Overview Statement on behalf of the Scottish Healthcare Workers Coalition

On the impact of the handling of the Covid-19 pandemic

Presented by Cass Macdonald on 22 December 2023

1. My name is Cass Macdonald, and I am one of the founding members of the Scottish Healthcare Workers Coalition (SHWC). I registered as a nurse in 2011 and worked with NHS Scotland from 2012. At the start of the pandemic, I was an audit and surveillance nurse for the infection prevention and control team within NHS Lothian. I contracted Covid-19 early in the pandemic and subsequently developed Long Covid, as a result of my role, which required me to gather data on wards including surgical HDU and ITU and have contact with staff from across the hospital site I worked on.

2. I tried to return to work twice but became unable to work from August 2021. Trying to remain in work and maintain my adjustments was extremely stressful. It eventually took its psychological toll on me, and I believe this contributed to my last severe relapse and ended my nursing career. I now suffer from serious health issues including Heart Arrythmia, Postural Orthostatic Tachycardia Syndrome, severe mobility issues, neurological damage with Functional Neurological Disorder, seizures, worsened Asthma and Mast Cell Activation Syndrome. It means that my immune system can react badly to pretty much anything. This has also had a devastating financial impact on me since 2020 and until very recently I was at risk of losing my home.

3. The SHWC was established to provide support and campaign for the rights of health and social care workers living with Long Covid or other post-Covid illness, sustained as a result of occupational Covid-19 infection. We came together organically via our workplaces, social media, and advocacy work. Our healthcare backgrounds and lived experience make us well placed to advocate on behalf of those who developed Long Covid and related illnesses. We are 87 members and growing, across 11 different NHS Boards, representing multiple backgrounds, and include doctors, nurses, pharmacists, social workers, paramedics, and other healthcare professionals.

4. Long Covid describes those symptoms that develop during or after Covid-19 infection, which continue for four or more weeks and are not explained by an alternative diagnosis.[1] It often results in chronic illness and disability. People living with Long Covid can struggle with the simplest of tasks and experience significant respiratory, neurological, musculoskeletal, gastrointestinal, and cardiovascular symptoms. The most common symptoms reported are fatigue, cognitive dysfunction (or brain fog) and shortness of breath. Long Covid can also trigger other conditions such as Postural Orthostatic Tachycardia Syndrome (POTS), and Mast Cell Activation Syndrome (MCAS). There is significant overlap with Myalgic Encephalomyelitis (also known as Chronic Fatigue Syndrome).

5. Long Covid is not a 'slow recovery' as some may believe; rather, it is a complex multi-system neuro-immune illness.[2] At present there are only very limited treatment options and no cure. It is thought that Long Covid may occur after a Covid-19 infection in as many as 1 in 10 cases[3] and can arise in people who were previously fit and well, many of whom who had a mild initial illness with Covid-19. It is inevitable that this will negatively impact on an individual's ability to perform at work – or work altogether. It is thus key to the full and proper understanding of the long-term consequences of the pandemic.

6. SHWC members are involved in the Keyworker Petition Campaign[4], seeking compensation and pensions for keyworkers affected by occupational Long Covid, which I helped to set up. We are key stakeholders in high-level meetings with the Scottish Government and collaborated in research with the BMA[5] and the TUC[6] to share our lived experience in relation to government measures and decision making during the pandemic. We have spoken about 'aerosol generating procedures' (AGPs) on the BMA Scottish Council and Scottish GP Committees. In addition, our members have provided evidence to the Scottish Parliament Covid-19 Recovery Committee at their Inquiry into Long Covid. More recently, we wrote an open letter[7] to the Scottish Government requesting that it re-consider its decision to remove masks and employ clean air initiatives in healthcare settings. I have also previously worked with Long Covid Nurses and Midwives U.K. and Long Covid Scotland.

7. The SHWC contends that the consequences of the handling of the pandemic have been borne, unfairly and disproportionately, by Scotland's healthcare workers. We worked tirelessly and at exceptional risk to ourselves, to save lives and provide care throughout the pandemic. The Scottish Government and the NHS Health Boards failed to properly manage and support healthcare workers, placing them in harm's way, and at unreasonable, unconscionable, and frequently avoidable risk of serious harm to their health.

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[1] 'COVID-19 rapid guideline: managing the long-term effects of COVID-19', National Institute for Health and Care Excellence, version 1.20, 3.11.22, p.5

[2] 'Long COVID: major findings, mechanisms and recommendations' by Davis, H.E., McCorkell, L., Vogel, J.M. *et al*, *Nat Rev Microbiol* **21**, 133–146 (2023).

[3] 'Coronavirus disease (COVID-19): Post COVID-19 condition', World Health Organization, 28 Mar 2023

[4] See attached Key Worker Petition Campaign Briefing

[5] 'Over-exposed and under-protected: the long-term impact of Covid-19 on doctors' (BMA report, 2023)

[6] 'Worker's experience of Long Covid' (TUC Report, 2023)

[7] See attached Letter to the First Minister, 16 July 2023 by the SHWC

8. We were treated as heroes during the pandemic. We did our job but now we have been left disabled, we feel abandoned and forgotten by the government and the healthcare systems we worked for. Policy has not changed for the better and new evidence is being ignored, with mitigation measures that were already poor being dropped. Our position is that both the Scottish Government and the NHS have been negligent both in the discharge of their responsibilities and their failure to keep up to date with contemporary research.

9. Our key areas of concern currently to be addressed are as follows:

PPE AND RPE

"I felt let down, like cannon folder, in the initial wave due to inadequate PPE. I was actively denied a Covid test when I was unwell."[8]

"Both patients and staff were equally exposed to the risks of contracting Covid-19. No risk assessments or face mask fittings were carried out or any training received regarding Covid-19. Face masks were out of date, and we only had basic PPE."[9]

"(My workplace) knew that they were being gaslit by the Government by being told that 'coughing was not aerosol generating.' They knew that the Government was ignoring WHO guidelines on reducing the risk of viral transmission...Infection Control Nurses were told to downgrade their Enhanced PPE to Basic PPE because the virus was being compared to Tuberculosis (a minute virus compared to a massive bacterium). The PPE Guidelines were resource led not science led because there were insufficient stocks of appropriate PPE... We were all scared but had a job to do and just hoped that we would be ok."[10]

10. As per the Health and Safety at Work Act 1974, it is the duty of employers to ensure the health, safety, and welfare at work of all their employees. SHWC contests that these duties were not adequately performed, leading to large numbers of healthcare workers contracting Covid-19 in the workplace, with many subsequently developing Long Covid or other post-Covid illness. Indeed, the Office of National Statistics data demonstrates that healthcare workers were, and still are, at much higher risk of both Acute Covid infection and subsequent Long Covid than the general population, with at least 4% of healthcare staff estimated to be affected.[11]

11. Previous Coronavirus outbreaks, such as SARS-Cov1 and MERS, have been shown to spread via airborne transmission.[12] This should not have been disregarded when considering SARS-Cov2. Whilst airborne protections were provided in the very early phase of the pandemic, for example to specialist teams in Infectious Diseases, for the most part this then was rapidly

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[8] SHWC Member A
[9] SHWC Member B
[10] SHWC Member C
[11] Prevalence of ongoing symptoms following coronavirus (COVID19) infection in the UK, Office of National Statistics, 1 April 2021 to 30 Mar 2023
[12] 'A multinational Delphi consensus to end the COVID-19 public health threat' by Lazarus, J.V., Romero, D., Kopka, C.J. et al, Nature, 3.11.2022, 611, 332–345

downgraded to droplet protections only: fluid resistant surgical masks, plastic gloves, and aprons.[13] As such the majority of healthcare workers were provided with Protective Personal Equipment (PPE) that was inadequate to protect against the transmission of an airborne virus.

12. In addition to this, many members of SHWC report no provision of PPE at all in the early phase of the pandemic, despite the fact they were seeing Covid positive patients.[14] An arbitrary and dogmatic decision was made around the concept of 'Aerosol Generating Procedures' (AGPs) for which airborne protections such as FFP3 respiratory masks were mandated. It was not considered that when a person coughs, speaks, or breathes, they also generate aerosols, which if they are infectious, will contain the virus, and put those around them at risk of infection.[15] This decision deprived many frontline healthcare workers of airborne protections resulting in significant workplace exposure with high viral load.

13. Where FFP3 masks were provided, accessing fit testing was difficult. The process was not well executed, particularly in the early stages of the pandemic, leading to significant delay and in some cases complete lack of availability. We believe that for many years there has been a lack of organisational and governmental policy and decisions on fitting, re-fitting, and use of RPE in the event of a pandemic or disease outbreak.

14. SHWC are also greatly concerned that for those working in healthcare, when PPE is used it is mostly only fluid resistant surgical masks, even in Covid wards. The Health and Safety Executive is explicit in stating that fluid resistant surgical masks are not adequate PPE against an airborne hazard, yet this recommendation is not being heeded.[16] A far greater reduction in transmission occurs when using tight-fitting PPE called Respiratory Protective Equipment (RPE).[17] [18] [19]The few staff in limited settings who did have access to respirators had been at far reduced risk of developing COVID-19 compared with other staff who did not.[20] The Scottish Government withdrew its recommendation for mask use in healthcare as of 16th May 2023. Instead of downgrading guidance, SHWC strongly believe that masks should be continued in healthcare settings and that those working with Covid positive patients should be supplied with FFP3 masks or other RPE.[21]

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[13] Infection Prevention and Control Guidance for SARS-Cov-2 in Health and Social Care. Evidence towards the initiation and perpetuation of anti-airborne narratives by UK Public Health bodies by David Tomlinson, 8.10.23

[14] See attached SHWC survey response

[15] See FN 13

[16] Pandemic Flu - Workplace Guidance (Health and Safety Executive)

[17] 'FFP3 respirators protect healthcare workers against infection with SARS-CoV2' by Ferris M, et al, Authorea, 30 June 2021

[18] Airborne protection for staff is associated with reduced hospital-acquired COVID-19 in English NHS Trusts' by Lawton T, et al. 2021, J Hosp Infect, Feb 2022

[19] Royal Society Paper on Effectiveness of Non-Pharmaceutical Covid measures, Aug 2023

[20] 'Risk of hospital admission with coronavirus disease 2019 in healthcare workers and their households: nationwide linkage cohort study' by Shah A S V, et al, 28 Oct 2020, BMJ, 371, m3582

[21] Respiratory Protection of UK Health and Care Workers against SARS-CoV-2 Virus Infection, An Independent Review by Dr Osborne (5 March 2021)

15. RPE therefore must be available universally for the health and safety of staff and patients and must form an ongoing component of robust mitigations across health and social care settings, alongside clean air[22]. Vaccination alone is not sufficient, as it remains possible to contract Covid-19 even if vaccinated[23]. As such we recommend that FFP3 fit testing should be included as part of workplace induction, with scope for regular re-testing as a routine process.

CLEAN AIR

"Ventilation on general wards was (and still is) by "natural ventilation" i.e. opening windows. Windows on wards however can only be opened a small amount by tilting – for safety reasons they cannot be opened fully. It is unclear what number of "air changes per hour" this provides and obviously if a patient decides that it is cold and closes the window then ventilation is reduced"[24]

16. There is now sufficient evidence to demonstrate that SARS-Cov2 is transmitted through aerosols.[25]As such, high quality ventilation in public buildings is an essential tool to reduce virus transmission[26]. Notably, the Centre for Diseases Control (CDC) in the USA advises at least five indoor air changes per hour to help prevent Covid transmission.[27] In high-risk inpatient areas, such as airborne infection isolation rooms and operating theatres, the recommended rate of air changes increase to 12-20 air changes. This demonstrates a clear governmental acceptance that aerosols are a key driver for infections. At present, the Scottish Government Infection Control Guidance states SARS-Cov2 is transmitted via droplet/airborne spread.[28] As such, SHWC contest that Scottish Guidance for ventilation should match the CDC standard and international guidelines such as those set out by the Lancet Covid-19 Commission.[29]

17. Hospitals have had longstanding problems with ventilation, which further compounds the likelihood of workplace infections and inpatient outbreaks.[30] SHWC desires improved air quality measures in healthcare buildings, such as HEPA filtration[31]. In addition, we suggest

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[22] Swiss Cheese Model—How Infection Prevention Really Works (infectioncontroltoday.com) by Saskia V Papesku (Infection Control Today, January/February 2021, Vol. 25 No. 1)

[23] 'Long COVID after breakthrough SARS-CoV-2 infection' by Al-Aly Z, et al, 25 May 2022, Nature Medicine, 28(7), 1461- 1467

[24] SHWC Member D

[25] Brown J, et al. 2021. A quantitative evaluation of aerosol generation during tracheal intubation and extubation (Anaesthesia, 76: 174–181); also see FN 12

[26] Including other airborne pathogens with outbreak potential eg. influenza and adenovirus

[27] 'Ventilation in Buildings,' 12 May 2022, CDC

[28] National Infection Prevention and Control manual 19.5.23 (NHS National Services Scotland)

[29] 'Proposed Non-infectious Air Delivery Rates (NADR) for Reducing Exposure to Airborne Respiratory Infectious Diseases,' by The Lancet COVID-19 Commission Task Force on Safe Work, Safe School, and Safe Travel, Nov 2022

[30] 'Scientific consensus on the COVID-19 pandemic: we need to act now,' by Alwan NA, et al, 31 Oct 2020, Lancet, 396(10260), e71-e72

[31] Application of HEPA filtration devices for air cleaning in healthcare spaces: guidance and standards (NHS England, 9.5.23)

that all new healthcare buildings have appropriate filtration systems fitted and consider retrofitting existing buildings to achieve the above standard for ventilation.

OCCUPATIONAL ILLNESS

"From the start she (my manager) hasn't believed my diagnosis and admitted this to my union at the start. She emailed my union to say that there was no way I could have caught Covid as I was in "a green zone". She also brushed off my struggle to communicate as "anxiety."[32]

18. It is of great concern that the lack of adequate RIDDOR reporting to the Health and Safety Executive by responsible organisations means that the true number of work related Covid-19 cases and deaths is unknown and is likely greater.[33] [34] This is compounded by the fact that there has been a failure to use the internal reporting systems within organisations. As a result, this has enabled widespread denial of workplace exposure to SARS-Cov2 by employers, a problem frequently reported by our members.[35]

19. The SHWC desire that Long Covid should be formally recognised as an Occupational Illness particularly for those key workers who were at highest risk of Covid infection both during the initial stages of the pandemic and beyond. This would enable those suffering to receive appropriate compensation[36] and provide access to Ill Health Retirement and Industrial Injuries Disablement Benefit. At present Ill Health Retirement is being denied to healthcare workers or is only considered over an impossibly short time scale. The decision to approve Ill Health Retirement is made by pension companies or agencies, which are frequently denying both Tier 1 and Tier 2 pensions. SHWC members who are attempting to retire on health grounds have been informed that this is a new illness, that no one can say if they will improve or not, and therefore being denied employment-based pensions.[37]

20. Long Covid should also be better recognised as a disability under the Equality Act 2010.[38] This would enable those suffering to request formal reasonable adjustments in their workplace, and access financial support more readily. At present, some members attempting to return to work have reported reasonable adjustments being denied by managers.

21. Members also report that they were unaware or failed to realise that they could raise a disability discrimination claim against their employer, by which time they were time barred from raising such a claim. Extending the period in which to raise a disability discrimination claim from 3 months to at least a year will be a more simplified process, recognising that people cannot be

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[32] SHWC Member E

[33] 'Cover up' Allegations as Most NHS Trusts Say No Staff Died of Covid on Their Watch, by Mortimer J., 6 April 2023, Byline Times

[34] FOI requests by the SHWC for information about RIDDOR reporting and related questions to 14 NHS Trusts including the Scottish Ambulance Service with table of responses

[35] See FN 13

[36] The BMA Report 2023 also includes this in one of its 12 recommendations

[37] See FN 13

[38] This was backed by the Cross-Party group on Long Covid

expected to raise such a claim in such a short time frame when suffering with energy limiting conditions such as Long Covid.

OCCUPATIONAL HEALTH AND WORKPLACE SUPPORT

"I asked OH if I could wear a respirator when I returned to work and was told that infection control wouldn't allow this."[39]

"I'm about to make a return to work (after nearly 2 years). In one sense I'm looking forward to (it), on the other I'm angry: I'm angry about the pressure on me to be well in order to return to my NHS job, in which I caught this illness...I'm angry that I could possibly lose my job if and when I get ill again! I'm angry there's no financial support for me apart from a return to work (refused PIP)....In order for me to live in this world I must do "what's expected of me" and put my health at risk, only to be possibly sacked anyway!...I know how many are in the same boat as me, and I know what it's like to not be able to pay for private healthcare. Again, I felt I had no choice as the pressure from my NHS job was too much (the same NHS who can't treat me)!"[40]

22. Occupational Health support has been variable across health boards, with common themes suggesting under-resourcing and underfunding, with many experiencing long waits to be seen. Only Greater Glasgow and Clyde NHS Trust developed self-management resources for staff suffering from Long Covid. The Scottish Government, however, decided not to make these resources available nationally despite requests to do so.[41]

23. Risk Assessments have been of poor quality and often delayed, particularly in the early stages of the pandemic. Instead of a meaningful exercise to consider individual risk, these practices have often been felt to be a box ticking exercise. For example, the decision from NHS Scotland for those living with asthma was that it was safe for them to be at work. This contrasted with the advice given to the rest of society about shielding. Workers felt unable to challenge this for various reasons, including the feeling that they would be letting their 'side' down. Shielding letters were also delayed compared to the rest of society and decisions often did not take into account all the underlying conditions that staff were suffering from. This led to clinically vulnerable and disabled staff being put at risk in the workplace, following which they have contracted Covid-19 infections. It is also unclear whether post-viral illness was ever considered as part of such risk assessments.

24. In cases where Occupational Health has recommended reasonable adjustments, it has been common to hear that they are subsequently disregarded by employers. Instead of an empathic individualised approach, managers often appear determined to follow policy at the expense of staff health and wellbeing.[42] Some are berated or criticised by colleagues and managers for

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[39] SHWC Member F

[40] SHWC Member G

[41] (a) Letter to Name Redacted by Cass Macdonald, dated 4.4.22 and (b) letter to the Chief Executive of Lothian NHS Board by Cass Macdonald dated 4.4.22 and (c) response on 5.4.22

[42] "Employers must provide better support to workers with Long Covid" by S Thomson (BMJ 6.4.23;381:p800)

"not keeping up" or for not "getting better," and that they possibly cannot have Long Covid. Sometimes their condition is being used to push them out of their job. This is especially harrowing for those with a pre-existing disability. For those who contracted Covid-19 in the early phase of the pandemic, testing was also unavailable. As such we have many reports that employers disbelieved those who were obliged to self-report their Covid infection for want of available testing.

25. For some time now there has been concern that within the NHS there is a lack of awareness of the existing policies that are designed to support disabled people. The NHS Attendance policy is often considered in isolation without considering other supportive policies. This can result in harm to an individual's health and career. The long-standing problem of unfilled vacancies within the NHS has further exacerbated the pressures felt by staff living with Long Covid and related illnesses. They find themselves under great pressure at work due to staff shortages and at the risk of compromising patient safety rather than reducing it. Members felt forced to follow a presenteeism policy, attending work even when unwell. Others say they cannot "keep up" like they used to yet feel pressured to do so. This has led to burnout and long-term sickness absence for multiple reasons. Instead, workers should be receiving the ongoing support of management, occupational health, and unions; a strategy that should be championed by both government and employers.[43]

26. The SHWC desire that recommendations for reasonable adjustments should be legally upheld, which would better facilitate those with Long Covid returning to work. Where managers have been supportive, they report that their hands are tied due to the lack of provision for Long Covid. We would therefore be in favour of investment in a multi-disciplinary model within Occupational Health services which would include access to specialist allied health practitioners such as occupational therapy, physiotherapy, and counselling alongside clinicians across all NHS Boards.

27. It is well documented that NHS staff from minority groups may face more challenges than those who are not, including discrimination.[44] We feel it is therefore vital that the Inquiry considers whether the risk of Covid to minority staff members was adequately considered. It must consider how systemic racism and negative institutional attitudes towards ethnic minority health care workers with post-Covid illness have compounded their experience of employment loss, income loss, support at work, and all other aspects of application of NHS and Scottish Government policy.

JOB LOSS

"*At the end of Covid leave, my attendance meeting felt very bullying in nature, I was told that if I returned to work then [when] I was ill again then they would have to "terminate my*

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[43] 'Abandoned by governments and employers' by Tywcross, Ceolta-Smiths and Raynor (Editorial in Evidence Based Nursing, 23.12.22)

[44] 'We must make the NHS a better place to work for everyone – and root out racism and discrimination for good" BMA Scotland', 22 June 2022

contract." I told union I wasn't happy at this meeting, but she said this is just the process and not to worry."[45]

"I will lose my job with The Scottish Ambulance Service as they cannot find me administrative duties. I have life- long health issues caused by a virus caught because I was a keyworker who had to work. I am extremely angry"[46]

"I tried twice to return to work but this exacerbated my symptoms. I applied for the NHS Injury Allowance which staff can apply for if they have had an accident or injured at work, but my application was rejected because the panel decided I had more likely caught Covid outside work during lockdown, rather than in a busy Covid ward. I know that very few NHS staff have been successful in claiming NHS Injury Allowance. My NHS contract has now been terminated on grounds of ill health. I am unable to work in any capacity. I've applied for Ill Health Retirement despite being told by the Occupational Health Doctor that I would not be successful because 'there is not enough money in the pot for all the NHS people who can't work due to Long Covid' and 'one day I may spontaneously recover.' I now have no income and totally reliant on DWP benefits."[47]

28. Long Covid is a disabling chronic illness. Symptoms such as severe fatigue, cognitive dysfunction, and post-exertional malaise lead to significant challenges to continue in the workplace. The current NHS Attendance Policy[48] implements a four-week phased return, which is not suitable for an illness such as Long Covid, or indeed similar conditions like ME/CFS. Instead of adapting this policy to accommodate such chronic illnesses, the tendency has been to push people beyond their limits, often leading to deterioration in their illness. To extend the period of phased return many of our members have had to use accrued annual leave.

29. In the initial phase of the pandemic, all sick leave associated with Covid-19 was managed under the 'Covid Special Leave' policy. Of note this did not include self-employed General Practitioners. The Scottish Government then ceased Special Leave on 31 August 2022, following which those who remained on long-term sick leave were transferred onto standard sick leave policies. Many of them have already been moved towards termination of their contracts, with inability to access Ill Health Retirement as detailed above.

30. We must ask ourselves, why has there been little to no organisational change in terms of new job creation and improving redeployment to retain valuable skills that our staff have? There is so little flexibility, with job matches being offered but no guarantee that managers of those posts will be willing to make the adjustments that staff need. For many it may have been possible to redeploy them into new roles taking into account their new employment needs. Rather than facilitate return to the workplace, the tendency has been to terminate contracts rather than explore these options. This has been a long-standing problem worsened now due to the high level of staff affected by Long Covid. Redeployment should not be used as a method of moving staff on or even dismissing them altogether.

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[45] SHWC Member H

[46] SHWC Member I

[47] SHWC Member J

[48] NHS Scotland Attendance Policy

31. It is of great concern to SHWC that a significant number of the group are losing, or have lost their jobs, as a direct result of developing Long Covid.[49] The Scottish Government and NHS Scotland needs to make sure that health and social care professionals remain in the workplace, so that they can further develop their careers and earn a living.[50] [51]

LACK OF ACCESS TO HEALTH AND SOCIAL CARE

"I saw my GP with raised heart rate, palpitations, shortness of breath and felt faint. My GP referred me to Forth Valley Hospital where I had a d-dimer test to check for blood clots, chest x-ray, ECG, and other bloods. All normal. Pulse was racing. With hindsight, these were not the right tests to take. Could have had POTs but not tested for it. Advised to take lots of rest and water and returned home."[52]

"It's so hard having to manage this condition for 3 years now and try and keep your job and fight for basic healthcare! It's so unfair. I'm so tired...I just feel, with regard to prescribing, she (GP) could do more. She keeps saying no point in referring as I will wait too long!...I'm angry about having to pay privately to receive any treatment. I'm angry that our government continues to not only ignore Long Covid but to continue to spread lies about Covid messaging to the public."[53]

32. The EAVE-II study using medical records to estimate prevalence of Long Covid in Scotland, suggests that Long Covid has the same prevalence among Scots as both Stroke and Chronic Obstructive Pulmonary Disease, estimating that around 91,000 Scots are suffering from it.[54] Importantly, the study authors conclude that this figure is likely to a "significant underestimate" and the Office of National Statistics data has estimated that around 175, 000 people have self-reported Long Covid in Scotland.[55] The prevalence appears to be greatest amongst women in 35–69 year olds; thus the majority of people affected will be working age often with years of experience.

33. In Scotland there has been a lack of recognition and awareness of Long Covid across all spheres; government and policy makers, the medical establishment and the wider public.[56] Alongside this people living with Long Covid frequently experience stigma,[57] including gaslighting and psychologising from medical professionals.

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[49] See FN 14

[50] "As a doctor with Long Covid, I feel abandoned by the NHS" (BMJ 2023;380: p337)

[51] 'Long Covid and return to work – what works?' (A position paper from the Society of Occupational Medicine, Aug 2022)

[52] SHWC Member K

[53] SHWC Member L

[54] Identifying Long Covid using Electronic Health Records, Usher Institute EAVE II Study, Mar 2023

[55] Prevalence of ongoing symptoms following covid infection in the UK, 23 Mar 2023, being the last published data before funding by the govt was withdrawn. See FN 11

[56] The Scottish Parliament, Covid-19 Recovery Committee. Long Covid. 26 April 2023

[57] Pantelic M, Ziauddeen N, Boyes M, O'Hara ME, Hastie C, Alwan NA (2022) "Long Covid stigma: Estimating burden and validating scale in a UK-based sample."

34. The current care pathways for Long Covid in Scotland remain inconsistent and underfunded. They primarily focus on rehabilitation, thereby neglecting to treat the underlying active pathophysiology. There is no cohesive network of services across the country, and the onus remains on GPs to manage this complex condition. Often due to lack of knowledge and awareness, even gaining a diagnosis can be challenging. Where hospital specialists are involved, this is in a piecemeal fashion, often with extremely long delays. As a result, many people are turning to private services, further driving health inequalities.

35. The SHWC consider this approach wholly inadequate and recommend the development of a network of multidisciplinary specialist services. This should include access to diagnostics and biomedical research, including trials for treatment. Such research could also lead to clues about other related illnesses such as ME/CFS. In addition, clinicians need support and training on Long Covid and related illnesses (such as POTS and MCAS), to provide improved care for people suffering from Long Covid. Early recognition is essential, to prevent deterioration and to help to maximise functional status. Neglecting to provide adequate funding for this is a false economy; thousands have become disabled by Long Covid and are unable to contribute to the workforce whilst they remain sick.

36. During the whole of the pandemic there had also been very limited, and often inaccurate, public health information about Long Covid. The SHWC have great concern that reinfections can occur in as little as two months after the previous infection regardless of vaccination status.[58] Reinfections carry an increased risk of developing not only Long Covid, but also cardiac disease, thromboembolic disease, diabetes, and neurological disorders following each infection. As such, SHWC strongly desire a high-profile public health campaign for prevention and awareness of ongoing risks of Covid-19.

THE PSYCHOLOGICAL IMPACT

"I contracted Covid-19 from a patient who was transferred from another hospital. I suspect that the staff in the previous hospital knew the patient had Covid-19 but did not inform me. It was very irresponsible and dangerous. When I saw the patient, he had not been tested for Covid -19 yet. A few days later, I developed symptoms of Covid-19. They were severe and I was scared of dying...I have young kids and no relatives in Scotland...It was a very traumatic experience for me... I received messages from my workplace asking me to return to work. I felt pressured and went back to work after one week...It was like being paraded like a slave ...I had a terrible time, was under tremendous stress, unable to sleep, irritable, had bad dreams, and felt humiliated. After three months, I went back to work but was bullied in my office."[59]

"(Before Long Covid) I would regularly go running and walking in the hills and trails in the evenings and at weekends and would routinely commute to and from work cycling around 50km

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[58] 'Acute and postacute sequelae associated with SARS-CoV-2 reinfection,' by Bowe, B., Xie, Y. & Al-Aly, Z. 2022, Nat Med 28, 2398–2405

[59] SHWC Member M

per week...I can see the hills from my home and feel frustrated that I can no longer run there. I also feel frustrated (but not depressed) about the state of my health ...(I) worked hard for the NHS and for patients and have been so negatively impacted due to purely doing my job with not only inadequate protection but also no acknowledgement of either the effect this has had on me as an individual but also my family and colleagues. It has significantly affected my ability to be the father, husband, and friend that I once was."[60]

37. The adverse psychological impact of working during the pandemic is attested to, by all our members, in various ways. Many of our members were frontline workers. Some were living alone and at higher risk of contracting Covid-19 due to their ethnicity. They felt acute stress (indicative of PTSD) and pressure trying to care for a high number of patients whilst wearing poor quality, and at times no PPE.[61] Seeing a high number of patients die of Covid-19 in their care, whilst at the same time hearing of relatives abroad pass away with the same disease but without the ability to travel to see them, added to their trauma. They inevitably contracted Covid-19 but were pushed back into work whilst still ill due to staff shortages. To be further disbelieved and left to deal with and manage the debilitating symptoms of Long Covid, with no support or reasonable adjustments offered by the NHS, has left them with life-long trauma and scars that are difficult to heal.

38. There was also fear amongst members of infecting their family members. With inaccurate information or guidance on how the virus could spread, they chose to further isolate themselves resulting in a decline in their mental health. Under this climate of fear, pre-existing mental health issues due to under-resourcing or other unresolved organisational work challenges were further exacerbated.

39. When we developed Long Covid, some of us felt as if we were stuck in a vicious cycle of depression and illness. Attempting to return to work under these conditions was stressful which manifested itself in different ways, such as burnout. This was even more challenging when trying to navigate all the different obstacles in our way to seeking support from our workplace.

40. We are all grieving for the loss of our health. I describe it as losing a limb. It takes time to accept this, especially for those who are new to disability. Short term counselling, offered via Occupational Health for some, while a supportive measure, was not an adequate substitute for proper psychological assessment, support, or treatment. This is symptomatic of a funding crisis in the mental health sector pre-pandemic. When we were also not believed about our symptoms, we felt like a failure, self-doubted or pushed ourselves back into work prematurely to the further detriment of our health.

41. A sharp decline in income has also created uncertainty surrounding the affordability of existing housing. And within the current cost of living crisis, the loss of a steady income in tandem with a harsh decline in health has paved the way for mental health to spiral out of control for many of us in addition to coping with our Long Covid symptoms. The cumulative impact of

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[60] SHWC Member N

[61] "The impact of Covid-19 pandemic on the mental wellbeing of health and social care workers (HSCWs) in Scotland" – research study by Glasgow Caledonian University, published Feb 2021

all this on our families and friends is severe, as we often cannot be the friends, parents, siblings we used to be. Everything about our lives has changed, with no end in sight to our ongoing suffering.

HUMAN RIGHTS FAILURES

"Key workers were abused and not treated like people"[62]

42. The SHWC would like the Inquiry to investigate the extent to which the rights of health and social care staff were being protected when policies and measures were being implemented and decisions being made, for instance in relation to PPE. And to understand to what extent the Scottish Government were aware of the long-term health risks posed with Covid-19.

43. Considering that Scotland has already started the process of incorporation of more international human rights into Scots law,[63] this is a matter of pressing concern as the process of further incorporation begins.

44. An obligation on the State to secure the right to life is imposed by Article 2 of the ECHR. This has included the partial right to health that is, the duty of the State to provide an effective framework of healthcare.[64] The right to life is also protected by Article 6 of the UN International Covenant and Civil Political Rights and Article 10 of the UN Convention on the Rights of Persons with Disabilities in the context of those with disabilities.[65]

45. Whilst the State is not under a duty to take steps which would pose an impossible or disproportionate burden, it is under a duty to take appropriate steps to protect life where there is a known risk to life (or the risk at least ought to be known). In the context of the Covid-19 pandemic we believe that this duty included prioritising the provision of available PPE and RPE to healthcare staff, other frontline workers, and people most vulnerable to the virus such as those with specified underlying health conditions.

46. The foreseeable risk of serious deterioration in health also engages the right to be free from inhuman and degrading treatment enshrined in Article 3 of the ECHR.

47. When it became clear that black, Asian and minority ethnic communities were suffering disproportionately from the effects of Covid-19, the right to life read together with the right to non-discrimination in the enjoyment of the substantive ECHR rights under Article 14 of the

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[62] SHWC Member O

[63] The new Human Right Bills intends to incorporate 4 human rights treaties into Scots law, which includes the International Covenant on Economic, Social and Culture Rights.

[64] Lopes de Sousa Fernandes v Portugal [2017] ECHR 1174 at paragraph 166.

[65] The right to health appears also in different forms in international conventions that the United Kingdom has ratified, including Article 12 of the International Convention on Economic and Social Rights, Article 12 of the UN Convention on the Elimination of Discrimination Against Women (which stipulates the right to health care of women); and Article 5(e)(iv) of the Convention on the Elimination of Racial Discrimination.

ECHR should have required the prioritisation of the allocation of PPE to, for instance, BAME doctors and nurses. Our evidence shows the reverse has in fact been the case.

48. To prepare for further waves of Covid-19 or future pandemics, the Government must take steps to ensure that the allocation and prioritisation decisions and policies relating to the provision of PPE are evidence-based and non-discriminatory.

49. We hope that our recommendations as outlined above will be seriously considered and implemented. What the Scottish Government fails to realise is that Long Covid has cost us immensely already. If this continues to go unrecognised, and we do not change the status quo, we run the risk of new, long-lasting inequalities being created, with its damaging long-term impact on people's lives, their families, wider society, and our economy. The Scottish Government and the NHS must now show us the same level of courage and conviction that we showed to them during the pandemic.

Signed Personal Data

Date 18/1/2024