are listened to by government, policy makers and employers. We speak for our members and we represent them.

Personal Data

Signed …………… ……………………………………

Date ………16/04/24……………………………………………..