Scottish COVID–19 Inquiry

Witness Statement

by

HSC00192 Karen Leonard

Introduction:-

1. My name is Karen Lilly Leonard, PD My details are known to The Inquiry. I am employed as the Lead Organiser with GMB Scotland. I have been in this role since 2012 and I have been with GMB Scotland for 38 years.

2. I started working with GMB Scotland after leaving school. I started as an Office Junior and worked my way through the organisation. I left the headquarters at Fountain House in 1996 to work for the National Admin Unit where I was Team Leader. In 2012 I was made a full-time Officer.

3. On the 6th of February 2024 I met with witness statement takers from the Scottish COVID-19 Inquiry team, and I am happy to provide a statement about the experiences of my members during the pandemic. I have signed the consent form provided. I am happy for my information to be contained within reports and published.

Overview of Role within GMB

4. The job remit of my role as Lead Organiser covers the GMB membership for staff working in NHS Scotland, including NHS24, and the Scottish Ambulance Service. My role is primarily to work with, and organise, our workplace reps.

5. We have voluntary reps in the workplace that represent our GMB membership as well as attending partnership meetings with the NHS, attending meetings with the Scottish Government, the civil service, and other employers.

6. I cover all the Scottish Ambulance Service across Scotland and for the NHS I cover Glasgow, Ayrshire and Arran, Lanarkshire, Forth Valley. I also cover Dundee and the Highlands and Islands as additional cover. However, my usual place of work is based in Glasgow.

7. There are four other persons who assist with this role and I report to a Senior Organiser, who then reports to the Scotland Secretary.

8. I do not function as a line manager, but rather as an organiser for all the reps. There are 70 volunteer reps who report to me, but my interactions are mainly with Lead Reps, who have more seniority. They then organise regional reps and so on. We usually have at least one or two face-to-face meetings with all reps annually, but more frequently with some organisations, such as the Scottish Ambulance Service, who we meet with face-to-face every three months or NHS Glasgow, who meet every month. I interact with NHS24 sporadically.

9. The purpose of these meetings is to discuss local issues and campaigns. We use that time to keep each other up-to-date or if any of the reps wish to raise any issues with myself. Following on from these meetings, there is a summary, but it can depend on what has occurred in the meetings. Usually, if needed, I will follow-up with the employer in writing to make them aware of what is going on.

Overview of GMB membership

10. GMB membership is a general membership in that it does not stick to specific professions. In the NHS, we have members who are porters, catering staff, cleaners, healthcare support workers, nurses, admin etc. We have members spanning across the NHS employment classification, from Band 2 up to Band 8. In the Scottish Ambulance Service, our members would include patient transfers, ambulance technicians, paramedics, ambulance call-centres, admin staff, and some area managers. In NHS24 our members would mainly be call-handlers.

11. There are thousands of members from the Scottish Ambulance Service and there are many thousands of members from NHS Scotland, which includes NHS24.

Role in the Workforce Senior Leadership Group

12. Prior to March 2020, there was no direct communication about COVID-19 from the GMB or the Scottish Government. Only what was available publicly.

13. At the start of the pandemic, the Scottish Government had set up a Workforce Senior Leadership Group (WSLG). It was April 2020 before the GMB became part of that group. Prior to that, I think there were meetings held without the GMB in attendance.

14. I was the GMB representative at these meetings, alongside my senior Drew Duffy. At that time we had meetings with the WSLG three times a week to discuss and report issues around health and safety, the lack of PPE, and social distancing. Generally, these meetings would discuss what was going on out there in the workforce with a view of getting communication out to our members.

15. Around 60-100 people attended these meetings including representatives from the NHS health boards and the private sector. It started off as a teleconference call before it went on to Teams. Usually, these meetings lasted an hour. An agenda and an action log were circulated prior to the meeting. Following the meeting a minute would be circulated. The person who chaired the WSLG originally was Gillian Russell from the Scottish Government and if Gillian couldn't be there, there would be somebody to deputise for her.

16. The input in these meetings was primarily from trade unions – the employers would be there, but it was mainly trade unions across health and social care. Where we had concerns or questions, they would come back to us with an explanation or how we could change. It did work.

17. A lot of what was being discussed at those meetings would be more localised. It wasn't until we had talks around shielding and things like the death and benefits settlement, the big things that would be affecting a number of members, that non-localised issues were discussed.

18. The Scottish Government sent a lot of guidance out as things changed around social distancing and shielding. Those in the WSLG were all part of those conversations about guidance. There would be information coming back to us to share with our members.

Communication

19. At the start of the pandemic we shifted to working from home which made communication with our members a lot more difficult as many of our members are front-line workers. I was relying a lot on hearing what was happening from the local reps as they were NHS workers themselves. Those were still around the rest of the workers and could hear what was going on.

20. At this time, there were a lot of Teams meetings with the reps and with different groups of members. It would be general calls from people concerned about what was going on in their workplace, but also the day-to-day trade union work that continued.

21. At that time, it was just constantly jumping from telephone call to Teams calls. Not everyone had access to Teams at the outset. Everything took longer, whether it was getting information to filter down to the reps, communicating information to reassure people if there were changes, or to makes sure that guidance from the Scottish Government was being implemented in the workforce. That was where, on a number of occasions, it would come back to us that it wasn't.

22. The communication with reps at that point was primarily through email and text. In certain workplaces we have notice boards. Where we had notice boards, we would get information out to the reps and ask them to put it up on the notice boards.

23. When it comes to communication with the wider membership, that is done through us, but the more individual communications would be done on a workplace basis. We try to encourage our reps who are in the workplace to have that sort of communication with members directly. A lot more was expected of the reps due to the problems and challenges arising, which were tenfold to what we would normally expect.

24. It was challenging I think for the NHS, because it is a national employer, it was one message that was going out to everyone. I think that made it a bit easier for us to get that message out to our members, but then problems occurred with employers where the information wasn't getting out there to our members.

25. The Scottish Government and the NHS boards highlight that they work in partnership with GMB, but that partnership could be quite challenging. The NHS would issue communication to their workforce but the GMB did not have an input into that. The NHS would not share this communication with the GMB so we would pick up on the information going out to our members through our reps bringing the information back to us.

26. When the message was coming from the Scottish Government through the Workforce Senior Leadership Group, it was coming directly to the trade union and the employers. The employers would then have their own newsletters to communicate the message to their employees.

27. We felt like we were plugging a gap. We were trying to get out what we felt was an important message to our members, but some of the information coming down from the employer that we felt wasn't right and didn't feel they had interpreted it properly. We did this on numerous occasions. In our opinion, the reason for different interpretations in different departments was that each middle manager was left to interpret for their

own area, which lead to inconsistencies and sometimes incorrect interpretations. .

28. Our way of communication with members was by email and text to the people we had contact details for. Our support workers did that. Given the size of our membership you are talking about several thousand emails to the NHS that had to go out. We were trying to make things as clear as possible, but then some folk wouldn't pick up on it or get the wrong end of the stick, so it was important to make sure that what we're putting out was as accurate as possible.

29. Around July 2020, the communications and guidance in relation to the Death in Service benefit payable to families of workers caused some confusion. I had taken, from my reading of it, that it would apply where a worker had died through COVID. However, I think originally when the message came it out it only applied if the worker didn't have a pension. There was a lot of discussion around that for clarification. In the end it became clear that it was for all families who had lost someone through COVID.

30. What the Death in Service policy was, and the guidance from the Scottish Government on how that was to be applied, wasn't that clear. It was the trade unions who tried to tease out what the guidance meant and communicate that to their members.

    Communications were therefore difficult and challenging and required constant attention. There was confusion and there were inconsistencies. The impact of this on our members in the health service was confusion and uncertainty.

<u>The concerns of the Scottish Ambulance Service</u>

31. There were lots of concerns from the Scottish Ambulance Service at the beginning of the pandemic because they would be the first people to be sent out to patients and they didn't know whether the patient had COVID. On 13 March 2020, the GMB wrote to the First Minister outlining the concerns of our members. This included:

32.

    (i) *"Ambulance service call centre staff being told to continue working despite staff returning from Italy and displaying symptoms that should necessitate self-isolation".*

    (ii) *"Paramedics in the Lothians were sent without warning and without appropriate PPE to treat a patient with suspected covid-10, who*

subsequently tested positive for the virus. This happened at the same time as the Chief Executive of SAS confirmed to us that only 15 per cent of front staff had received fittings and training for the use of respiratory masks. Yesterday one of the two paramedics who attended to the patient has now also tested positive for covid-19".

33. Some of the concerns raises by our members within the Scottish Ambulance Service included:

PPE

34. For specific instances of PPE concerns you should speak to Scottish Ambulance Service workers. However, in general, the concerns in the early days of the pandemic revolved around PPE, or rather the lack of it. It then moved on to be the validity and safety of PPE as it became apparent that covered up expiry dates on the boxes became an issue.

35. The PPE for the ambulance workers should have been more robust than the PPE in some areas of hospitals because they were going into the homes of people. The virus was around about them and in the ambulance. Every time they had someone in the ambulance who was suspected to have COVID they had to do a deep clean of that ambulance.

36. At the start of the pandemic, the masks that Scottish Ambulance Service staff were wearing was the small blue surgical masks. A letter was sent by GMB Scotland Secretary Gary Smith on the 17 March 2020 to the First Minister with concerns about providing ambulance staff with insufficient PPE and poor-quality masks. The letter referred to it being 'pound shop protection', a term one GMB member described the facemasks, which were the quality of facemask the public were purchasing to wear on the streets. A copy of that was submitted to the Inquiry.

37. The situation was so dire in the Scottish Ambulance Service that the Cabinet Secretary for Health, Jeane Freeman, issued an apology to Scottish Ambulance Service Staff on 20 March 2020 for the *"anxiety and concern"* around the supply of PPE.

38. There were changes over time. Obviously, it improved in the sense that PPE went from surgical masks to more secure facemasks – fitted FFP3 masks. There just wasn't enough PPE and then, when PPE did appear, some of it appeared to be expired.

39. That expiry dates for the face masks was a serious issue. I wrote to PD PD the Director of Workforce at the Scottish Ambulance Service on 21 April 2020. (a copy of which was provided to the Inquiry) about the face

fitted masks when it became known that the virus was more airborne, and the fitted higher quality masks should have been used. Within the letter I also raised that some of the masks being provided to our members should have been taken off the shelves years beforehand, with some expiry dates going as far back as 2012.

40. I have photographs they were given to us by our reps which show that some of these boxes of masks had two or three stickers over the expiry date and, once you peel off these stickers, you can see the expiry date going further back in time. I have provided these photographs to the Inquiry.

41. Following receipt of these photographs, we challenged the issue of expired masks with the relevant employers - all the trade unions were challenging that at the time. We were asking "How safe were these masks?". These masks were appearing during times of low stock and throughout the NHS there was an element of not wishing to frighten people but, at the same time, if they weren't sufficiently protecting them, people should know that.

42. What we did have were people wearing the masks and whatever it was, whether it was the expiry date or how long they were wearing them, they were causing skin irritation and coughs. We never got an answer as to what was causing those symptoms. We emailed the manufacturers and eventually it came back that these masks were obsolete and should not have been used.

43. The Scottish Ambulance Service were constantly adjusting their practices according to the changing guidance from the Scottish Government. There was a big urgency to get people FFP3 face-fitting masks.

44. Later, perhaps April 2020 or thereabouts, the Scottish Ambulance Service staff were fitted with FFP3 masks, but there were issues as to whether those masks were appropriate or had been fitted correctly.

45. There was an issue with 'double-looping' that was picked up in a letter dated 21 April 2020 as referred to above. One of our members who helped to fit these masks later became a whistleblower over these concerns about the Scottish Ambulance Service not picking up on what they should have been done.

46. Our member advised us that the way of testing face fitting masks was this: when the mask was being fitted there was a spray being used and if you could taste or smell the spray, then the mask wasn't fitting properly. Our member had witnessed other people fitting the masks when people could

still smell or taste the spray and they were just carrying on, giving them the mask to go away with, even though it had not passed the face fitting tests. It was being put through as a pass on the test and that's where they were tightening the straps, trying to make the mask tighter, double looping.

47. The fitting of PPE was where the real challenges were. When they had obtained PPE suits for them for ambulance staff to wear, it was one-size fits all, mainly directed towards males. So, for the small women ambulance workers, it was not suitable.

48. Workers were also having issues if they had facial hair. Masks would not fit correctly if people had a beard, so they were asked to remove them. An alternative was to use a hood, but initially there was reluctance to offer this given the increased cost. We had to fight for that whenever it arose. It was yet another battle which shouldn't have been necessary. . .

49. The issues with PPE affected staff morale, and made them feel undervalued because their safety was being put at risk.

Test and Trace

50. When the Test and Trace system was introduced, ambulance workers were never notified under that system if a patient who had been in their ambulance subsequently tested positive for COVID. On occasion they may have found out from informal discussion with other healthcare workers, but there was no formal connection or notification as part of the Test and Trace system.

Health and Safety

51. The health and safety issues raised with the GMB usually lay with the employer, not the Scottish Government. There was poor communication about whether incoming callers could potentially have COVID. Patients usually weren't tested until they were in a hospital environment so, at that point, the ambulance crews would be sent out to emergencies and would have to make a judgement call on whether that caller could have COVID.

52. Ambulance staff had to make judgement calls based on suspected symptoms, such as temperature and persistent cough. It wasn't until they got to the patient that they could assess that that. Also, there wasn't really any way for the ambulance control centre to ascertain whether somebody did have COVID.

53. It is important to remember that, at that time, ambulance workers were arriving at homes with serious uncertainty as to what they might encounter, and the extent to which the person, or others in the house, may have been infected. We must also remember the lack of PPE at that point too. Unless workers knew for certain the call was COVID positive, they had to treat the call as any other call and arrive with surgical masks and not full PPE. If they were aware of someone being COVID positive, then they had to go out and put on their PPE kit.

54. They did on occasion take a bit of stick from families, perhaps because they had been waiting for an ambulance, or the PPE protocol they were going through. Of course, the public would not know what the protocol the worker would have to go through to keep them safe.

55. There were also staff shortages as staff members caught COVID, meaning that those remaining at work had to work more and longer shifts.

56. In terms of cleaning, staff were expected to use their normal cleaning wipes that they would have used pre-COVID to mop up blood, which did not seem to be adequate.

57. The Scottish Ambulance Service then brought new cleaning equipment in, but the crews didn't feel that what they were being given was adequate for cleaning the vehicle properly. This new equipment was intended to prevent them from going back to the station between patients to have a proper deep clean. They were just expected to wipe down their vehicle themselves and staff had concerns about that, that they were exposing themselves and potentially taking COVID home to their family.

58. At times it just seemed that the Scottish Ambulance Service t were not making sure that their staff were safe. Sometimes it seemed like they were ticking boxes. When we raised concerns, we felt it wasn't always taken onboard in the manner it should have been. It is important to remember that this was potentially a person's life we're talking about. Theere were times when we, the GMB, had to force the employer into providing what they should be.

Ventilation

59. There were also concerns about the ventilation within the ambulances because information kept changing as to whether or not the virus was airborne, and about how that would be affected.

60. Our fleet members and mechanics were of the belief that the air in the back of the ambulance was just recirculating and not coming in from outside. The GMB asked for risk assessments to be carried out on this but we never received any.

61. The ambulance crews in some parts of the country were told not to put their heater on. The ambulance service were expecting patients in winter to be in the back of the ambulance without any heating. They would just always say that the ambulances were safe, but we never saw anything to prove that.

62. The guidance from the Resuscitation group – I can't remember the name of it – advised that there was an issue around the airflow, in the ambulances and in hospital, and what level of risk there was. At the time there was information in England that was different from what we were being given in Scotland. I know some of our reps were challenging that at the time.

63. Our reps told us that the new ambulances being brought in recently have a new ventilation system which brings in fresh air from the outside. We haven't really done much about that I must say, but it is something that we want to explore. It is telling that there has been a change.

Death of an ambulance worker

64. In March 2020 there was the death of an ambulance worker who was a GMB member. This was at the time when the only PPE they were using was basic masks; so they had the blue surgical mask and the ventilation issues with the ambulance. The crew was transferring a patient from Campbeltown to Glasgow or Paisley. This would have been about a two-hour drive. In the days after that the ambulance worker was then diagnosed with having COVID. He had always said to his wife prior to that, that he felt that they weren't being given proper PPE, and that the heating in the ambulance recirculated the air. He died after that long journey. We understand that thee patient he had in the back had symptoms of COVID.

65. It's difficult to get figures on the number of the people from the Scottish Ambulance Service and the NHS who contracted COVID. Also, The Scottish Ambulance Service, like most of the NHS, were of the opinion that their workforce were free to go out and about, and therefore did not necessarily contract COVID at work. I'm sure there will be figures somewhere documenting the number of NHS workers whot died of COVID.

Long Covid

66. Long Covid is more prevalent for Scottish Ambulance Service workers because of the job that they did. We have members suffering from Long Covid. Long Covid has a huge impact on people's health, meaning that they can't do the physical aspects of the job. The Scottish Ambulance Service are taking people with Long COVID through capability procedures. Some members have lost their jobs. The difficulty is that workers can't prove that they contracted COVID in the workplace which makes it difficult to prove that the Scottish Ambulance Service is liable for the illness that they have.

67. We are supporting them, but there are people who will never be able to physically do those jobs again and need to be redeployed, but when the jobs aren't there they are instead having their employment terminated. One of the redeployment options would be to go into the ambulance control centre. Control centre workers are generally paid less, so it's a significant drop in salary.

Mental Health Impacts

68. We have several reps who are representing people who have mental health issues because of things that they have been through during the pandemic; like the things they have seen and the pressures put on them.

69. The pressures on staff has caused a number of ambulance service workers to be off with mental health-related problems over the past few years. All the GMB can do is just support them and make sure they are being treated as fairly as possible.

<u>The Impacts on NHS workers</u>

70. I should say that a number of the issues raised by NHS workers are similar to those raised by our members in the Scottish Ambulance Service.

Flexibility within the NHS and Scottish Ambulance service

71. Some employers or managers within the NHS and Scottish Ambulance service were more reluctant than others to help their workforce by being flexible about start times and finish times of their shifts. There were issues around transport, or childcare issues, which affected workers and their

ability to get to work. These matters were day-to-day conflicts with some being unsympathetic.

72. There was a huge impact as well on people who were shielding. This meant long periods of relative isolation, and fear and challenges when returning to work having been off for a while. Those that were not shielding had to worker longer hours to cover the necessary service.

PPE

73. The concerns of NHS staff about PPE are similar to members of the Scottish Ambulance Service.

74. We were hearing from members in hospital settings that were having to wear masks for long periods of time, which was challenging for a variety of reasons, for example skin irritations, breathing difficulties, overheating. Some manager were unsympathetic to that and rather than looking for 'work around' simply told them 'you have to wear the masks'.

75. In terms of the issuing of PPE, domestics should have been given the proper FFP3 face fitting masks when it was discovered the virus was airborne. A lot of the time, they wouldn't be told if they were going to clean a room that had a positive COVID patient in it. A lot of the time they were going into these rooms with just a facemask and a plastic apron. It wasn't adequate protection.

76. The domestics, catering staff and porters were being treated differently from others, for example clinical staff, when it came to prioritisation for PPE. When entering a room where there were or had been COVID positive patients, they just had their blue masks and the aprons; whereas others, for example, clinical staff had face fitted FFP3 masks which was different and much more adequate protection.

77. A survey conducted of GMB Scotland NHS Scotland members on 24 March 2020 showed the following:

    a. 75% did not consider they had been provided with appropriate PPE.
    b. 46% said they did not have trust and confidence in NHS Scotland to keep them safe during the covid-19 outbreak. With a further 46% unsure.

c. 35% said there had not been any enhanced cleaning procedures.

Health and Safety

78. Health and Safety measures would just be about the working environment and, again, the GMB were trying to get a bit more consistency for the workforce.

79. The domestics and caterers all come under an umbrella called Facility Staff and it was generally felt that there hadn't been enough risk assessments, or anything done health and safety wise, to consider them. At the beginning of the pandemic, before lockdown, I think we had a couple of reps trying to get involved in the health and safety inspections, but it was just getting difficult for them and sometimes the inspections didn't even exist.

80. The lack of risk assessments was a concern for the GMB in relation to most NHS Health Boards..

81. The workforce across the whole of the NHS were terrified. The profession that they do, they have a real love the job that they do and for the people that they look after. Their focus is always on what they can do to look after patients. However, it was our job to make sure that we could get the workforce everything they were entitled to, to make sure that they felt safe.

82. Changing guidance was difficult to filter down to the workforce. There seemed to be a middle area where information and guidance stopped filtering down. Those who were at high risk were not always getting the information because of the jobs they were doing – domestics, catering and porters – because they were just being ordered to go in and carry out their duties without being given information about the rooms they were entering. They were being exposed to these rooms, sometimes, without the adequate PPE.

Pressure on NHS Nurses

83. Nurses were under pressure during the pandemic, and I have a few examples of the decisions made that led to that.

Example 1

84. There was a group of specialist nurses who had been advised that there was going to be a COVID ward opening in one of the hospitals and that they would be responsible for managing those patients. Firstly, there was the issue that they would be working on a COVID ward when they've all got families to go home to. Then there were concerns about patient safety and the care they could give patients. They had been working in theatres which is very different - and some had never worked on a ward at all, while others hadn't worked on a ward in years.

85. Some of the nurses were in tears and extremely distressed. It was the lack of experience and the expectation of managing a ward of COVID patients. There would have been safety protocols about working in a ward, but they had the fear of the care that they could give the patients because it had been outside their skillset for so long. If anything went wrong with the patient, it could affect the nurse's registration and ability to practice.

86. This is an example of things being haphazard. It was a reactive thing that came completely out of the blue for that group of workers. Things like that, when things were having to be changed, at times it would just happen without being properly assessed for the worker's safety or the patient's safety. There were lots of times where things happened with no consultation with the unions or the workforce. The employer just wanted it done quickly

Example 2

87. There were also instances of nurses being expected to work in 'red' contaminated COVID areas and 'green' non-contaminated areas on the same shift. What should have happened was there should have been nurses working specifically with COVID patients and a separate group of nurses working with the non-COVID patients, so that there wasn't any cross contamination. They were not required to change their uniform or anything and, during staff shortages, they'd be pulled from one ward to the other. Members had their concerns about that and again they wouldn't know that was going to happen to them until they turned up to work that day. Some members had to go home, knowing that they've just come from a COVID ward when primarily, their shifts are not in that ward.

88. It's a mental health matter too, it affects people. It was never seen as acceptable by the workforce. They workforce thought that was wrong. They should never be working in both these wards at the same time.

Example 3

89. There were a number of newly qualified nurses who were asked to work in the ICU, due to staff shortages. This is a lot to ask of newly qualified staff.

90. They did so with little experience and were placed in the worst of it You're a newly qualified nurse, you should be mentored, have training, have help there but a lot of that they were just expected to pick up on their own because of staffing levels.

Staffing

91. Staffing was impacted firstly by shielding, then when the tests came in there were a lot more people off because they had tested positive. Thereafter Track and Trace came in. As a result, as things developed with the aim of isolating and reducing the spread of COVID, it was having a big impact on the staffing levels and those that would be available for work.

92. This in turn meant that remaining staff had to work longer shifts and sometimes they weren't having days off. Staff were discouraged to use annual leave in order to take on more shifts.

The Presence of Management

93. In general, for most frontline staff their managers would normally be present within the hospital. However, at the beginning of the pandemic, managers weren't there and they weren't seen to be there because they were working from home. I think the observation was that the higher up the NHS banding you were, the less likely you were to be at the hospital. The impact was that staff felt more vulnerable and unsupported.

Special COVID Leave

94. Special COVID Leave meant that anyone taking time off sick due to COVID would not have it counted in their absence record for the purposes of the triggers within the sickness absence procedures The Scottish Government had introduced guidelines to that effect.
95. I heard from our reps on the ground of some instances where managers were threatening/pressurising workers that being off sick would result in actions under the absence policies , contrary to the agreement reached. normal Again, this was another challenge we sometimes had managers taking on board the direction coming from the Scottish Government.

96. Given the circumstances the staff were in, for some this was just an additional pressure. The threat of any sort of conduct procedure is a pressure for any worker at the best of times . I don't think many people

would have in fact been put through punitive measures, but it did get to the point where the reps were having to come to me or go to more senior reps for support, or to the point where I had to contact the NHS Boards to send them a copy of Scottish Government directives saying, 'look, this is the policy, please use it'.

The Impacts on NHS24 Workers

97. NHS24 is where call handlers work when people phone 111 as opposed to 999.

98. In relation to the call centre, there were concerns with social distancing, PPE, staffing numbers, and the shifts and times that they were having to work. Some of the concerns around these issues were similar to those raised by our members for NHS Scotland the Scottish Ambulance Service.

99. The big difference was the concerns NHS24 members had about social distancing in the call centre. NHS24 were initially refusing to comply with the Scottish Government's guidelines about moving desks around to make it safe for staff to be working in their call centres.

100. That did have an impact on staffing levels because people wouldn't work if they didn't feel safe. At the time I think there had been recognition that some, obvious patient-facing environments couldn't keep a 2m distance, but this wasn't a patient-facing environment. It was a call centre so it should, relatively, have been quite easy to do it.

101. We received a draft email from the NHS24 Head of Clinical Services on 8 April 2020 advising of a 1m distancing guidance between colleagues in the call centre in Clydebank, and stating that this was agreed with the trade unions.

102. The GMB responded the same day to confirm that they did not agree with the 1m rule and set out the GMB stance that 2m distance should be afforded to NHS24 staff in a non-patient facing setting. However, I remember it specifically at the time, a lot of the communication was over the telephone because it was difficult to get a response from the Interim Chief Executive through email.

103. We had carried out a survey because members had reported the difficulties . 91% of those working reported that they didn't feel safe. 100% of those who responded were concerned they were not 2m apart or socially

distanced from colleagues. 90% of those who responded said because of health and safety concerns they were thinking about not going into work.

> I think it was down to their permitted staffing numbers. If they introduced 2m social distancing then there would be less staff permitted into the building at the one time.

104. The GMB escalated the issue to the Cabinet Secretary for Health because we did not get a response from NHS24. On 29 April 2020 I wrote to the Cabinet Secretary for Health, Jeane Freeman, setting out the issues regarding social distancing within NHS24. A response was received the next day, 30 April whereby it was confirmed that the 2m distancing for staff would be applied on the operational floor for call handlers. The middle seat in each pod was removed to facilitate this.

GMB surveys

105. A GMB survey went out to the NHS around the 24th of March 2020. This would have been at the beginning of the lockdown. 75% of those that responded to the survey had not been provided with appropriate PPE. 8% indicated that they had trust and confidence that the NHS would keep them safe during COVID. 46% said no. 46% were unsure. In terms of the question about enhanced cleaning, 29% said yes, 35% said no and 36% were unsure.

106. The rationale of this survey was to investigate the feelings around PPE and the concerns about how this was all unfolding so we could pursue it with the Scottish Government as, at that time, we didn't know what was going to happen next. We continued to use surveys as a way of gathering data.

107. A survey of Scottish Ambulance Service members conducted on 18 and 19 March 2020 asked whether they had received what they believe to be the proper PPE to enable them to respond to potential coronavirus cases. From those who responded, 14% said yes, 86% said not. When asked whether they had received what they believe to be appropriate training to enable them to respond to potential coronavirus cases, of those who responded, 15% said yes and 85% said no.

108. A Key Worker Value Survey conducted with Scottish Ambulance Service members in June 2020 asked members whether, as a key worker, they felt they had been fairly rewarded for working during the pandemic. Of those who responded, 93% said yes and 7% said no. When asked if they would feel safer if all of their PPE was in date, of those who responded 92% said yes and 8% said no.

109. A flash poll of Scottish Ambulance Service members in January 2021 asked whether they felt safe with their current PPE. Of those who responded, 39% said yes and 61% said no. When asked if they supported upgrading PPE to FFP3 masks when treating all suspected COVID-19 patients, 94% said yes, as long as supplies are available, and 6% said no they did not think it necessary.

Lessons to be learned

110. I would hope that the lessons to be learned from the covid-19 pandemic would be that the voice of workers, of those carrying out essential work, on the ground, is heard by employers and Government who are taking decisions about their workplaces. Too often during the pandemic the guidance and proposals of managers and officials simply did not survive contact with the reality of our members' jobs. Those carrying out the jobs must be consulted to ensure that the guidance and proposals are workable in practice.

111. Further to that, I would say that those working in the lowest paid occupations cannot be forgotten. As outlined above cleaners and porters were often the last group of workers to find out about guidance – they did not have IT access at work - or be provided with the appropriate PPE. This was despite being required to clean spaces where there had been covid-19 positive patients or to transfer patients with covid-19. These workers deserved as much protection as the clinicians involved in their clinical care. The pandemic really demonstrated the value decision makers put in different job groups.

Hopes for the Inquiry

112. I hope that the Inquiry holds to account those decisions makers who made decisions during the pandemic which failed to take into account the reality of workers lives. I hope the Inquiry questions why those making decisions – whether it be employers or Government – did not always listen to the voice of the workers. Why did it take several levels of escalation for basic concerns to be raised and properly dealt with.

113. Ultimately, I would hope that the Inquiry sets down a clear blueprint of lessens which can be learnt in a future pandemic to ensure that workers are safer and less likely to lose their lives by doing their day to day work.

Signed:

Dated: