OPUS 2

Scottish Covid-19 Inquiry

Day 33

April 16, 2024

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(9.45 am)

(Proceedings delayed)

(9.51 am)

MR CASKIE: We can't hear you at the moment, my Lord. We can hear you now.

THE CHAIR: Very good. I said I'm sorry you can't hear me. Good morning, Mr Caskie, good morning, Mr Cumming. When you're ready, Mr Caskie.

MR ALEXANDER CUMMING (called)

Questions by MR CASKIE

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

A. Sure. It's Alexander Douglas Cumming.

Q. And in what capacity are you here today?

A. I'm here representing, SAMH, the Scottish Action for Mental Health.

Q. And what position do you hold in that organisation?

A. Executive director of operations.

Q. And how long have you been with SAMH?

A. Four and a half years.

Q. During the pandemic, what was your role?

A. For the start of the pandemic, my role was assistant director, so I covered services across Scotland but mainly in the east of Scotland.

Q. Can you tell us something of the history of your organisation? When did it start?

A. Sure. So SAMH was founded in 1923, so we just celebrated our centenary last year. And we were an organisation since that time that has been representing and supporting individuals with mental health problems and mental illness and representing and advocating for them during that time.

Q. At paragraph 9 of your witness statement you talk about a large growth in the organisation in the 1980s and 1990s. Can you just tell us why that came about?

A. Yes, sure. So at that time it was obviously the inception of the Care in the Community Act so a lot of the kind of psychiatric wards and the hospitals where individuals were admitted that were -- that had diagnosis and mental illness were being -- yeah, were patients, they were supported in the community. So right across Scotland there were organisations that were supporting the delivery and recovery of mental illness and mental health problems in the community -- in their own homes, but also within care homes as well.

Q. At paragraph 10, we can see in the witness statement that you operate over 70 services and, at paragraph 11, you have 26 registered services regulated by the Care Inspectorate. Just to get an idea of the scale of your organisation, can you tell us what your overall budget is?

A. Sure. So our overall budget is £22 million a year and we have our workforce of 590 individuals.

Q. 590. And tell me about your geographic spread.

A. Sure. So we are a national organisation, we're Scotland's mental health charity, so we have national provision and intervention and programmes that cover all of Scotland, so information service, we have national psychological well-being services as well that are available in all 32 local authority areas. But predominantly our kind of services, our 70-plus services, are based and commissioned by local areas, local authorities, health and social care partnerships and NHS boards as well. So primarily Murray, right down the east coast to the Scottish Borders, right across the central belt to Inverclyde and also some services in Ayrshire as well.

Q. Right. At paragraph 11 you provide an indication of the range of services that you provide, including seven care homes. Tell me about those.

A. The care homes specifically?

Q. Hmm.

A. Yeah, sure. So we have seven mental health care homes. Five of those are based within Glasgow and two of those

are based in Forth Valley. Those are care homes -- they're not, I suppose, maybe the traditional care homes that maybe you would expect for older people, where there are quite often sometimes hundreds or -- dozens or hundreds of individuals. These are much smaller, you know, communal living and range from a number of service users from five to 11.

Q. And the service users are people who suffer from mental health problems?

A. Yes, a lot of them will have had stays within psychiatric wards and hospitals and we are supporting the exit and recovery back within the community, with the ambition and hopefully the intention of moving them on to their own tenancies where possible.

Q. Is that the general pattern that you hope will be followed by individuals who move into your care homes?

A. It is. Probably 10/15 years ago, I suppose the set-up and I suppose priority was slightly different. Those individuals that maybe moved into care homes, it maybe was seen as a kind of home for life, whereas now it's very much around kind of through care and trying to support individuals back into their own tenancies and more independent living.

Q. You move on at paragraph 12 to talk about your -- you describe it as your "Children and Young People

portfolio". Can you tell us a bit about that?
A. Sure. So I think 2017 -- well, I suppose part of the work that SAMH does, we have a very, very strong public affairs and campaigning element of what we do and for a long time we've recognised the kind of challenges within the mental health system for children and young people, particularly the redirection from CAMHS support as well and obviously the availability of local support services. Now, that's kind of changed dramatically over the last three or four years. About five years ago we initiated a programme to develop direct delivery services and interventions for children and young people as well as a range of kind of resources and support that's available for them.
Q. Okay, I did say to you before we came in, we're a bit tight for time given the length of your -- and detail within your very helpful witness statement, but can I say that the evidence that you give is being typed up by a stenographer and I think their fingers will be melting --
A. Slow down.
Q. -- if you don't slow down.
So you also, in paragraph 13, talk about online services. Tell me a bit about that.
A. Sure. So I guess a number -- well, all of us during the

pandemic -- there was a massive transition in the way we worked to online, internet-enabled support, and during the pandemic that allowed us to really kind of push forward with providing not just to support differently locally, so that was around not just phone, but also internet-enabled support through the various programs and software that's available, but we also were able to develop a number of new national services where individuals from across Scotland could access a range of kind of tiered support, depending on their mental health needs.
Q. At paragraphs 14 and 15 you talk about what might be called "higher level involvement" with Scottish Government, when programmes or policies are being developed in relation to mental health. Can you tell me about your organisation's involvement in that?
A. Sure. Well, it has been a -- as we know with the launch of the mental health strategy back in 2017 -- and that has just been kind of revised last year -- we also have a new suicide prevention and also self-harm strategy as well. So SAMH will, I suppose, engage strongly, either directly or through some of our partner organisations, maybe like CCPS, to engage in the --
Q. Now, CCPS, we've heard about that before. It's a kind of --

A. I suppose a consortium -- so a membership body, a consortium of care providers in Scotland, not just covering mental health -- I suppose care services, but right across the board.
So I guess we're engaged in a whole range of kind of consultations. We're quite often engaging in a lot of our own kind of research as well to ensure that the voice of lived experience aims at the core and is central to what we do, but we also have been, on a number of occasions, engaged in a lot of the kind of Scottish Government programme boards, whether that be children and young people in the past. We continue to be and were very, very involved in the Suicide Prevention National Leadership Group as well and we supported and led the Lived Experience Panel for the kind of Suicide Prevention Strategy (overspeaking - inaudible) --
Q. At paragraph -- sorry. At paragraph 17, you make reference to volunteers. You give us a figure there for 450 staff members and I think there it says "operational area of the business". So the figure that you gave earlier isn't inconsistent with that. You'll have back-room staff --
A. Yeah.
Q. -- on top of the 450 presumably?

A. Yeah, and that 450 has increased since I probably gave this statement as well.
Q. Right, so where are you now in terms of operational staff?
A. Operational staff, just close to 500 staff.
Q. You talk about volunteers. What's the mix between volunteers and paid staff within the organisation?
A. So our volunteers within the organisation is much, much smaller than our kind of paid staff employees. Probably the vast, vast majority of our volunteers -- if you take fundraisers out of the equation, and we have hundreds and hundreds of fundraisers that are supporting the organisation across Scotland every year -- but our volunteers are mainly our media volunteers that support some of our campaign work, some of our blogs, and some of our public affairs work as well. We have a handful of volunteers that work within the services, but that's a very, very small number.
Q. Right. So predominantly the services that you provide are professional --
A. Yes.
Q. -- with paid staff?
A. With staff, yes.
Q. At paragraph 20 you talk about the Coalition of Care Providers and you've already told us about that, but you

also say, at paragraph 21, about the Scottish Parliament Cross—Party Group On Mental Health. Can you tell me about your organisation's involvement with that group?
A. Yeah, sure. So we have been the secretariat of that group for the last four years or actually before the pandemic. I think that's —— yeah, so we're supporting the kind of agenda and I suppose pulling together the partners that want to engage with that particular cross—party group and servicing that in the way that you would expect.
Q. And at 23 you talk about your role in the —— during the pandemic in terms of the National Suicide Prevention scheme. Can you tell us about the organisation's involvement with that?
A. Yeah, so we were one of the kind of key kind of third sector partners as part of the national Suicide Prevention Strategy and particularly the leadership group, and our chief executive was a key member of the leadership group. And we were supporting four or five of those actions —— there were ten key actions as part of the last strategy and we were involved —— we're actually involved in all of them because the Lived Experience Panel was contributing to them all, but we had, I suppose, core responsibility for three or four of those actions.

Q. Okay. You then talk about, at paragraph 24, identifying —— basically seeing COVID coming —— I'll put it that way —— and you move on immediately then to talk about IT. Can you tell us how those two things connect?
A. Yeah. I think we probably weren't alone in relation to organisations and probably particularly the third sector as well, where a lot of our work, you know, was face to face. You know, we've probably had —— we had services that were probably still quite paper—based and, because it was all face—to—face services —— that's what had been commissioned and obviously that's what our service users wanted and engaged with —— there was definitely, I suppose, a shift required in relation to our IT infrastructure but also in relation to the workforce as well and making sure that they had the skills that were needed to engage in some of the kind of technology that we now know and we use as kind of commonplace.
Q. You described earlier I think that some of the work that you do involves supporting people moving into their own tenancies and, presumably, continuing that support once they've moved in. Was IT significant in that?
A. Yes. I guess —— and you'll be well aware that particularly those with mental illness are quite often the most vulnerable and most disadvantaged in our society and, you know, digital —— I suppose the most

digitally excluded as well. So I suppose as part of our —— it's part of what we do now, but certainly during the pandemic there was a real shift around digital inclusion as part of people's individual care plans. So we were encouraging them —— you know, because they couldn't necessarily go down to the bank every week or every couple of weeks —— so again engaging them in —— I suppose engaging with all areas of life digitally was a big part of our care plans.
Q. Right. You talk about one of the impacts of —— let me clarify this. I'm looking at paragraph 30. You talk about the risk assessments that were carried out. Was that something that was in place before COVID came along or was it something that you developed in light of COVID?
A. No, I mean, that was something that was —— you know, that's something that has been in place and would be in place in any kind of care provider that's delivering the support that we're delivering and I guess we're looking at the risk and vulnerability of individuals and the care that they need. I suppose what we then needed to do as part of the pandemic and some of the changes, I guess some of the kind of guidance that was coming out as well and the restrictions, I suppose flagging and risk—rating where —— who were the individuals that were

absolutely critical, where we needed to provide that support, and who were the individuals that actually —— perhaps kind of lighter touch support, that they maybe weren't seen face to face every day or every couple of days, but could maybe take a step back and be supported digitally or through phone calls as well, through well—being check—ins.
Q. You had three broad classifications: red, amber and green.
A. Yes.
Q. For those assessed as being red in that risk assessment, are they people that you would in general see every day or every couple of days?
A. Primarily. I suppose, as a generalisation, yes. Those would be individuals primarily within, obviously, our care homes and our registered services, so care at home housing support and our support services as well. So these are individuals with maybe multiple diagnoses that have maybe had stays within psychiatric wards as well. So these are individuals with severe enduring mental health problems, and I suppose encouraging them and ensuring that they're able to continue to live well through all the restrictions and changes that happen through the pandemic.
Q. Now, at paragraph 33, you talk about what you observed

as a contrast between what SAMH were doing and what the statutory services were doing. Can you just explain what you identified as the contrast there during the pandemic?

A. Yeah, and I know it was a phenomenally difficult period for everybody and I know that some of our service staff were pulled away to do other duties and no doubt other statutory services were the same, but I guess generally there was this feeling that all of a sudden everyone was working from home and there was no engagement, but, actually, certainly the SAMH services, and I know across our kind of third sector partners that are delivering health and social care services, they were still engaging daily with individuals, with obviously the appropriate restrictions and kind of I suppose supporting the appropriate guidance as well. But there were individuals that we were supporting on a daily basis because, without —— we were the lifeline for them, to be able to support their recovery and enable them to live well.

On the —— I guess the stark contrast was we found it particularly difficult to engage in statutory services, and that was particularly difficult when we were trying to support our service users, to engage with some of the statutory officials and supports that there were maybe

available.

Q. Sorry, what statutory officials are you talking about?

A. So it would be around maybe care managers, social work, mental health officers.

Q. CPNs?

A. CPNs, absolutely.

Q. Psychiatrists?

A. Yeah, possibly. There was definitely a —— yeah, there was a real challenge to try and engage —— yeah, to kind of engage them and particularly kind of care managers. I think our engagement with commissioners was different and actually they were ——

Q. When you say "commissioners", are you talking about —— what are you talking ——

A. So commissioners, I would say those that are not necessarily involved in the direct support and the care planning of individuals that we support but those that are looking at the commissioning of the services, I suppose, and how do they deliver holistic services across a local authority area or a health and social care partnership area. So those would be, I guess, those individuals that have I suppose commissioned the services, set up the services and they've identified what the needs are within that particular area. So certainly they were usually very, very good about

engaging and checking everyone is okay and ensuring —— and wanting to ensure that staff were kind of okay and the service users and also working with us to change and adapt some of the service models as well. But, as I said, some of the staff members and statutory services that were maybe more directly involved in individuals' care and support, it was much more challenging to kind of engage with them and that had quite a negative effect on service users.

Q. So you're drawing a distinction, if I'm right, between people who were essentially office—based within statutory services and who presumably could continue their work from home and front—line staff?

A. Yeah, that's correct. And a lot of the cases —— you know, I think I lot of the staff, you know, all ended up working at home and it was often quite difficult to, you know, identify and find social work staff and care managers that were assigned to some of the individuals that we were supporting.

Q. So was that something that was a new problem or was that something that had existed prior to the pandemic?

A. I think it sometimes depended on a particular service user, on a particular area, but there's no doubt that that was amplified because of the pandemic.

Q. Okay. You then talk about a challenge, at paragraph 34,

in managing staff expectations. Tell me about that.

A. Yeah, I think it was a very different space for everybody and of course there were —— you know, lots of us were watching the news every day and all the bulletins, you know, multiple times a day, and very much the message was around staying at home, "don't use public transport", but at the same time obviously we had a duty of care for our service users that we were supporting. So understandably a number —— well, most of our staff were anxious about that. They were the ones that were on the public transport, they were the ones that were engaging and going to individuals' homes and occasionally there was the challenge where perhaps some of our service users weren't following the guidance that we would want and that we would expect.

Q. And did the organisation feel that your staff were continuing to do what you might call face—to—face work but statutory services weren't?

A. Certainly that was our impression, yeah, and certainly a lot of our commissioned services and registered services —— certainly our staff were continuing to work kind of face to face. That might have been slightly different with some of our other services because they weren't perhaps as critical in relation to the kind of care and support for individuals.

Q. At paragraph 36 you talk about a particular feature that occurred in Aberdeen. Can you tell us about that?
A. Yeah, so very quickly through the pandemic —— and obviously there were a number of criteria for individuals that maybe needed to shield, that were at greatest risk because of the pandemic, because of the virus, so the whole of our Aberdeen Links team —— so that's a kind of primary care service and community link worker service that supports social prescribing, attached to every practice in Aberdeen —— and they very, very quickly I suppose changed because we couldn't go into the practices and we were still, I suppose ——
Q. This is GP practices?
A. GP practices. Sorry, GP practices, yes. So they were supporting individuals that had received shielding letters from the NHS and I suppose encouraging them and supporting them with what support was available and also trying to help them navigate some of the guidance that was available to them as well.
Q. So let me try and unpack that a little bit. Prior to the pandemic, your staff would be —— would receive referrals, would have contacts made through the GP services?
A. Correct.
Q. But because your staff were unable to go into GP

services, you shifted. What happened to referrals that GPs still wanted to make?
A. So there was a short period where things were paused through agreement with the Health and Social Care Partnership until I suppose that initial focus or that initial kind of priority was kind of dealt with and then we, I suppose, phased the staff back to, I suppose, their kind of —— their substantive roles, if you like. But most of that work happened through —— I suppose through digitally engaged or internet—enabled kind of care and support, so they were working online, through phone calls, et cetera, and there were I suppose slightly new kind of referral pathways and mechanisms that were implemented during that period.
Q. So the people who would normally have been served by the staff located in GP practices, you didn't leave them high and dry?
A. Sorry, say that again.
Q. There would have been people who you would have received referrals from or about ——
A. Yeah.
Q. —— from GP practices, but when you stopped the level of engagement that you had with GP practices, what happened to people who would have been referred ——
A. Yeah, so I suppose ——

Q. —— through that mechanism.
A. Through that mechanism. So where we had a caseload already, those individuals were still supported as part of that. As I said, there was a pause on referrals for a short period with agreement from the commissioners. So where maybe —— yeah, so there was a pause. So there would have been cohort of individuals that maybe would have liked to have that engagement with the community link workers, but, as I said, that was paused for a short period and then we transitioned back to that, back to the support.
I think one of the key challenges for everybody during that period was the number of services, particularly face—to—face services, that obviously just weren't in existence anymore. So a lot of the opportunity to use social prescribing techniques and signposts on to community resources just wasn't there until all the organisations got kind of back up and running in a slightly different modality.
Q. The next section of your witness statement which starts at paragraph 37 starts with the heading "Care Homes". I want to ask you about something else before we go on to care homes and that —— because we've heard lots of evidence about the guidance which was provided particularly in relation to care homes. Can you tell us

in general terms about your organisation's experience of dealing with Government guidance?
A. Yeah, it was a really challenging time, particularly for the kind of central staff and the leadership teams to I suppose try and navigate the guidance that was coming out from Government, from other bodies as well, and ensuring, you know —— because we're working across different settings and because a lot of the guidance was initially probably quite focused on clinical settings, on nursing homes as well, I guess we were trying to kind of adapt and make sure that things were relevant and appropriate for our own individual settings. So it was —— you know, it was multiple people's full—time jobs just to kind of make sure we were keeping on top of things. I think we did a reasonable job, hopefully, of trying to communicate that to staff, but I guess it was also quite challenging then to kind of balance that when we were getting obviously multiple questions from staff and also from our service users about public guidance versus health and social care guidance as well, whether that be care homes or some of our other services.
Q. We've heard that —— you've indicated yourself that a large amount of management resources was taken up interpreting the guidance that was provided. Can you tell us a bit about that and how that would then filter

down?
A. Yeah, so certainly at certain pinch points during the pandemic —— you know, there was often weekly updates to guidance and, as I said, because —— the joy of SAMH but also something of a challenge is that we do —— we work right across the mental health system, for prevention and early intervention right through to our registered services, as I mentioned, and I suppose it was just trying to support all of our different services with the different types of guidance.
So multiple frequently asked questions for different settings, for different services, trying to balance, you know, things like the different testing regimes that were appropriate for different services and then also the different kind of public transport guidance as well that was appropriate. And then also supporting our staff to support our service users with guidance as well because of course they were, I suppose, feeling very anxious and probably quite isolated and looking at public guidance but then also looking at when they could actually engage in services as well and what was appropriate to do and what wasn't appropriate to do.
Q. One of the things that we've heard from others who provide support to non—elderly care home residents is that the guidance which was being provided was

effectively designed for elderly care homes. Was that SAMH's experience?
A. I think on —— yeah, generally that probably was, yes. It felt that it was coming from, as I said, a kind of clinical, medical, nursing home perspective, and I think that's where we often —— you know, and maybe some of our staff felt that occasionally we were delaying things, but it was because we were then having to check with, you know, whether it be the Care Inspectorate, whether it be local health protection teams as well, around, you know, what was appropriate and were we interpreting the guidance and the recommendations in the right way and I suppose hopefully positively challenging where we felt things wouldn't work and were not appropriate for a setting and then sense—checking that what we were implementing was going to be okay.
So occasionally that took —— you know, there was a few hoops to jump through to then come back and kind of sign off. We definitely got more efficient with it as we went along and there was, I suppose, a kind of collective leadership group or organisation that was meeting, sometimes initially daily, and then that kind of moved into our kind of practice team, who were again looking at that on a daily basis and trying to keep ahead of the game.

Q. Do you think given —— and we've heard that guidance was frequently updated —— do you think organisations such as SAMH were well placed to keep ahead of the game or was that a challenging task?
A. I think we were —— just knowing some other organisations and their infrastructure, I think it is much easier for us as a national, you know, mental health and health and social care organisation to deal with things compared to some of the smaller local organisations that maybe didn't have a couple of extra bodies that would have been able to do that. As we —— and you will have heard lots from CCPS and organisations like myself referencing them. That's where a lot of the membership bodies really came into their own, to kind of advocate and support kind of collective guidance and summaries and frequently asked questions as well. That's where the kind of collective peer support across particularly the third sector was really, really important. So that didn't happen just across our own organisation with peers but also across organisations as well.
Q. Okay. Still focusing on care homes, I'm now looking at specific examples that you provide. For example, at paragraph 38, you're talking about one of your care homes being classed as a homeless service. Can you tell us a bit about that?

A. That —— I suppose it's a homeless service, and when we reference it as a homeless service, that just happens to be the commissioning route that it comes through, so it's not coming through our kind of core mental health funding, it's coming through a homelessness funding, and I suppose at that time there were still individuals that were coming to the service from hospital and were classed as homeless as well. We were working with them, as we work with all individuals in our care homes, to try and support their recovery, depending on their care needs and a kind of person—centred plan, to try and support that onwards transition to their own tenancies.
Q. You said something just then which I was going to ask you about later but I'll ask you about it now. You were saying people were coming out of hospitals back into the community. Was there a change in numbers who carried through that process during the pandemic?
A. Yes, there was. I think there's no doubt that all the pathways and processes, for multiple reasons, all slowed during particularly the first 18 months to two years of the pandemic. There were —— I guess there still is —— but there was a real lack of I suppose onward referral pathways, whether it be tenancies and accommodation that's available for individuals, and therefore both ends of the kind of pathway of the spectrum, there were

kind of pauses and delays to people maybe exiting hospital, but then also people being able to exit successfully on from care homes into other types of accommodation as well.

Q. Okay. You talk about, at 39, complying with guidance regarding visitors. We have a clear impression of what that guidance was and that for periods visitors effectively weren't permitted.

A. Yeah.

Q. Can you tell us about the impact of that, firstly, on the client base?

A. Yeah. It was, yeah, phenomenally difficult for our care home service users. There were -- I can't remember how many months, you know, some of that guidance was in place for, but, you know, not being able to have any visitors whatsoever -- you know, we -- for a lot of our service users, they maybe only have one or two individuals that are, I suppose, a part of their wider network, so it's the staff and one or two individuals quite often are kind of core family members, and not being able to, you know, visit the care home or -- at certain points during the pandemic as well also not even able to meet outside because they were already within a bubble elsewhere, you know, was very, very challenging for our service users, so it certainly increased the

isolation for our service users.

Obviously our staff did everything they could to engage and it allowed us to, at the appropriate time, you know, create bubbles in different ways within our care homes. But it was definitely quite an isolating time for our service users.

Q. The final paragraph on the screen at the moment is paragraph 40, and that reflects something that -- some evidence that you gave earlier. Again, can you say some more about that, particularly in relation to care homes?

A. Yeah, so I think, as we mentioned earlier, you know, whether it be care managers, whether it be CPNs, we saw -- or our service staff and our service users saw very little of the statutory support of their care managers. The only exceptions to this might be when there was really acute episodes of mental illness and there was an emergency and maybe somebody had to be readmitted to hospital, but there was very little engagement with our statutory services.

Q. Would statutory services normally provide important supports for people on the pathway into their own tenancy?

A. Absolutely. I suppose there is also around that ongoing -- there is ongoing case management reviews. You know, there should be quarterly meetings or

certainly six-monthly meetings to check on progress, how people are doing and what their pathway and what their support plan looks like over the next period, what sort of outcomes and goals are they working towards. You know, I absolutely recognise that there will be -- there was many other priorities during the pandemic, but, you know, it could be quite an isolating time, not just for service users but for our staff as well, around, as I said, trying to get access to some of the core statutory staff that they would usually engage with.

Q. Now, there's what I would refer to as a "bridge" between 42 and 44 in that in 42 you're talking about the support provided, the peer support provided by care home managers, then, at 44, you talk about the management team, who aren't care home managers presumably but work at a level above that, having to deal effectively all day sometimes with questions coming in from care home managers and others. How did that work in terms of them carrying out their normal management role?

A. Yeah, it was -- yeah, there were sometimes days where there was a real shift -- you know, there was a real kind of shift away from their core day-to-day duties, as I said, because the managers were either reviewing information, collating information, interpreting it in a particular way that's going to be relevant and then

thinking about what the most effective communication channels would be to all our service staff and then being able to support the managers within those services to then distribute that across our staff teams as well or across their own staff teams; thinking about different ways to, you know, deliver team meetings and do team meetings, so that people weren't missing out. And then obviously during that period as well all areas had obviously quite high staff absences because of COVID and it was making sure that I guess staff, when they were returning to work, again were kind of keeping up to date and up to speed with all the new guidance and the changes that had happened within services as well.

Q. One of the things that you spoke about was the management team being involved in providing what might be called "internal guidance" based upon guidance you were receiving from Government and other health bodies. Was there feedback in terms of the guidance that you were providing from your users and staff and was that incorporated?

A. Yeah, so I suppose because -- again, we had some, you know, very experienced individuals within our kind of practice team and, you know, we very quickly formed kind of internal kind of core groups and core assurance groups that would actually, I suppose, engage and be

able to kind of sense—check and support some of the solutions as part of implementing the guidance. So there will —— I'm sure there will have been times when, you know, guidance landed on a desk and they go, "How are we going to make that work?", and I suppose that was probably reflected back to us. But more often than not, the guidance and I suppose implementation and solutions were developed in partnership with our service managers and team leaders on the ground.

Q. So we're talking about within the organisation there being communication vertically, if I can put it that way.

A. Yeah.

Q. What about outside the organisation with the people who were providing the guidance? Was there communication both ways there?

A. Yeah, I mean, we've always had, I would say, a strong relationship with organisations like the Care Inspectorate, and that was probably —— in some areas the engagement over the period —— you know, that was definitely more intermittent during the pandemic, as people were pulled into other areas. There were some of our local areas where the guidance or the engagement was probably quite impersonal. It was just you got the kind of weekly or monthly kind of update around what was

going on. But there were some other areas where the local inspectors were certainly very engaged and, you know, making phone calls to the service staff or —— sorry —— certainly to the service manager to engage in about how things were going.

Q. From the level that you and your immediate colleagues were working at, did that appear to be a function of the individuals concerned?

A. Yes, it was. Yeah, there was definitely a bit of a difference there depending on the styles and approaches and because there was quite a turnover of staff with the Care Inspectorate as an example. So in some of our areas we might have had half a dozen different care inspectors during an 18—month or two—year period. That was sometimes quite difficult to keep track of.

Q. You talk about difficulties in accessing PPE for the organisation. Again can you tell us about that?

A. Yeah, I think we were all —— you know, particularly within our registered services, you know, infection prevention control was part of our kind of core responsibility, even prior to the pandemic, but obviously the pandemic brought in a whole other level of guidance and there was, you know, probably a much more kind of clinical setting kind of approach to what we

needed to do and what we were required to do. I suppose we maybe didn't have some of the kind of national procurement routes that we maybe do now to kind of think about PPE ——

Q. How did that change?

A. So I suppose locally or pre—pandemic it was really down to the service managers and a couple of national contracts to kind of identify the best routes and most effective ways to procure some of the different PPE that was required for the different services and that, obviously, continued during the early part of the pandemic. Obviously we tried to kind of set up some national things, but then there was probably a bit of a challenge because we'd got services from Murray right through to Ayrshire at the time —— you know, the distribution of that was quite challenging. So I certainly know there was a couple of days when I was on the roads, you know, handing out PPE and making sure that the staff —— you know, leaving things at the door and walking away and making sure that service managers and staff had the support that they required. So that was definitely a bit of a rush and probably a wee bit frantic for some of our services to be able to identify where to go and, you know, again changing guidance about, "Well, we've just bought this but actually we're

now being told this is the most appropriate solution to be using", in relation to the some of the cleaning products.

But certainly once the kind of PPE hubs were set up in the local areas, that was a huge relief. It definitely took a little bit of time for some of the communication to be clear around which services could access that. You know, maybe understandably there was a focus on again care homes, but, as I said before, all our other registered services were up and running and continuing to do what they needed to do. So it probably took a little bit of time for us to really break through some of those —— some of the early communication to understand that this was available to all of our registered services and also our health and social care services and mental health services.

Q. At paragraph 48 you indicate that there were no deaths of service users as a result of COVID but you then, I think very properly, recognise that, for example, in relation to your care homes, it wasn't elderly or physically unwell people who were in the care homes. But you say people in your care homes often had chaotic lifestyles. Tell us about that.

A. Yeah —— so, yeah, a number of our service users within our care home have kind of multiple diagnoses and, you

know, also a number of other kind of challenges around maybe addictions, substance use. I suppose the whole kind of combination and the fact that the external environment around the pandemic again was kind of quite isolating and, again, you're trying to think about -- positive kind of coping strategies during that period was quite challenging. So there were on occasion, you know, some of our service users that weren't necessarily following the guidance and we'd have had maybe individuals in their home that they shouldn't have had in their home.

So I guess it was about trying to educate and support our service users to kind of understand and comply and recognise that we had a duty of care to them and also they were, I suppose, putting our staff at risk as well by not kind of following the guidance. But it was about trying to support them to understand the reasons why and the rationale for the guidance being in place.

Q. You did that by trying to get them to understand rather than being prescriptive?

A. Yes, yeah, yeah, and where -- you know, and where situations weren't appropriate, you know, our staff always have the ability to kind of withdraw and take a step back. So, again -- and that's maybe around also

thinking about our risk assessment approach as well, for risk and vulnerabilities and maybe reassessing some of the risks for our staff but also for our service users. So where an individual, you know, maybe wasn't following the guidance, we'd maybe also have to look and communicate about having to change some of the different styles of support that was available to them.

Q. I know you wanted to say something about care assurance teams and you talk about that at paragraph 50.

A. Yeah, I suppose -- and I can't remember what month it was during the pandemic, but at some point, you know, kind of care assurance teams were kind of set up, and these were I suppose led by I think the Health and Social Care Partnership, so kind of multi-function/multi-disciplinary teams and they were there to kind of set up -- they were there to kind of conduct kind of unannounced spot checks and kind of visits to our care homes. We absolutely recognise that there was, you know, so many challenges and pressures on everyone at all levels during the pandemic, but there was a particular challenge for our care homes staff and as an organisation about how that was communicated and what the purpose of those care assurance teams was.

I think, as the engagement continued, it got more supportive, relationships got stronger, but certainly

initially, you know, some of our service managers weren't necessarily clear about what the purpose was, what the governance route was and the reporting routes were, and these were individuals that were clearly very experienced in their own setting. But I suppose our general view from our care home managers was that they didn't necessarily have any experience or maybe weren't as prepared for the setting they were coming into, which was a mental healthcare home, which kind of could be a block of flats or it could be kind of communal areas, and, as I've said before, it's not about a 100-bed nursing home, which looks very, very different.

They took a very kind of clinical, medical model, when they were thinking about some of the considerations and things they were looking at, and certainly initially it felt quite stand-offish, if we're honest, and it definitely put an added pressure on us as an organisation and on all the service managers as well. And particularly for our service users as well, I guess they were probably feeling that it was -- you know, as we've talked about, the guidance was no one was able to come into the care homes, but, yet, here we had individuals that were coming into the care homes, not really sure why, quite intrusive in some ways, and I think that was certainly one of the more challenging

areas for us during the pandemic.

As I said, after a number of months, six/nine months, et cetera, those kind of -- the kind of I suppose tone changed, probably, I think. It was much more supportive. I think everyone was clear about where the boundaries were and what the purpose was. But certainly at that time, when staffing levels were pretty critical, you know, we'd had no outbreaks, no deaths et cetera, that level of scrutiny was -- maybe it should have been expected but it was certainly a challenge for us.

Q. Okay. You then, in your statement, move on to the testing regime and you say something about that, in particular at paragraph 53, and the admin function which went along with testing. Can you tell us about that?

A. Yeah, and obviously things got quicker and slicker as everybody got better at it and better processes were put in place. But I think, yeah, the different types of test -- level of testing that we then needed to navigate and understand for our registered services, our non-registered services, community-based services, that was kind of quite difficult and there was also some real kind of practicalities around the way that we were having to manage our services because of workforce flexibility and some of the staffing challenges that we

all had during that period, you know, making sure that we were -- you know, sometimes those set deadlines around when testing had to happen and particularly our kind of PCR testing, it was really, really difficult for us to ensure that -- you know, ensure that staff were able to engage in that and we were doing things in the timelines, and then also reporting on the timelines -- reporting on it appropriately as well.

So we talked about, you know, some of the central staff and management staff being pulled away on different things. That was certainly a big focus for all of our service managers and our service staff during that period as well. And having to ask staff to kind of come in, you know, a little bit early or a little bit late or, you know, do testing at home, it was just a -- I suppose a different kind of -- a change of culture for all of us.

Q. Was there a degree of resistance from staff to that, the additional hours, if I can put it that way?

A. Yeah, I think -- I think all of our staff were -- just the resilience during the period was absolutely phenomenal and the changes that they had to make and, you know, being dynamic and flexible and having to move services when we asked them to move services, you know, within a particular portfolio -- but, yes, there was

definitely the odd occasion where there was a query around, you know, why we're having to come back -- you know, usually it was explained away with some of the guidance and some of the conversations that we were able to have, but there would have been the odd occasion where we were having to deal with additional queries and challenges.

Q. At paragraph 58 you talk about your fundraising taking a bit of a knock. You say something in paragraph 57 about not requiring to use furlough but in paragraph 58 you talk about your external fundraising.

A. Yeah, just quickly on furlough, there were a handful of staff that we needed to support through furlough, but, as I said, because we changed the modality of basically our service delivery, we were able to kind of continue to deliver a reasonably high level and in some cases continue to deliver as we were.

So, yeah, I guess the mass participation events -- any form of kind of bringing people together wasn't possible during the pandemic, so a lot of -- you know, a lot of organisations like ourselves took a bit -- it was really, really challenging to kind of engage in that way. We obviously looked at other kind of creative ways to think about fundraising, but particularly those mass participation events and events that we would put on to

bring people together just couldn't happen during particularly the first 18 months of the pandemic.

Q. So there weren't online jumble sales?

A. I can't remember if we had an online jumble sale, but, yeah, there were certainly a few online events that we managed to facilitate.

Q. Okay. You then go on, at 59, to talk about the impact on several services. One of the things which I don't think anybody -- well, very few other people have mentioned is the horticultural service that you provide. Tell me why the horticultural service is important.

A. Yeah, so we've got a number of therapeutic horticultural services across Scotland and actually they're some of our oldest services, to be honest. They've been in existence, yeah, in some cases for over 30 years. We know the benefit of physical activity, of working alongside somebody and just having that meaningful activity and, you know, being able to develop that kind of therapeutic relationship with individuals and also being able to provide that social connection is really, really important.

Our therapeutic horticultural services have a range of kind of outcomes around supporting people back to work -- it may be they've had a period of absence -- and also supporting employability skills and, you know,

providing different kind of interventions as part of somebody's recovery from kind of mental health or mental health problems. I suppose our -- because of some of the restrictions and because -- again, because of types of activities around sharing equipment and, you know -- and particular items of PPE as well and particularly the restrictions on transport unless it was absolutely essential, we had to obviously change the modality of our delivery there. So that changed very much to kind of online workshops, growing sessions, you know, growing chillis on your balcony, and different well-being approaches and techniques around kind of mindfulness, yoga as well. That was one of the kind of biggest challenges. I've already mentioned the kind of digital inclusion or exclusion of a lot of our service users. So actually probably the first kind of three to six months of some of our service delivery there was actually more around delivering IT sessions to some of our service users. And we were fortunate enough within one of our services to have an IT specialist, and that's always been part of their core offer as part of our Redhall service in Edinburgh. So he was supporting service users not just in Edinburgh but in some of our other therapeutic horticultural services as well.

Q. You talk about your national employment team. Tell me

about that.
A. Yes, so our national employment team delivers a number of programmes, but particularly individual placement and support. And that is a fantastic service that supports individuals while they're in work or while they're looking for work. And that's about focusing on their mental health —— mental health problems and positive coping strategies and recovery to maintain somebody in employment.
So we have services —— you know, we've probably got —— now we've got about 20—plus different services across Scotland, and, you know, they support a caseload of individuals that have been referred through a number of different channels, so that could feed through a community mental health team or it could be through —— yeah, a number of different routes ——
Q. Can you tell me how that was impacted by COVID and the lockdowns?
A. So that was impacted —— in relation to, you know, face—to—face support, it wasn't possible —— I guess we risk—assessed —— because of some of the community venues that we were using, they were fully shut down, but also, because the risk level was maybe identified as not being as high risk for the individuals we were supporting, we were able to kind of quickly move online and move to

digital support. That was a team, I have to say, that were probably, yeah, a bit more used to the kind of digital essentials or digital skills and were probably at a higher level than our probably baseline across the organisation, so they were quite quickly able to transition to digital delivery and maintain that support. Certainly that's one of the pathways that we were able to maintain and continue to be open for new referrals coming in through the pandemic.
Q. You then move on to talk about your suicide prevention team. Tell us about that and the impact of COVID.
A. Yeah, so we have a range of kind of suicide prevention support. It's one of our core strategic priorities and has been for 101 years now. So the type of support that we provide would be a whole range of kind of capacity—building activities and kind of consultative activities across Scotland. It's particularly the capacity building that had to change very, very quickly. One of the challenges that we had there was the —— I suppose the licensing organisation for the core pieces of training that we use, that are well used across Scotland, not just SAMH, and that's a licence that's owned by the Scottish Government. The provider there took the decision that they did not want the training to be delivered online because of lots of safeguarding

reasons but also because, again, they were trying to ensure the kind of quality and fidelity of the training that they were delivering. So that meant that ourselves and a number of other organisations had to kind of quite quickly pull together a kind of slightly adapted kind of training models for —— yeah, for a whole range of different partners.
So in some cases we were delivering to almost full local authority teams, you know, within schools, within health and social care partnerships, because it was just making sure that people were continuing to be aware of suicide prevention activity and the importance of, I suppose, having a conversation and identifying some of the —— yeah, some of the —— identifying challenges that people might be facing because it was, yeah, a phenomenally difficult time for everybody.
Q. Did you note any increase in the level of suicide?
A. I think it's probably best to go through the national statistics and I think we've only got up to 2022. I don't think we —— you know, in some cases, in some areas, we did see a slight increase. But I think across Scotland actually either it maintained or we saw a small drop in the number of suicides. But those would be available through Scottish Government statistics.
Q. Okay, thank you for that. I'm looking now at

paragraphs 68 and 69, which talk about particular services that you provided in the context of suicide prevention.
A. Yeah, so I suppose that was —— I guess that wasn't just broadly our suicide prevention services but probably our community—based —— a number of our community—based services because, again, types of community venues that we were using had been kind of closed and also because of some of the settings —— we have one particular service that is based in hospital grounds and, because of some of the particular restrictions in that case, we had to kind of shut that service, so very, very difficult to deliver any support in that particular case. But within the rest of our support, so particularly our peer services in Inverclyde and in Fife, we moved immediately online to provide kind of helpline support lines and provide a kind of listening service, if you like, for individuals —— individuals that wanted to and, yeah, that were finding things challenging during the period.
Q. More broadly than your suicide prevention work, you talk at paragraph 71 about a mental health hub being set up. Again, can you tell me about that?
A. Yeah, I think some of the feedback we had and we still obviously continue —— we did a number of surveys and

continued our kind of engagement with our service users and more broadly during that —— you know, members of the public during that period. So we recognised that we wanted to have a kind of central place online and we worked with our colleagues at MIND in England and Wales as well to kind of pull together all the key resources that we felt would be appropriate for individuals to kind of keep themselves well. You know, we always have a kind of core focus on population health and population mental health and well—being at SAMH, so it's about pulling together some of the resources and some of the tools, techniques, and identifying other places for support, not just within SAMH but across other organisations as well, to make sure that I guess people would have one place they could come and a place for kind of trusted support, information and resources.

Q. I'm going to jump forward and back a little bit. You talk again about the mental health hub at paragraph 82 and you talk there about numbers ——

A. Yeah.

Q. —— just over 75,000. Is that a Scotland figure or a UK ——

A. That was —— yeah, that would be accessing —— that's accessing the SAMH COVID hub, so that's just specifically the kind of COVID pages and information

that was on our —— yeah, that was pulled together on our COVID hub on our website.

Q. I'm going back now to paragraph 75. At the beginning of that paragraph you talk about a survey that you carried out. What were the main outcomes of that survey?

A. Yeah, I suppose the main outcomes of that survey or probably two key things, they still preferred —— and this was very, very early on in the pandemic —— most of our service users said that they preferred and they were missing face—to—face support from —— whether it be from ourselves or from other services as well, and particularly that —— yeah, that there is a massive increase in isolation and loneliness during that period because of feeling cut off from friends, family and others.

Q. And at the end of that paragraph you say there was little engagement by statutory services. Again, tell me about that.

A. Yeah, I guess that goes back to probably kind of previous points, and I know that services and staff were pulled in multiple different directions, but particularly the individuals that we were supporting and —— the kind of core view was, "We kind of felt like SAMH was the only one there for us", and I know that other third sector providers have had the same feedback

as well. We were the ones that were still travelling on the bus, still supporting them to, you know, ensure that they were staying well and, you know, maintaining their kind of life skills and everything else that they needed to do to maintain their homes or to stay well around medication as well, and it was only in the very, very extreme situations or crisis situations where maybe there would be engagement from other services.

Q. You talk at 77 about medication administration —— effectively medication administration visits and that statutory teams were effectively passing that work onto you.

A. Yeah, as part of —— one of our —— in some situations and particularly in our care homes, you know, the administration and support of medication would be something that we would usually do. I'm aware that certainly there was a couple of situations where certainly we were asked to take on kind of elevated responsibility around picking up, distribution and administration of medication. You know, that was all done within the appropriate kind of —— through the appropriate channels and risk assessments, et cetera. But, yes, it was definitely kind of another responsibility because maybe statutory teams were struggling for —— yeah, struggling for resources and

struggling staffing—wise.

THE CHAIR: Mr Caskie, I appreciated that you started a little bit late, which wasn't your fault, so I'll add a little bit of time on for that, but you're into your last 10 or 12 minutes.

MR CASKIE: Yes, I am. I was moving on to paragraph 78, where you talk about post lockdown, when things started to open up, and that, once statutory services, as it were, came back online, you saw an increase in your work. Tell me why you think that happened.

A. I think probably for lots of reasons. There was —— you know, there might have been occasions where —— well, I suppose everyone was asked to kind of think about, you know, "Do you really need to access this service? Certain services are only for absolute critical situations". So I think when things were opened up around —— and there was further engagement and particularly statutory services recognised the challenges, the needs, that were then being presented to them, we obviously saw an increase in the number of referrals as well. You know, there will always be conversations with our partners around what is an appropriate referral or not and, you know, we can have conversations around what a service specification tells us, but certainly towards the end of the pandemic and

into that period coming out of the pandemic there was absolutely an increase in some of the kind of more challenging referrals that maybe we wouldn't have seen pre-pandemic.

Q. At 79 you start to talk about your children and young people team. Again, can you tell me generally about that?

A. Yeah. I mean, during the pandemic, as well, you know, there was a number of our teams that were working in schools and working in the community, so obviously that had to kind of transition until the guidance was appropriate, that we could go back in and kind of change face to face. We recognised during that period particularly early on, when young people were at home, the support for parents, teachers and school staff was absolutely kind of critical. So we probably -- not that we changed our focus from actually supporting children and young people, but it was more focused on I guess the parents and some of the school staff, and I know certainly our teacher e-learning that we kind of developed just prior to the pandemic, within April 2020 it was accessed over 4,000 times.

Q. You say that at paragraph 83. You also say at the end of paragraph 83 that the website had a huge number of hits. How many do you estimate that to be?

A. Yeah, we know precisely. So over the kind of 2021 and 2022, our website had over half a million hits. We were accessed half a million times.

Q. Now, at paragraph 85, partway through the pandemic and then subsequently, you commissioned a piece of research. Please don't name the researcher but that research was called "Forgotten", and then the follow-up was called, I think, "Still Forgotten". Can you just tell me what the findings of that were?

A. Yeah, I think I've probably submitted the full research findings as part of the report, but I think it goes probably back to some of the kind of key points -- you know, the key points during this kind of witness statement is that those with severe enduring mental health problems with maybe kind of dual diagnosis, multiple diagnosis, they were quite often the most disadvantaged and most vulnerable prior to the pandemic and that was kind of -- yeah, that kind of gap widened during the pandemic as well. So we know that particularly accessing a certain kind of support was very, very challenging. Some areas got probably slightly higher levels of satisfaction, so, you know, in areas around engaging with kind of psychiatry, et cetera, the kind of feedback was relatively positive. But also there was again the feedback around the

essential nature of accessing face-to-face support.

Q. Okay. In terms of accessing face-to-face support, obviously different organisations might do that at different times. You say something about that at paragraph 91.

A. Yes, so I guess one of our core services prior to the pandemic and through the pandemic was our SAMH information service, and it's not necessarily a helpline, but -- you know, not listening service, but it's an information service, so making sure people that know where to go to access information and resources and guided self-help tools. So during the pandemic or just prior to the pandemic we were supporting over 5,000 individuals and at the end of the pandemic that was 7,000 individuals on an annual basis. So we saw quite a sharp increase there, as other organisations such as NHS 24 saw during the pandemic.

Q. And in terms of the information that you were receiving out of this survey -- I'll try to summarise it -- you had good levels of satisfaction amongst those surveyed for GP services but poor levels of satisfaction in relation to crisis services. Can you tell us about that?

A. Yeah, I suppose that, as I said, the kind of probably psychiatry and more -- yeah, probably the lower levels

of satisfaction was probably with -- was actually with primary care and crisis services during -- yeah, during that period, and it didn't necessarily change, you know, between the two different surveys, the Forgotten and Still Forgotten as well.

Q. You then move on to lessons learned and at paragraph 97 you talk about the improvement, as it were, in terms of using information technology. Is there anything that you haven't said that you want to say about that?

A. I think just generally, you know, our systems are better and more reliable, more resilient, you know, whether it be our kind of IT infrastructure but also the kind of -- the implementation of those different kind of platforms as well, which has been absolutely kind of critical.

There's a huge amount of learning around I guess our quality assurance but also our quality improvement within the organisation as well, and I guess that has been because of the kind of -- probably the constant kind of focus and scrutiny that has been on infection prevention and control and other -- and service user outcomes as well over the last few years. So that's definitely moved us on and definitely the kind of flexibility and being much more dynamic in the way we kind of deliver our services as well.

Q. SAMH have become nimble?

A. Yeah, we were fairly nimble before, but, yeah, much more dynamic and nimble.
Q. Okay. At paragraph 100 you talk about improvement in national contracts.
A. Yeah, when I referenced national contracts, I mean within SAMH as well. You know, as I said before, quite often things were distributed or were left to our local service managers to identify the best local channels to kind of work with local partners. However, particularly around some procurement routes we've identified, you know, national contractors for things and national procurement routes for things like PPE as well, which certainly helped -- yeah, helped our --
Q. In terms of those national procurement routes, was that something that it took time to develop within the pandemic?
A. It did a little bit, partly because we were just trying to, yeah, identify best providers, you know, organisations that also could have a Scotland-wide coverage as well, because that was obviously really, really important for us.
Q. Could you read paragraph 101?
A. Sure.
"If there was another pandemic, I would like to see additional support and resources being received by the

Third Sector. I would like to see transparency surrounding this process. I would also like Third Sector service providers to be able to access resources and equipment like PPE right from the outset."
Q. Those are all the questions I have for you. Is there anything that we've not covered today that you think is important to cover?
A. No, I think -- yeah, I've had the opportunity to say what we wanted to say and I think -- yeah, I appreciate the opportunity to kind of speak today and I suppose just want to thank all my colleagues within SAMH for kind of their help, support and resilience during the time.
MR CASKIE: Thank you very much, sir.
A. Thank you.
THE CHAIR: Very good. Thank you, Mr Cumming. I'm very grateful for your evidence.
MR CASKIE: 3 minutes past 11, not bad.
THE CHAIR: Yes, very well done, Mr Caskie. We'll come back about 11.20.
(11.04 am)
(A short break)
(11.20 am)
MR STEPHEN FINLAYSON (called)
THE CHAIR: Right. Good morning, Mr Caskie. Good morning,

Mr Finlayson.
A. Good morning.
THE CHAIR: When you're ready, Mr Caskie.
MR CASKIE: Certainly, my Lord.
Questions by MR CASKIE
MR CASKIE: Would you tell the Inquiry your full name, please?
A. Yes, my name is Stephen Finlayson.
Q. And on what basis are you here today?
A. So I am representing Penumbra Mental Health, who are a Scottish mental health charity, so to represent an organisational perspective on the events of the last few years.
Q. And what's your position within that?
A. So I'm head of innovation and improvement for Penumbra, so my responsibilities are for all our internal kind of quality systems, our evaluation, our learning and development, practice development, those kind of areas.
Q. Okay. You have provided us with a witness statement which is very helpful and detailed. However, the witness statement is written by yourself and another person who was then a member of staff --
A. Correct, yes.
Q. -- at Penumbra. Are you able to speak to the information that she provides?

A. Yes, I am. Yes.
Q. So we can take her evidence now as your evidence?
A. Yes, that's absolutely fine. I know that she's aware of this and I know, I think, Inquiry officials have been in contact with her and she has signed the statement as well, so I think we can consider it a joint statement that I can speak to.
Q. That's perfect. You tell us something of the history of your organisation at paragraph 5.
A. Yes.
Q. Can you just summarise that for us?
A. Yes, so Penumbra was founded in 1985. It was one of the first organisations who were trying to support people who historically would have been in hospital due to mental health reasons and who at that time there was very little alternative provision for, but they probably didn't actually have to be in hospital so a group of social work professionals at that time had a vision of, "We can do this differently and better for people", so they started what was some of the first supported accommodation for people with mental health difficulties, particularly long-term kind of mental health -- ill health difficulties.
So -- sorry -- were you going to --
Q. I was going to say, there will have been a change in the

early 1990s as a result of new legislation that came in. Can you just refer us to that?
A. Yes. So from the 1990s, I guess there came to be a policy legislation—wise as well and a much greater focus on community support for mental health, the organisation grew significantly at that point. I guess a lot of the work moved away from that more kind of supported accommodation focus to supporting people in their own homes, to supporting people in the community to become fully active members of the community. We would talk a lot about people's citizenship rights, so to be able to take up their full roles as citizens in society. So providing support that really enables that connection and ability to live in and participate in the community from the kind of I guess mid—1990s onwards.
Q. When did you join the organisation?
A. Just over five years ago, so early 2019.
Q. At paragraph 10 there is reference to the scale of the organisation. It says you have 77 services across 23 social care partnerships in Scotland. Can you just tell us broadly about that?
A. Yes, so we now provide a very, very wide range of mental health services, as you say, across really most of the —— certainly the heavily populated areas of Scotland and quite a few more rural areas as well. It covers

a very wide range of mental health support, so a significant part of that will be supported living where we will go and support people in their own homes who are experiencing mental health difficulties. We are very involved with —— which we talk about in this statement —— the Distress Brief Intervention programme, which is about providing a very rapid compassionate response to people experiencing stress.
Q. I'll ask you about that in detail as we go on.
A. We have several supported accommodation places still, which, again, support people with long—term mental health conditions generally and some who support people specifically with alcohol—related brain damage. So we have them. One of the things that really has emerged since the pandemic is that we are also very involved with support for people who experience self—harm and we have launched the Scottish Self Harm Network over the last 18 months or so, which has really emerged from some of the working concerns around self—harm within the pandemic. And a big bit of our work kind of at this point in time is also around Scotland's Suicide Prevention Strategy. So there are four outcomes for the Suicide Prevention Strategy and Penumbra were appointed as the lead role for outcome 3, which is about the responsiveness of services, how do we have supports that

really respond well when people are at a point of kind of suicidal crisis.
Q. In paragraph 10 also you talk about the Self Harm Network. Can you tell us about that?
A. Yes, so the Self Harm Network, as I say, is a fairly kind of new feature. Penumbra have worked in self—harm support for many years, but what there hasn't been across Scotland is a really kind of joined—up approach to that. So the Scottish Government have a dedicated self—harm strategy now and, as part of that, there is the Self Harm Network, which provides support to people across Scotland. But one of the new features of that is the ability to access that digitally, so the Self Harm Network has a website and people can access support directly through that website, so it has an interface whereby people can access and request support and have that support provided.
Q. You talk there —— and I think this might be for not users but providers on the Self Harm Network —— you talk about peer support.
A. Yes, absolutely.
Q. Tell me about that.
A. So peer support is a massive part of our entire ethos, you know, of how we work. It's that belief that mental health support should be very much informed by people

who have got the experience, who have got that expertise, that actually, you know, their experiences, their knowledge, their background, is absolutely critical to that. And we very much bring that into how we operate, as many organisations do now.
Q. I'll ask you about that in a moment. But just at this stage, can you tell us, what's your budget?
A. Our budget, so it's —— our turnover in 2023 was about £16 million.
Q. 16 million?
A. 16 million, yes.
Q. And how many staff do you have?
A. Just about 600 —— you know, 600 kind of mark.
Q. At paragraph 14 —— and I'm not trying to limit what it is that you do —— but at paragraph 14 you list three main areas that I think you work in ——
A. Yeah.
Q. —— which are home services, community services and distress services; is that right?
A. Yes, that's how we tend to kind of conceptualise it as a simple kind of way of summarising. So, as I say, home services are the ones where you literally go into people's homes and provide support from home; community ones are the ones that are really about supporting people to be part of their communities, you know, to

make connections, relationships with other organisations or supports, to build natural supports; and then our distress services are a range of services, such as the Distress Brief Intervention. We also have a crisis centre here in Edinburgh, a fairly new similar kind of place in Dundee called "Hope Point", that have that great focus on actually responding to people in immediate crisis and distress ——

Q. You've mentioned a couple of times the Distress Brief Intervention ——

A. Yes.

Q. —— programme. Seeing it written down and hearing people talk about it, I think people don't necessarily put the pause in the right place. It seems to me that the correct way to say it is "Distress, Brief Intervention".

A. Yes, yes, I can see what you mean there.

Q. It's not about long—term support necessarily for people. It can simply be go in, give advice or support and then possibly walk away or signpost to another place?

A. Yes. Do you want me to talk a little bit more about the structure of the Distress Brief Intervention?

Q. Yes.

A. So the Distress Brief Intervention programme began in 2016 and was a partnership between Scottish Government, the University of Glasgow and several providers.

I guess a lot of it was about recognising that there was a real gap particularly with kind of first responders, with police, with ambulance services, et cetera, who might come across people in distress but didn't actually require really a police response in terms of any criminal behaviour or didn't need to be in hospital but there was a need for support, so it was recognised this was a real kind of gap there. So the idea of Distress Brief Intervention was to try and fill that gap.

So they talk about having two levels, level one responders and level two. So level one is about training people like the police, like ambulance services, to provide that very immediate response, so that when people, you know —— they come across people who are in distress, they have the skills to provide an immediate, compassionate and kind of skilled response.

But what it then allows is the level two response. People can be signposted to this level two response which organisations like Penumbra provide, where people get a very focused two—week period of support and that support is really about helping them to really think about through what's causing the distress, "What are your kind of strengths and things that we can really support you to build on to manage this distress and how do we help you to create a real kind of action plan that

are going to address issues that are causing this and to take that forward?". Like I say, some of that will include kind of signposting.

So it's not that people are just kind of left at the end of the two weeks, it will be about having a plan that you can take away, that's got the skills, that's got the approaches, and if you need further support you've got a clear plan of how you're going to access that.

Q. So who else are first responders in this context?

A. So it would primarily be emergency services in terms of, you know, a police/ambulance service, to some degree fire service, et cetera. I guess one of the things that changed in the pandemic was the establishment of what they call the "national pathway", and that was very much a response to the recognition of the distress that many people were facing during the pathway [sic]. So one of the things that that created as well was the ability for NHS 24 in particular to then refer people to this DBI national pathway and that national pathway then provided that level one kind of response for that very immediate response, so actually some of the providers then also undertook that kind of level one response of doing that very first stage kind of response to the distress that people may be phoning NHS 24 about.

Q. We'll look at —— when we come to look at DBI, we'll look at the types of causes of distress that you're involved with.

A. Yes.

Q. But you also indicate at paragraph 15 of your report another part of the work which you do, which is accommodation services.

A. Yes.

Q. Is that essentially a care home?

A. So that becomes some of the interesting discussions, I think, in terms of policy and things during the pandemic. So they are shared homes where people live together. So we have some in Aberdeen, some in Glasgow and one in Edinburgh. So certainly in terms of registration, in terms of the kind of policy and registration kind of frameworks with the Care Inspectorate, these are registered as care homes, but there's an interesting kind of conceptual discussion there I think about actually, "What do we mean when we're talking about a care home?", which I think probably is one of the real kind of issues (overspeaking — inaudible).

Q. Well, one of the examples which you provide at paragraphs 18 and 19, I think, demonstrates the extent to which the use of the words "care home" in what you

might call the ordinary sense doesn't really fit what you do. In those paragraphs you describe essentially a block of flats ——

A. Yes.

Q. —— in which people live ——

A. Can I just say for clarity, though, these are slightly different types of services again in terms of their registration status, so these kind of services wouldn't actually be classified as a care home, where people have their own individual flats in a tenement block et cetera, as that refers to there. As far as the Care Inspectorate would classify them, they would be more kind of supported accommodation services or housing support or kind of caring support, so ——

Q. So we've now excluded out from that care home part of your work, the supported accommodation. What's left? Tell me about the actual care homes that you operate.

A. Yes, so, as I say, we do have these buildings which are completely shared buildings, where people would have a bedroom as opposed to having their own kind of flat in a tenement, sort of kind of things. So, say, for instance, in Edinburgh, we have Milestone House out at Oxgangs, which can support 12 people experiencing alcohol—related brain damage, for people living within the one property with their own bedroom and are

receiving support all within that one property. So that does have I guess more of that kind of feel of a care home.

As I say, the ones we're referring to at paragraph 18 are supported accommodation where people do have their own tenancy, they have their own flat, but within that property there is a staff base that allows, you know, support to be very easily accessed and provided to the people living in those flats.

Q. Okay. And the care home element of it, the people who are in the care home, they're not necessarily —— or they're not elderly; would that be fair?

A. No, in principle they could be, but, yes, by and large they are not.

Q. That would be coincidental?

A. Yes, it would and it's probably actually very rare. I suspect when people who are more elderly and also have significant mental health difficulties, that is often not the kind of place they may go to.

As I say, we have probably two key types. One is the alcohol—related brain damage services, which, by definition, is supporting people with alcohol—related brain damage, who are often people who are coming from hospital, having gone through an initial kind of treatment programme for alcohol, and then this is

a supported place where they can then try to rebuild their lives.

There are other accommodations, such as our service, Carntyne, in Glasgow. It's primarily supporting people with relatively complex long—term mental health conditions; you know, they may have diagnoses of things like schizophrenia, for example. So it's people who have ongoing fairly kind of chronic issues with their mental health who require a lot of ongoing support and who —— in terms of what we'd refer to as their "recovery journey", they're finding their way back to a good life. That is likely to be an intensive sustained support over several years at least, you know, so (overspeaking — inaudible) ——

Q. And for those who are in the supported accommodation you spoke about, the block of flats, with one of the flats being for care providers ——

A. Yes.

Q. —— tell me about the progress ——

A. So that would be sort of more of a —— and I guess it would be slightly different levels of needs. So I think the people in supported accommodation, where they have their own tenancy, will very often be people, again, who have fairly significant long—term support requirements around their mental health but are perhaps at a place

where they are more able to manage a tenancy and to manage their day—to—day lives to a greater extent than the people who may be in the care homes as such.

Q. Is it fair to say that the majority of your work, though, isn't provided through the accommodation areas that you provide, it's much more in the community?

A. Yes, that's correct. So the significant majority of our work is with the support to people in their own homes or through the distress services, such as Distress Brief Intervention, et cetera.

Q. Prior to working for Penumbra, where were you working?

A. So I worked for an Edinburgh organisation called "Thistle Foundation", who are primarily more of a physical disability —— kind of physical and learning disability kind of oriented organisation, so they support a significant number of people primarily in the Edinburgh area with learning and physical disabilities. So I worked for them for 20 years through a variety of kind of support roles and management and training and equality roles.

Q. So there are similarities in that, although you're involved in ongoing care, it's not care—home modelled?

A. Yes, absolutely. So the Thistle Foundation only support people in their own homes. They have no care homes at all. And there's a very, very significant similar ethos

in terms of the values and approaches and what we would refer to as "person-centred approaches" about how do you actually design support very much around that unique individual, you know, about their needs, about actually who they are, what they want to get from their life. So a very, very similar ethos and --

Q. And you talk about that ethos at paragraph 26. Can I have you just read paragraph 26?

A. Sure thing. So this is referring to my role I think.

Q. Yes.

A. So:

"This was a new role in Penumbra, and there was a bit of a change in how things were structured which very much attracted me because it provided the opportunity around areas like equality, impact and evaluation, what we are doing and really all about really telling the story of Penumbra's work. That is one of the things I am quite passionate about, actually being able to describe why and what we do, how we do it and why it makes a difference for people we work with. There is something different and distinct about the way that organisations like Penumbra deliver support for mental health and being able to tell the story and describe that really well is very important."

Q. Well, I'll ask you to do that today. You spoke earlier

about or I asked you earlier about the number of staff that you had and you say something about your staff at paragraph 28, where you talk about the staff being effectively peer support.

A. Yes.

Q. Tell me about that.

A. Yes, so as I said, peer support is a really important element of our work and has been for at least the last kind of 15 or 20 years. So Penumbra have an absolute commitment to employing people who bring their own lived experience of mental health and very often that will be experience of quite significant challenges with mental health. You know, it will often be people who have been through some of the support systems, who have been through perhaps the kind of psychiatric system, for example. And there's a very strong ethos -- we also host within us a semi-autonomous organisation called the "Scottish Recovery Network", who are committed to also kind of having that ethos about, "How do we really make sure policy and practice is led by people who have got that experience?".

Q. So still in paragraph 28 you give a statistic about --

A. Yes.

Q. -- the number of staff who have a history of mental health problems. Can you just give us that figure?

A. Yes, so 26% of our front-line staff is delivered by people who are employed explicitly within peer roles and we have an ambition to increase that to at least 30% --

Q. And again you say something about the philosophy of the organisation in terms of employing people who can act as peer supports at paragraph 29. Could you tell us a bit about that in your own words?

A. Yes, and it's maybe helpful to just talk about connected to that. So we would refer to ourselves as being a recovery-focused organisation, and what we mean by that is that what a good life with a mental health difficulty or a mental ill health difficulty looks like will be different for every person and that our role is to help support people to identify what a good life would look like irrespective of whether actually they still experience symptoms. You know, part of the ethos is that people may still experience symptoms but can still lead a good life as defined by them if the support is really effective at helping them to do so. I think that's where a lot of peer work comes into that because it's being led by people who have been through their own journey themselves of working out, "Okay, I've had these real challenges in my life, I've had real difficulties with my mental health, but I've been able to find a way through it. I've been able to find a way to lead a life

that is full and satisfying, you know, despite these".

So I think it's really connected to that sense that while we work very closely with clinical partners, we don't work from a clinical perspective ourselves. We are not there to diagnose people, we are not there to treat people with diagnosed mental illnesses. We are there to work alongside them as citizens, to think about, "Given where you're at with your life and the challenges you experience, what would a good life look like to you and what support can we provide that would help you to move towards that?". Peer work and people who have been through that journey themselves is a really, really critical part of that for us.

Q. In terms of Penumbra's public profile, you say something about that at paragraph 35. Again, can you tell us about that?

A. Yes. It's interesting -- so this was my colleague who I think was referring to this, but I suppose I think, compared to some organisations, we probably don't have the highest kind of public profile. You know, I think, in terms of actual kind of provision, we're a fairly large provider but we don't have quite such a high public profile and we're not particularly a campaigning organisation. Certainly at the moment you don't see a kind of high profile campaigns led by Penumbra. We

primarily see ourselves as influencing by doing. We want to provide really good support and provide really good services and do it in that way.

You'll see we talk actually there about a kind of rights—based recovery and again I think that's a really kind of critical part of that ethos, that we see ourselves as working alongside people to make sure that their rights are respected because, you know, with things like stigma and lots of processes in place, very often people who experience significant challenges with their mental health I think can face risks to their rights being respected. So there's a really strong kind of human rights focus to I think our ethos and our values and kind of things that I guess we —— yeah, we try to kind of focus on in the doing. But I think what we're saying there is we probably aren't one of the organisations who are out there with shiny PR campaigns and that kind of thing ——

Q. I'm not going to get stopped on the street by someone asking me to sign up to Penumbra?

A. No, you certainly wouldn't be.

Q. At paragraph 37 you talk about the Scottish Recovery Network. Again, can you tell us about that?

A. Yes, so Scottish Recovery Network are actually —— they're a semi—autonomous organisation, so —— we refer

to it as "hosted by Penumbra" so their staff are all Penumbra employees and, you know, for —— in the practicalities of running an organisation, they exist within us, but they have a largely independent remit. They are funded by Scottish Government. And their remit is to promote specifically that recovery model that I referred to about —— you know, a kind of view of actually, "How do you build a life that is based on you and your needs and your aspirations for your life?", and very particularly about bringing that sense of lived experience; how is that model furthered by really listening to and really involving the people who have got lived experience of their own mental health. So they do a lot of just fabulous work around kind of advocating for and supporting that way of working.

Q. At paragraph 39 and onwards you talk about your services prior to the pandemic. Just as a base, can you tell us about that?

A. Yes, so I think —— you know, as I say, I was only with Penumbra a year before the pandemic started, but Penumbra is a very well established organisation. We had a whole range of services, as I say, largely up and down the country, particularly in the supported accommodation services and the supported living services, our crisis centres. The Distress Brief

Intervention programme launched in 2016 had probably been one of the really significant developments over the two or three years prior to that.

I think, when things had hit, it was a well—respected and remains a well—respected organisation in terms of things like the Care Inspectorate, who regulates about 50% of our services, that, you know —— the Care Inspectorate have a 1 to 6 kind of scale of grades, with 6 being the top, and our consistent kind of average has always been about 5, the second—top from the highest. So, yes, I think, you know, a well—regarded kind of organisation at that point.

Q. You talk about, at paragraph 40, a lucky break.

A. Indeed. Yes, indeed.

Q. Tell me about the lucky break.

A. Yes, so as many organisations are, of course we were looking at our IT systems and we had been planning a really kind of significant shift to an entirely new IT system, in which we'd incorporate all of our back office stuff, in terms of HR and finance, but also all the records for the people we support, our support planning, our staff rotas, et cetera, so that was all being brought into one new system, and that system literally went live two weeks before the first lockdown happened.

It has been true to say, I think we have thought many times, we can't quite imagine how we would have done some of what we did had we not had that. Like all IT systems, it had its challenges and still does, but in particular what it allowed us to do was really look at all the people we support and really think about prioritising, really thinking about individual support needs, and we had that in a very accessible way that allowed us to, in that dreadfully corny term, pivot very rapidly. We could really look very quickly at all the people we support and think, "Right, who do we have to see? Who are people who we can perhaps have a phone call with and just check in with? Who are the people we absolutely have to still go out and see?". And also, just in terms of the communications with staff and scheduling and just being able to think about actually how people go —— particularly I guess with things like staff isolation, you know, starting to kind of impact, you know, being able —— it gave us that flexibility to just have that picture very readily to hand. And while it may not be a perfect system it certainly I think made a massive, massive difference.

Q. You refer at paragraphs 42 and 43 to the Distress Brief Intervention programme.

A. Yes.

Q. I'm going to ask you about that in more detail, but I need to set something up about that so we'll do that first. At 44 and 45, you say -- sorry, you talk about the immediate impact --
A. Yes.
Q. -- of COVID and the lockdowns. Again, tell us about that, please.
A. So I guess, like all organisations, we had to move pretty quickly, particularly, you know, once the full lockdown was launched in the March of 2020. So we set up a daily kind of group of our senior management team that I was co-ordinating to really kind of plan that. A huge amount of that was about thinking about, "How do we really think about the services that we provide?", and, as I mentioned there, particularly about thinking about who are the people we support, which of them are people we think absolutely need support, that we need to keep seeing, you know, that actually things will get to potentially really quite serious situations if we don't keep seeing these people; are there people who we think actually, if we keep in touch by phone, et cetera, they will be fine. So a great deal of thinking about how do we prioritise people.

Also, as I guess lots of organisations did, shifting to where we could -- supporting people remotely. So

I think in the first couple of weeks that was -- a big part of what I was doing was working on a kind of model for telephone and video support, you know, kind of a structure for how we might actually engage with people and make sure we're having an effective interaction with them as much as possible, about where they were at and about how their needs were kind of things, and inevitably a huge amount of kind of staff communications as the kind of official guidance started to emerge and trying to start to translate that into practical guidance for our staff.
Q. In paragraph 47 you're talking about the set-up of those new systems to deal with the pandemic and at paragraph 48 you say then you just go into a zone. Tell me about the zone.
A. Yes, I think that's actually -- I think that's my colleague that was speaking there, but --
Q. Aha. It's your statement now.
A. No, no, I'm just trying to put my head into ...

Yeah, I mean, I think it was just that sense of -- you know, as everybody did -- of, "Okay, how do we respond to this? How do we reassure our staff?", because -- I think that was one of the big challenges we faced, as many organisations, who were going to continue to provide services, about the messaging to staff and

about balancing that -- taking staff concerns really seriously with reassurance and trying to manage that guidance.

But I think a lot of it was also -- you know, I was looking back at some of this over the last few days, about some of our messaging that was going out -- about trying to get really clear about actually -- there was a lot of talk about essential services -- that actually we are an essential service and what we do is essential. But I think a lot of that zone was creating that messaging, that culture of an organisation of, "We still have a job to do here" -- you know, "While the country is in many ways shutting down, we still have a job to do here and we're going to carry on as much as we possibly can". I think, yes, trying to establish, I guess, that kind of organisational culture of communication and support and how do we continue to do the job to the best we can and do that safely.
Q. At paragraph 49 you talk about using the IT system to manage --
A. Yes.
Q. -- risk levels to identify where the greatest risks are for your users.
A. Yes.
Q. Tell me about that.

A. Yes, so actually that allowed us to really think through actually what are people's needs because I think it's one of the ways that perhaps mental health doesn't necessarily always have the obvious needs that people may assume for many people, but actually a very significant number of people we support do have long-term support needs. So, you know, people -- just things like medication, many people will take medication for their mental health, without which things may become really kind of difficult for them fairly quickly and who will not -- and many people may not take that medication without that support going in, so kind of some real practicalities with that.

There are many people we support who do have significant difficulties or have real challenges just about very day-to day tasks, like getting food, like cooking for themselves, et cetera, paying bills, et cetera. So there's a significant number of people who I suspect a member of the public -- it may not be obvious that, actually, without support going in, their lives may become really difficult really quickly.

I'm bound to say, at the other end of the spectrum, we will support people who actually by and large get by in their life okay but still need support and so therefore we might be able to check in with them by

phone or have a video call, et cetera. So that's what that system allowed us to go, was to be able to go through people and really identify, "These are the people that we absolutely have to go and see", actually ——

Q. Now, whilst you're managing that internal system, you're also receiving guidance from Government.

A. Yes.

Q. You talk about that at paragraph 54. That will appear on the screen in a second.

A. Yes.

Q. Tell us about that.

A. Yes, so obviously, when things —— the lockdown things first started or before that really, when the kind of restrictions on schools, et cetera, started to come in, we started to receive guidance coming from various places, from Scottish Government directly, from local authorities, from Care Inspectorate, from the Scottish Social Services Council, who are the regulator for the workforce, and Social Care in Scotland, from Public Health Scotland —— so we started to get quite a wide array of guidance coming in, both directly relevant to our sector and relevant to the wider health and social care sector. So that started to become that question of, "How do we translate this into something that is

meaningful for our staff", and what very quickly became pretty vast swathes of guidance.

Q. In your statement at paragraph 53 you use the phrase "translating guidance [as read]" and you've just used it again. Was the guidance not something you could just read off the page and apply?

A. Certainly not specifically as it applied to us. It was often very detailed and very understandably so, given the circumstances we were facing, but particularly initially I think it had quite a broad brush about health and social care and actually what that looked like for an organisation like us often did not seem clear at all or took a great deal of trying to unpick —— of go in and trying to extract, "Okay, these are the bits that actually apply to us". And of course what we had to do —— our staff who were out delivering the support don't have the time to be reading through vast amounts of policy and guidance, so we —— initially we actually started a daily communication of, "This is what the guidance is saying, this is how it applies to us and this is what we need you to do", you know, trying to break it down into very kind of small chunks of, "This is what this means and this is exactly what we need of you in order for us to kind of be working within this guidance and applying it".

Q. At paragraph 59 you talk about impact on service delivery. You talk about that happening in three ways. I'll take you through each of those in turn.

A. Yes.

Q. Firstly you talk about supported accommodation.

A. Yeah.

Q. Tell me about the impact there.

A. So the supported accommodation services probably did have to some extent the biggest impact for us both on a kind of practical level and I think for our staff in terms of anxiety and stress and kind of things in terms of actually following the guidance, and very understandably, given what we know happened in many of the care homes, you know, having that —— I can very much understand where a lot of that guidance came from.

But I guess one of the things that was different in the care homes was that in a lot of our other services we could move staff about more easily. You know, the care homes had to have staff on site and obviously we didn't want, as much as possible, to be bringing a vast range of staff. So that created real pressure on the staff teams, just in terms of maintaining the service, particularly when things like isolation kind of started to come in, you know, if people did have symptoms, et cetera. So that created some kind of real

challenges.

But also the guidance around care homes —— and I'm sure —— I don't know if you want to get into this now or come back to it —— but we particularly found the guidance around care homes very difficult to work with and to interpret because it really did feel that it was written with an assumption that a care home is a place for elderly people, for people with significant physical impairments, and it didn't seem to have any kind of recognition that actually care homes in a mental health setting —— many of those assumptions about who is in those kind of —— in a care home like that and what kind of restrictions you might be able to put in place don't apply; you know, they're not appropriate, they don't apply. So I think some ——

Q. From your perspective, was that predictable? If someone was writing guidance, was it predictable that one size would not fit all?

A. I mean, in principle, yes. I have much sympathy for people trying to create that guidance at the times that were going on. I think what it does speak to, at those kind of levels, is a lack of broad understanding of actually the breadth of the sector and the breadth of the types of support that are out there. It felt that the guidance was being written from a very kind of

health—focused, conical—kind—of—focused perspective by people who perhaps just didn't appreciate that actually there's a whole range of supports out there that your frame of reference, your understanding of the world, doesn't apply to.

So in principle, yes, but I think probably the challenge there is about actually having the structures, you know, that allow that kind of clarity of actually the variety of support that is out there.

Q. At paragraph 60 you move on to the second area of work that you predominantly do ——

A. Yes.

Q. —— which is visiting support.

A. Yes.

Q. The impact there?

A. Yes, so, as I say, we did a lot of the prioritisation about who are the people who we absolutely still need to see, and while we did move a lot of our support to video support or telephone support, a significant number of our services continued going out and visiting people, particularly, as I say, for those people where things could start to get really difficult in their lives if they weren't receiving that support.

On many levels that actually went okay. I think staff were able to do that. I think, you know, we were

able to kind of make sure that we were able to do so safely. The people we supported almost overwhelmingly were incredibly supportive and understanding about distancing, et cetera, and wearing masks and all this kind of stuff. A lot of the challenges were actually quite practical ones. Many of our staff use public transport. Getting actual public transport to go between people was often a challenge ——

Q. You don't exclusively work in the central belt.

A. No. No, not at all.

Q. You do work in the Borders.

A. Yes.

Q. I understand that in some parts of the Borders there isn't good public transport systems.

A. Yes. I don't live in the Borders myself, but ... yes, certainly that was what we were told. At best of times, the public transport could not be good and I think that became particularly challenging for staff when they were trying to move about in those kind of more rural areas such as the Borders.

And just some really actual pretty brutal kind of practical things, like accessing toilets —— you know, public toilets were closed, and staff might in previous times have gone to a supermarket and supermarkets were often —— you had to queue to get into kind of thing. So

just some of those real practicalities of actually —— with society closing down, the way you would structure your day to make it manageable became really, really challenging for a lot of staff.

Q. Now, I'm moving on to paragraph 69 about the importance of the home visits. Just from your experience, can you tell us about that?

A. Yes, because it's a real interesting one, because from a mental health perspective —— and again that's part of the wider mental health discussion about the whole pandemic —— that sense of connection, of having people in your lives, of people that care about you, of that interaction, is just a massively, massively important part of all of our mental health. So we definitely saw that with people that we support, a kind of real impact of that sense of isolation.

It was complex, in honesty, because some of the people we work with also I think found some of the pressure eased slightly in terms of, you know, actually kind of being out in society, which many people can find a challenge. I think the fact that there was less expectation of that, for some people actually it was welcomed in some kind of ways. But I think there is no doubt many, many people found that challenging. And again, inevitably in our care homes —— I think the

challenges about having visitors within care homes, you know, was a real kind of challenge for people for that.

Q. At paragraph 70 you talk about the digital poverty amongst your client base.

A. Yes.

Q. Tell me about that.

A. And that was a big focus for us in the early stages about recognising —— there was a kind of push to move in many ways to kind of digital delivery of video calls, et cetera, but there was an absolute reality that a substantial number of the people that we would work with did not have easy access to digital devices; you know, many didn't have a smart phone, never mind kind of tablets or laptops, et cetera. So that was a real kind of challenge for us and one —— there was work with the Scottish Government, kind of thing, in its early days to try and access kind of resources to buy, you know, devices for people, which we were able to do to some extent. But I think that's one of the things the pandemic did highlight, was that they still retain a significant kind of discrepancy. I think people with —— a significant number of people that we support will be people from areas of significant deprivation and in those communities of people not having the devices that allowed that to happen easily.

Q. And we've spoken exclusively so far about problems, but it wasn't all negative and you talk about some of that at 71. Tell us about that.
A. Yes, so it is that interesting thing about that actually, I guess for all of us to some extent -- you know, in a crisis, it also gives the opportunity for people to respond positively and, as I say, I think the people we supported were extraordinary actually, you know, partly in the way they interacted with our staff, the levels of kindness and support to our staff and concern for our staff was massive, but also I think a lot of people did discover skills -- I think many people did discover that actually they could actually perhaps do things that perhaps previously they hadn't been aware of.

I think I talked a little bit later about I think some of the challenges with this perspective, but there is a danger with support that actually it becomes entrenched and that actually people become deskilled, and I think there was an opportunity for some people to kind of reassess actually, "What actually is it that I need and is there a risk that actually some of the support that I've come to rely on is actually getting in the way now?" and "Oh, actually I can do some of these things for myself". So we definitely saw that and we

definitely saw some people who you may have predicted beforehand things might be really difficult for them without support and actually they did fine -- you know, that actually they got by, they found ways to do things or they found alternative kind of forms of support, et cetera, so a very kind of mixed bag.
Q. But for organisations like your organisation, that carries a danger. Can I take you to paragraph 74?
A. Yes, in honesty, I wouldn't necessarily frame it as being a risk for us as an organisation as such. I think where there is a challenge with that is that we did start to, I think, get some kind of senses from some funders of, "Okay, if people have got by, then they probably didn't need that support in the first place so maybe actually we don't need to fund this anymore". And I get that. If you're the person responsible for limited budgets, I can understand that form of thinking. But I think when the risks of that thinking is conflating people getting by -- you know, of people managing in a crisis situation, in a societal-wide really difficult situation, to survive, and support that is actually about them having a good life, about them really finding ways to manage their mental health, that recovery that I talked about, you know, really building a life that's meaningful and worthwhile -- and I think

there's a risk that, actually, if we just view it of, "People coped so maybe they don't need support", it has a real kind of risk to it as well.

I think I talked about there being a double-edged sword. I don't know if that's actually quite the right term, but I think it's really important that we recognise that some of these do provide really useful insights into actually people's ability to be resilient, to create their own supports, but we need to be really cautious as well about not saying, "Well, that just means they don't need support", when actually support should be about a much bigger picture of people's lives, to have a long-term good life.
Q. At paragraph 75 you talk about experiences coming out of COVID, and I think you're referring to services like psychiatric nursing and occupational therapists becoming less available during the pandemic.
A. Yes.
Q. Can you tell me firstly about that, about those services becoming less available?
A. We did notice without doubt that a lot of the statutory services that many of the people that we support will also interact with were certainly scaled back and in many cases really did seem to largely disappear. People were not seeing people like psychiatric nurses,

social workers, you know, psychiatry and psychology appointments, et cetera, were largely cancelled and they did seem, to a large extent, to disappear.

I was thinking about this earlier and one of the things that I think is useful I think about this going forward, there's a lot of talk about essential workers. What I think there probably wasn't enough talk about was essential work. So I think all of those people were clearly classified as essential workers but I think, when we were thinking about this, we were thinking, "Who are the people and what do they need? Do they need to see people, you know, do we need to go and support them?", and if we thought we did, we continued to do so.

It felt to me like for a lot of people who were classed as essential workers, though, the actual work that they were supposed to be doing wasn't necessarily considered -- "Is that essential? Is it essential we go and see that person?". It felt like a huge amount of that, the statutory provision, really just closed down with a kind of blanket, "No, we're not going to see people".
Q. In terms of the end of lockdown and things returning to normal, did those services become available quickly?
A. No, it really did feel that a significant way into the pandemic things were still very much operating on a kind

of skeleton level and people not seeing people. I say there my memory is that significantly into 2022, many of the people we support were still not seeing people like psychiatrists, social workers, et cetera —— you know, that things still felt very, very hands—off and distant.

Q. I'm going to move on now to ask you about Distress Brief Intervention Service. You have explained this was something that was set up in 2016 ——

A. Yes.

Q. —— and therefore technically is outside our remit, so the only reason I'm asking you about it is, had it been in place during the pandemic, what could it have done? Now, you've already explained the system of first responder and then organisations such as yourself being a second responder. What have you seen as the consequences of this programme?

A. Yes, so it was in place throughout the pandemic ——

Q. Ah, right.

A. —— I do think, so it exists to this day, and in fact it is intended to be a completely national programme over the coming year or so across all of the health and social care partnerships. So it began as a pilot in 2016 and it had a very good formal evaluation, so Scottish Government have now agreed that it should become nationally available. I actually think it was

probably one of the fortuitous things that that fundamental structure was in place because I think it did allow that very quick transition to the national pathway to respond to the distress of COVID.

So it has supported over 50,000 people to date, the Distress Brief Intervention programme, and the national pathway in particular saw a huge amount of calls during and continues, I think, to see calls connected to COVID, particularly around things like financial difficulties and particularly as the furlough scheme started to kick in and people's jobs were starting to be at risk, you know, financial distress, relationship distress, you know, caused by many of the challenges of lockdowns and kind of family difficulties and kind of things like that, just kind of employment kind of challenges, people ——

Q. Can I take you to paragraph 90, where you say something about that, what might be thought of as causes ——

A. Yes.

Q. —— for requiring engagement with a service.

A. Yes, so I guess that is about, you know —— obviously many people will have some very kind of practical, tangible things underlying their distress, so it might be relationship breakdowns or it can be relationship difficulties, financial breakdowns, job, employment kind

of concerns and things, and those are very much the kind of things that people will be bringing to the Distress Brief Intervention programme. I guess that's maybe where it's perhaps a slightly different side to our work that is with people with long—term, you know, diagnosed mental health conditions, such as schizophrenia, this is very much about responding to these social, economic pressures that create real mental health challenges for people, and that very often can lead to very significant levels of distress and many of those were inevitably really exacerbated during the pandemic.

So that was very much a part of that intention of the expansion to the national pathway for Distress Brief Intervention, to provide that kind of very rapid, solution—focused, compassionate approach to, "How do we get you a plan here, you know, to really think about what's going on that's causing this and helping you to move through it".

Q. You talk about that a bit more at paragraph 94. Can I take you there?

A. Yes, so I guess this is about the work that people —— that our practitioners within the Distress Brief Intervention programme will provide, which, as I say, is very kind of practical. We would talk about

solution—focused thinking, so it's really trying to get a very concrete sense of, "What is it that's causing your distress here?", and trying to actually —— we use a thing called the "distress scale" to try and measure that, actually on a level kind of 1 to 10, "How significant is this distress for you and what would it look like if you were to bring that down? What are the really practical things that we can do to address some of these ..." ——

Q. In terms of those practical things, you say something about that at the end of paragraph 94, where you say it's often about that sense of losing control of things.

A. Absolutely.

Q. Can you carry on from there?

A. Yes, so, again, in terms of actually causes of kind of distress and causes of pure mental health that are associated with distress, a lack of control over your life —— a sense of a lack of control over your life as well is a really critical factor of that. If it's feeling that things are spiralling out of control, whether that's finances, whether that's with your family breaking down, your relationships breaking down, that sense of life —— just losing that sense of control over it —— so that's really what we try to focus on in the Distress Brief Intervention programme; how do you get

really clear about what these challenges that are creating this distress are and how do you get a really kind of tangible plan for how you're going to address those and, you know, some of those -- maybe in terms of financial stuff about kind of getting financial plans, signposting to other kind of financial support agencies -- you know, so just trying to get a really kind of concrete plan of this -- (overspeaking -- inaudible).

Q. So if I approach a first responder or a first responder approaches me and identifies that I'm in distress, the first responder will make a referral possibly to your organisation?

A. Yes.

Q. And the next day someone from your organisation will contact me directly?

A. That's correct, yes. So the programme is a 24-hour contact point, yes, so somebody will contact you within 24 hours of that first responder passing on their details.

Q. But there's an expectation that, if required, you will maintain contact for two weeks?

A. Yes, yes.

Q. And by the end of that period you will pass me on to someone else?

A. Yes, if appropriate.

Q. If appropriate?

A. But part of that will be about actually what further support do you require; is there organisations that can help you here. So, you know, there will be a core kind of exit plan of, "You're not just being left now after these two weeks, you've got the strategies and you've also got access -- other areas of support that you can access" -- (overspeaking -- inaudible).

Q. You also provide, at paragraph 95, an indication that no one leaves empty-handed.

A. Yes, absolutely. So, as I say -- yes, my colleague there talks about it as a distress management plan. It really is that. As I say, that concrete plan of, "This is kind of concrete practical areas I'm going to address, this is other areas of support that I can access if required". So everybody is going away with something kind of really tangible.

Q. On paragraph 96 -- and I have to say we've heard this from almost everyone in your type of position, "Our staff were awesome" --

A. Absolutely.

Q. -- can I give you the chance to say something about that?

A. Absolutely. It was extraordinary, you know. There was

a real kind of sense of actually just commitment. People wanted to continue working. People wanted to continue providing support. I think the biggest challenges we probably faced were sometimes about saying to people, you know, "You don't have to do all of this, you know, and you need to look after yourself". I think there was just this incredible commitment that the people we work with need support and we should still be continuing to do this. So people were incredible. You know, we had almost no issues whatsoever of kind of people, you know, having huge concerns about actually what they were being asked to do or about kind of protocols or anything. Just a huge, huge commitment to the people we support and a phenomenal response.

Q. You talk at paragraph 98 about the importance of that because of what was happening to other supports -- three lines from the bottom of that paragraph.

A. Oh, of 98? Sorry.

Q. Yes.

"... particularly when other supports ..."

A. Yes, okay -- yes, I think that's connected to that sense of many kind of people not seeing things like psychiatric nurses or kind of social workers, et cetera. So I think there really was just a huge amount of care, you know, actually for the people that they knew and

have built relationships with and of wanting to make sure that they continued to have that support and that they were okay.

Q. At paragraph 100 you talk about the difficulties faced by staff at home.

A. Yes, indeed. So, as I say, we had a very mixed approach and there was a reasonable amount of our support that we were able to make digital, so we were supporting people by phone calls and video calls. I think one of the things in terms of some of the social inequalities that that affected us differently, that we weren't all in the same boat, to use that metaphor, is that our staff, social care staff more widely, are not particularly well paid -- well, many colleagues in statutory services are also not well paid, but there is an ongoing inequity for people doing similar roles, particularly in the third sector, that their salaries are often significantly lower. So these are people who earn very often not much more than minimum wage and to a large extent that will often mean that they're living in relatively small properties for many of our staff.

So some of those challenges of working from home, of trying to provide support from home, and often small flats where you may not have the luxury of a spare bedroom or a garage that you can turn into an office,

et cetera, were really, really challenging for people and created real challenges for us about our kind of guidance in terms of things like confidentiality. You know, obviously if you're having a support call with somebody, there's real confidentiality boundaries there, and of managing that in a very small flat or house. That kind of thing was really challenging for many people.

So I think it just probably highlighted to me some of those social inequalities about some of our very essential workers in society but who are not very well rewarded and so, therefore, when something like this hits, don't have the luxury of big houses and gardens and ...

Q. At paragraph 105, you talk about a particular group of your employees, first-level line managers --

A. Yes.

Q. -- and them facing particular difficulties. Tell us about that, please.

A. Yes, I think -- so I talk through about that kind of anxiety about getting it wrong, particularly as far as the guidance is concerned, and very particularly I think for the managers of what are registered as care homes. You know, the guidance was clearly very complex and I think there was a real fear of, "If we get this wrong,

we are going to be held responsible. We are going to be held accountable if there is an outbreak". Now, we were very fortunate that we actually had virtually zero -- not quite, but almost zero actual levels of COVID outbreaks or anything within our services or staff, but there was a huge amount of anxiety, particularly of the managers of accommodation-based services, that they would be held accountable.

I think -- I talk a little bit later about when the Care Inspectorate started providing reports to Parliament and naming providers. I think that really ramped up that anxiety, the real fear of. "If we do get a COVID outbreak in our service, that we're going to be kind of named before the Scottish Parliament as a service where something has happened". So I think that put a huge pressure and anxiety on our staff.

Q. You then move on to talk about the guidance and at paragraph 108 you talk about getting new guidance coming in at 4 o'clock on a Friday --

A. Yes.

Q. -- and the expectation being you would implement it on the Monday morning.

A. Yes.

Q. Tell me about that.

A. Absolutely. It felt like that for a significant length

of time, of guidance changing very rapidly, you know, certainly week to week and sometimes much less than that. There was definitely times I remember it coming in on Friday afternoon, with, "This is operational from Monday", and you're kind of thinking, "Okay", and that's, like I say there slightly flippantly -- but a sense of putting out communications to staff saying, "What we told you last Monday no longer applies. It has now changed to this".

So rapidly changing and also just the guidance coming from multiple sources. You know, we'd have guidance from Public Health Scotland, from Scottish Government directly, from the Chief Nursing Officer, I recall at times there would be letters coming out from, from the Care Inspectorate, which were by no means always aligned. So this mammoth exercise of trying to unpick this and, as I said earlier, breaking it down into, "This is what this means for us and this is what we need you to do", and quite often having to do quite a lot of backwards and forwards to officials to say, "Can you clarify this, please, because this doesn't make any sense to the third sector" or --

Q. You provide quite a lot of detail of that from 100 to about 116 but can I try to summarise what's there by having you read the final sentence in paragraph 112?

A. "It just didn't feel well designed for our sector."

Q. Is that how you still feel?

A. Yes. I think what I said earlier was, particularly as regards care homes, there seemed to be this assumption that a care home is a care of the elderly home and that the people within that are people with physical impairments. The reality is that most of the people that we would support in the settings are probably young to middle-aged people. They are physically perfectly capable of going about. We would have no powers whatsoever to direct them or to restrict them. You know, we would have no legal powers that would allow us to kind of mandate that they follow any particular guidance.

Now, again, I would have to say that just about all of those people were fabulous. They got what was going on and they respected the rules. But in terms of actually, "Can we actually implement this guidance?", there was a real question for us, and I think for me -- and I'm probably speaking to some degree more personally here -- it felt very apparent to me, reading that guidance, that -- some of the concerns about human rights felt really -- it felt like there was a sense of, "Because people are old, because they physically can't move, that's okay, just keep them in their room. Just

keep them out of shared living rooms, et cetera", and I think perhaps because actually that was virtually impossible for us to implement in any kind of enforced way, that contrast of actually we are talking about essentially people's rights here and we're kind of saying that because people in some sectors may not physically be able to stop that, we can do it.

Q. You move on to talk about what you viewed as difficulties with the Care Inspectorate and you alluded to that before. Can you tell us about that?

A. Yes, and I think we have to be balanced here as well. I think we got a huge amount of support from the Care Inspectorate with our relationship manager, and particularly in the early months the care inspectors were actually very good at keeping contact with our services, they were phoning up and kind of offering support.

But to a large extent, you know, care inspections stopped for the first kind of part of the pandemic and they were then prioritised. Our services really didn't start to actually have visited inspections until well into kind of 2022, 2023. I think primarily actually 2023 was when they really started again.

One of the challenges was about the guidance, that we were getting guidance from the Care Inspectorate that

at times would not be consistent for instance with Public Health Scotland. I know my colleague talks about, for instance, with care homes, "Actually are you a care home or not?". Public Health Scotland would say, "Oh no, we don't think of you as a care home"; the Care Inspectorate would say, "You're registered as a care home so you need to follow that guidance", so things like that.

I think as things started to open up again, there was a real sense that, when inspections restarted, nothing had changed. It was on exactly the same basis as before. And so some of our managers felt very aggrieved, it's probably fair to say ——

Q. Can I try to ——

A. Yes.

Q. —— unpack that a little? You had a system of regulation prior to the pandemic?

A. Yes.

Q. During the pandemic, obviously, there were changes in the guidance and then after it, and you had concerns about that and you talk about what you've already mentioned, about reports going to the Scottish Parliament.

A. Yes.

Q. And I'll ask you to say something about that.

But then, after the lockdowns ended, you still had problems with the Care Inspectorate; is that right?

A. With some of the systems. I mean, in particular what I think could have been done differently was that the criteria that services were being inspected on hadn't changed. Now, inevitably some of the things that services would have been on top of prior to, they hadn't been as on top of because they'd been focused on, you know, the hygiene, keeping people safe and that kind of thing. Services were then critiqued for not having some of these things in place, you know, and it felt like there was kind of no leeway. I think individual inspectors got this, but there was a bit of a sense of ——

Q. You talk about the difference between the organisation as a whole in the Care Inspectorate and individual inspectors at 119. Do you want to say something about what's there?

A. Yes, I think it was that sense that many of the individual inspectors, I think, very much got these kind of things. They were saying, "We know why you've not been able to kind of maintain perhaps some of these areas, we get that, but we're operating to the same guidance, we have no choice". So some services would, for instance, be downgraded because of some things they

didn't have in place and they'd kind of say, "But we've been keeping people safe for the last two years, you know, we've been doing these things so of course we're not quite as on top of some of these other areas that would usually be inspected".

And it felt to me there should have been some different criteria about: "How well have you kept people safe during the pandemic, how well have you kind of managed to maintain people's rights and connections, kind of things, and how well are you now emerging and getting back to normal?" Rather than just a: "Right, all the things that you should have had in place before, are they all still 100% in place now?" when I think no service across the country could possibly have maintained the focus on all those kind of things when you've got so much to do just to maintain things.

Q. At 126 ——

THE CHAIR: Mr Caskie, you're almost out of time.

MR CASKIE: I know that.

At 126 you say:

"Because there were different things, the Care Inspectorate, Public Health Scotland, communications from the Chief Nursing Officer, there was definitely a sense that these were not always coherent."

A. Yes, absolutely. So that sense in terms of the

guidance, with the formal guidance and, you know, we refer there to some of the informal guidance, about things like, "Are you a care home or not?", there was very much kind of not a shared voice in that. And that would be some of my sense of this, that going forward, if we were to repeat this, how do you have that single point of truth? You know, how do you have a system that enables that kind of just clarity of communication from one place?

Q. You start then to talk about funding and you make a positive comment that, if you had been given an amount of money to do a particular thing but you were unable to do that thing ——

A. Yes.

Q. —— funders would simply say, "Spend it where you think it's needed".

A. Yes.

Q. Is that fair?

A. Yes. In many, many cases, I think a lot of the people who funded our services understood that an organisation like ours would collapse if they just said, "Well, if you're not providing that in the way that you used to, we'll have the money back thank you". So I think they largely allowed us to kind of retain that money, you know, and to keep paying the staff. Because, as I say,

we furloughed no staff whatsoever so all of our staff were still being paid, were still trying to deliver things in different ways. And certainly the large majority of funders I think were very understanding about that and did not attempt to kind of claw money back which I think in different times they probably —— many might have done.

Q. At 136 you talk about private sector assistance?

A. Yes, and honestly that's probably a relatively small thing. I think that was particularly about things like the sanitiser and the ——

Q. And you refer to that at paragraph 140. Can you just tell Lord Brailsford about that?

A. So that was about those challenges with PPE, particularly in those kind of first six months or so. There was real kind of challenges. We were able to do so but it was really, really difficult. The private sector stuff was about sanitiser really, about actually these kind of gin factories and things that kind of pivoted to providing, so we were able to get some from them.

But we did —— we were able to get PPE but it was very challenging and particularly that sense about actually it being reserved for the NHS. You know, so consistent with being told of, "We can't issue you

supplies because actually we've been told we have to reserve this for the NHS", and I think that was one of the things that caused some degree of kind of ill feeling with some of our staff, about a sense of not being valued as much, you know, that actually the work that we do is lesser and not as important as perhaps the NHS kind of services.

Q. In addition to the services, was there also a feeling about the attitude towards your staff, that they were less important?

A. I think there was on a kind of structural level. I wouldn't want to say that any kind of individual, you know, actually believed that they weren't as important. But I think, again, it connects that sense of services disappearing. I think there was a sense of shut—down in a lot of the statutory services, you know, "We have to protect these people, we have to protect the NHS". That didn't feel, you know, as if it applied to other sectors, you know, such as ours, that actually it's okay for those staff to go out. I know my colleague refers to an example of an OT asking one of her staff to go and visit somebody and saying, "I can't do it because we have to protect NHS workers", and a kind of, "But it's okay for you to go".

So I think there was that kind of broader sense of

that, that I wouldn't want to in any way attribute to any kind of malign or, you know, anybody actually in their own values not valuing, but a kind of structural issue about ——

Q. To the end of your very helpful statement, you provide two sections: lessons to be learned and hopes for the Inquiry. I don't intend taking you through those. They will be read and considered. The lessons to be learned are derived from the matters that I've already gone over and they are your conclusions on that evidence. We will take into account that, all of that evidence and your effectively opinion.

In terms of hopes for the Inquiry, you say at 176:

"It is really important to say that we look at this through the lens of the sector we are working in which is community based mental health [services]. We are not talking about staff who turned up to do a shift at A&E or the people that carried on in the private care homes, we are thinking about community—based health services."

That's your function, isn't it?

A. Yes. And I think particularly what my colleague did in trying to express was, in terms of some of the concerns about perhaps statutory services not always being there, I think it's not wanting to be, you know, kind of highly critical of them either. You know, clearly there was

hundreds of thousands at least of people doing incredible jobs every day. I think it's more a question about that kind of structural systemic stuff, about why did some roles kind of disappear from actually some of that kind of actually seeing people, actually engaging with people. And I think that's the real question for me, about actually, you know, what -- I said there is something for me about that sense of actually essential work as well as essential workers. How do we actually identify the tasks that people should be doing? Because that's where some of it seemed to disappear. People were at work but they weren't actually necessarily prioritising some of the tasks that I think needed to happen to keep people well and to keep people safe.

Q. Those are all the questions I have for you. Is there anything in the ground covered in the witness statement which I've not asked you about that it's important that you say in your own words?

A. I think there was something that just struck me there, just back a little bit there, about reporting. I think, again, in terms of some of the challenges that our managers in particular faced was a vast array of reporting requirements, which were really -- you know, when they were already incredibly pressured just trying to think about, "How do we keep this service going? How

do we keep the staff team going?", there were expectations to report to multiple levels, to Care Inspectorate -- you know daily reports to the Care Inspectorate about COVID levels, staff absences, et cetera; authorities were looking for bespoke reports from services; Scottish Government were also kind of having different reporting requirements. There was a really very substantial amount of requirements for reporting and enormous amounts of time needed for that.

Q. Was that reporting overlapping?

A. Yes, absolutely.

Q. Were you needing to tell the same things to different organisations?

A. Yes, absolutely. Clearly there would be some differences, but very substantial amounts of overlap, as I say, about kind of staff levels, staff absences, about levels of COVID within services, et cetera. So a great deal of overlap.

Again, I think if there was one thing that -- were we to face this again, a bit like the guidance, how do we have a single point of reporting -- how do you have a single point of truth for guidance and how do you have a single point of reporting. I don't underestimate the challenge of doing that, but I think that would be hugely helpful because a lot of people's time was taken

away from actually keeping the services going and supporting staff teams and things to adhere to these reporting requirements.

MR CASKIE: Mr Finlayson, thank you very much.

A. You're very welcome. Thank you.

MR CASKIE: Thank you, my Lord.

THE CHAIR: Thank you, Mr Finlayson.

A. Thank you.

THE CHAIR: We're back at 1.30.

MR CASKIE: Thank you, my Lord.

(12.39 pm)

(The short adjournment)

(1.30 pm)

THE CHAIR: Good afternoon, Mr Caskie. Can you hear me, Mr Caskie?

MR CASKIE: Apparently not.

THE CHAIR: I can hear you --

MR CASKIE: And we can hear you.

THE CHAIR: Good. Fine. Thank you.

MR EWAN AITKEN (called)

THE CHAIR: Good afternoon, Mr Caskie, and good afternoon, Mr Aitken.

A. Good afternoon, my Lord.

THE CHAIR: Good. When you're ready, Mr Caskie.

MR CASKIE: Thank you, my Lord.

Questions by MR CASKIE

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

A. Ewan Ritchie Aitken.

Q. In what capacity are you here?

A. I'm the chief executive of Cyrenians.

Q. And you've provided us with a very helpful and detailed witness statement. Firstly, can I check that, with one exception, which I'll deal with just now, at paragraph 87 -- go to paragraph 87 -- in the second line of paragraph 87, you provide an example.

"For example, the 17% increase in those being made homelessness for the first time ..."

A. Yes, I know that example. Unfortunately the paragraph numbers here do not appear to be the same as you, but I'm aware of the example -- the statistic that you referenced and, whilst I know where I heard it, I cannot find the evidence to --

Q. No, I understand. We'll come back to that. I need to work out -- because we're obviously working from differently numbered statements. I have the Inquiry's witness statement which Lord Brailsford also has access to. Are you able to find in the document you're looking at the 17% figure?

A. It's referenced in --

Q. It's just the paragraph number I'm looking for.
A. There's a reference to it in paragraph 54.
Q. Of your version?
A. Of my version.
Q. Obviously we have completely different versions. My paragraph 54 says:
"Homelessness prevention needs to start upstream and strong social relationships are key."
A. Mine starts:
"In August 2020, first time homeless presentations in Edinburgh, increased by 17% from the previous year."
Q. That's paragraph 56 in my version of it.
Sir, I'm going to ask for a pause just so we can get the ——
THE CHAIR: Get the right —— get a copy of the Inquiry statement for Mr Aitken.
MR CASKIE: Yes, so a copy has been asked for. If we could just rise for maybe ten minutes.
THE CHAIR: Surely, yes, we'll do that.
MR CASKIE: Thank you.
(1.34 pm)
(A short break)
(1.52 pm)
THE CHAIR: Very good. On you go.
MR CASKIE: Thank you.

I'd just asked you to provide your name for the Inquiry.
A. Ewan Ritchie Aitken.
Q. And your position? The reason you're here?
A. Chief executive of Cyrenians.
Q. I'll ask you some questions first about your background and to do that I'm looking at paragraph 8 in the witness statement which you now have.
A. Yes.
Q. I see there that you were a —— sorry, I've jumped forward. Before I do that, can we go to paragraph 87?
A. 87, yes.
Q. In paragraph 87 there is reference to an example where you say:
"For example, the 17% increase ..."
Now, as I understand it, firstly that's referred to at one other place in the witness statement but also, as I understand it, you've not been able to track down the source of that figure ——
A. Yes.
Q. —— and therefore you want to have your statement amended to have the two references to 17% taken out?
A. If that's okay. I know where I heard it but I can't find the —— there's not a written version of it so I'd rather take it out.

Q. That's fine. No difficulty with that. Apart from that correction, is there anything else in the witness statement that you're uncomfortable with or that you are not able to say to Lord Brailsford "That's the absolute truth"?
A. No, I'm absolutely fine with that.
Q. Good. Can we then go back to paragraph 8? At paragraph 8 we see a little bit of your history. You were a parish minister for seven years before you were elected as an Edinburgh councillor.
A. During those seven years I was elected.
Q. You then held positions within the council as convenor of education and leader of the council.
A. That's correct.
Q. When did you leave the council?
A. In 2012.
Q. And was it around that point that you took on another policy—related job?
A. No, I'd taken that job on in 2008, where we were in opposition again on the council —— sorry, part—time councillor and full—time with the Church of Scotland as head of policy in the building opposite this building.
Q. At 121.
You were also chair of Children in Need Scotland ——
A. Yes.

Q. —— and sat on various strategic committees?
A. Yes, that's correct.
Q. You've detailed those there. Now, I want to ask you a bit about the Cyrenians.
A. Okay.
Q. How large is the organisation?
A. So we're over 200 staff, about 215 now. We're —— turnover of about 9 million. We have 20 —— we have 63 projects across 20 sites and five of them are national projects, although all of those ones are largely digital, not entirely, and some of that as a result of what we learned during COVID.
Q. You say that you have some national projects, most of which are digital.
A. Yes.
Q. I'm asking at the moment about the non—digital physical projects that you have. Where are they geographically located?
A. In the east coast, Edinburgh, the Lothians, the Borders, Fife, Falkirk and Stirling.
Q. So not as far up as Dundee?
A. No.
Q. At paragraph 11 you talk about what the Cyrenians are about and what leads to people coming into contact with you, common themes.

A. Yes.
Q. Can you just tell us about that?
A. So Cyrenians is a homeless prevention organisation; in other words, we want to stop people becoming homeless in the first place as well as supporting people who are. So a lot of the work we do is what you would describe as "upstream", so we engage with people who are grappling with poverty, people who are socially isolated, people with mental health challenges, people who have been through the criminal justice system, young people struggling at school, although some of what they have experienced is as a result of some of those other things, people who have experienced challenges with drug and alcohol addictions, women who have experienced domestic abuse, families who are struggling with conflict. We know that family breakdown is the most common reason given when somebody presents as homeless, therefore getting into families and supporting them so that conflict doesn't have a consequence of homelessness is one example of that.

We also do have street teams and work with people in crisis, people who are actually homeless and get them into a home. The plan there is to get them into a home that they won't lose again because that's part of the problem. But at its heart we're a prevention

organisation rather than a crisis organisation.
Q. You talk about some of the ways that you do that at paragraph 12.
A. Yes, so the mediation, for example, that I describe. We worked with about 200 families last year and virtually everyone in that context the family stayed together or, if the young people left, because the focus is on young people, they left in a planned way rather than a conflict—related way.

Mostly we create a space for people to have the conversation that they want to have but haven't been able to do so. We also support folk with mental health challenges through the Royal Edinburgh Hospital and the Midlothian. With gardens —— we've been able to evidence that patients who spend time in the gardens spend less time in hospital but they also get an opportunity to build relationships. One of the challenges about mental health is you're less able to create the social relationships that will give you the capacity to continue your life when you're living —— when you're out of hospital again, so we do that. We have five residential communities ——
Q. That's exactly where I'm going next. Can you tell us about that? I'm going to take a break in your evidence after you've told us where they are and what they do and

so on.
A. Okay, so we've five communities, two for young people, one is in Edinburgh and one on a farm in West Lothian. These are young people who would be otherwise homeless. We have a community for unaccompanied minors and a community for people who have left hospital having had long—term mental health challenges and we also run the Social Bite Village as well. So a range of —— we provide accommodation for around 50 people in our communities.
Q. You spoke about providing support to unaccompanied minors. I think that organisation, from paragraph 13 of your statement, is called the "Lotus Community".
A. Yes, that's correct.
Q. I want to ask you some questions about the Lotus Community. As you'll be aware, this Inquiry is not just examining questions to do with health and social care but also education. My colleagues who are dealing with education have asked me to put some questions to you about the Lotus Community and also one other aspect. Why was the Lotus Community needed?
A. The demand is enormous. The numbers of young people who arrive in this country and in Edinburgh in particular who are somewhere in their teenage years with no accompanying family and no papers is growing all the

time. There are aspects of trafficking there, either for economic reasons or for sex trafficking. We need to provide safe places for folk so that they get the support they need to deal with the trauma they've experienced and then get them engaged into settled accommodation and employment.
Q. And can you give us an idea of the numbers involved that Lotus have been dealing with?
A. So we have 13 —— we're able to provide accommodation for 13 at any one time. We've never had voids —— you know, empty beds as it were. As soon as one is —— somebody moves on, the next one comes. As I noted in my evidence, we actually set that up during COVID because —— we had been talking about it before COVID but we continued to get it set up during COVID, despite the fact that it was a very difficult thing to do, because the demand was such that we needed to get on with it and not let the pandemic get in the way. And, you know, there's (inaudible) it's difficult to say, it depends on each circumstance, but they spend somewhere between nine and 12 months with us because they need to get themselves settled. It's not just a legal status, they need to get themselves settled and ready to move on.
Q. Those who are resident with you, do they have access to training and education whilst they're with you?

A. Yes, yes, and that happens in a variety of ways. Some of them are at college. Some of them are actually able to get to work relatively quickly, and that's where they get the training they require, particularly if they are from a community which has a presence in the city and therefore they have folk from home, as it were.
Q. Were they able to access hub schools during lockdowns?
A. No, they were not at school, they were at college.
Q. Right. Do you take in people of school age?
A. Not in our communities. Our communities are 16—plus and they tend to be people who have left school. If they go into education, they're getting into college. We engage with schools in a number of other of our services which I've also referenced elsewhere. I presume you want to come back to that rather than deal with that here.
Q. Yes.
At 157, which is almost at the end of the statement, you say there:
"We're developing a new pathway to support young people with no qualifications to get into college around the green economy —— environmental and outdoors work which has been helped working with Balfour Beatty, SWECO, Edinburgh University and Edinburgh and Borders College."
What stage is that programme at?

A. So I'm pleased to tell you we just got some funding for it, so I'm able to run a pilot this year for 20 places and then —— but we've got money for three years.
Q. Is that going to be linked into NAT 5 or other ——
A. Yes, so during COVID we created a NAT 5 level of outdoor learning because we needed to get young people who were not engaged digitally with school some support. We had the farm and we had several green spaces and actually our depot, which is open enough for people to be part of, which is our food distribution depot, so we were able to create a qualification, in partnership actually with Newbattle College, that has no written work, because these were young people who were just really struggling, and it's about outdoor learning. So there will be that as an aspect of it, but there is a series of other taster elements. There's construction, there's recycling, tech and various other aspects. The college has agreed that part of the journey will be —— they'll take that as enough for them to be taken on into college.
The biggest challenge we've got is we keep talking about a green economy but nobody really knows what that means, and if you've not been at school for two or three years, which is where we're now seeing young people with support who have not been at school for that length of

time, their capacity to get what it takes to engage in this new economy that nobody can really describe as it is is even more difficult and therefore we're trying to create that pathway for young people without qualifications to get into this economy as it comes because, if they don't, they'll end up in poverty and their chances of ending up as homeless is significantly increased as a consequence.
Q. And that's why ——
A. That's the rationale, yes.
Q. That's the rationale for being in that space?
A. And we're trying to model that behaviour, so I might as well pick that up as well. We have to be in that space. It's taking what we call a public health approach to homelessness prevention.
Q. At paragraph 14 you talk about LEAP and say that that's an addiction rehabilitation service.
A. Yes.
Q. Can you tell us a bit more about that?
A. So there's kind of —— when somebody gets to the point of being willing to take part in rehab, in other words getting clean, there's the medical aspect but there is also a huge social aspect and a social change. You essentially have to leave the community you were part of and try and work out how to be in a different type of

community because, in the world of addiction, you're amongst people who are in a similar space, you're engagement is with these people in a similar space. So that change is huge and your sense of yourself and how you take yourself into relationships also changes because you're taking this person who is making a massive physical and medical change, biological change in a way, into new relationships.
So the medical bit is done during the day by clinicians and then we provide the accommodation and support around that, so that, you know, when folk finish that, they can go to their —— they can go to other activities, they can go to the NA groups or the AA groups or whatever is appropriate, but also can start again to talk about, "What am I going to do when I get out of this?", because it's a 12—week programme.
That's why we also run —— as well as that, we also run what's called "ERA", which is Edinburgh Recovery Activities, which is a community of peers who have been through that journey who support folk then, having gone through the medical, the clinical bit, to keep going, because in the first two years after a clinical —— after you've gone through rehab and got clean, you are more likely than ever before —— than subsequently to relapse. You're liable to be at a point of relapse about seven

times in that period of time and the best possible support is peers. So we provide that —— develop that capacity to be in a relationship with people in a new context and then create the context for those relationships to happen, and in that context you are then more likely to flourish and therefore less likely to become homeless.

Q. Okay. I just want to now go through a number of other services that you provide, but on a headline bullet—point basis.

Paragraph 16, you talk about your involvement with the Community Payback system.

A. Yes. If you're in the criminal justice system, you are 13 times less likely to get a job. We provide people the opportunity to do Community Payback activities, largely outdoors —— not all the time but largely outdoors —— through our community gardens, but also training so that they can then get into work. Again, if you're in work, you're less likely to get into poverty.

Q. At paragraph 17 you talk about your team embedded in the Royal Infirmary and at the Western General.

A. People who are in unstable accommodation are significantly more likely to use health services, so it is a point of intervention that we can make because people are asking for help and, if you can add to that

support into better accommodation, then you're more likely to get support.

Q. What you say there is that everyone who walks into an A&E in Edinburgh and identifies themselves as no fixed abode or ——

A. Actually it's not —— they don't need to identify themselves. We've got about 5,000 temporary accommodation addresses in their system for no fixed abode and it's flagged up for them —— so they don't have to make the identification —— it's flagged up digitally, and that information goes to our team, who then go to the ward, engage as part of the care package and —— I can give you examples if you wish of how that point of asking for help and you can provide that support has a —— is significantly more likely to engage and they're more likely to stay healthy. So one of the things this project has been able to do is reduce the attendance at A&E by people who are more likely to use A&E because of their circumstances by 63%.

Q. Housing First you do in the Borders ——

A. Yes.

Q. —— at paragraph 18. Tell us about that.

A. So Housing First started in America. It works on the principle that, instead of saying to somebody, "You need to get your drugs sorted and your finances sorted and

your socialisation sorted and your employment sorted, and then we'll give you a house", because you'll never get there, that's how people bounce around the system, we say, "We'll give you the house and we'll provide the support around you so you can maintain the tenancy and get that stuff fixed".

Q. And you organise that in the Borders?

A. In the Borders, yes. So we are contracted by Borders Council to deliver that.

Q. You provide food through the FareShare Initiative?

A. Yes, so we're part —— it's a British—wide —— a UK—wide service and we're the franchise holder for the south—east of Scotland. We're in partnership with 170 organisations and we deliver about 100 tonnes of food a year to those organisations. They get it at about a fifth of the cost —— this is food that would otherwise go to landfill out of the supermarket system —— and it ensures that that food is used well and those organisations can make their money go further. With that, they're more likely to be able to deliver the support they require for the people who use their services.

Q. I want to ask you to explain the positive impact on your food distribution service that the furlough scheme had.

A. So food was an issue, as we know —— access to food in

lots of different ways. We needed to ramp up and we shifted from at that point doing 40 tonnes a month to doing 100 tonnes a month.

Q. Well, how were you doing the food? Do you have kitchens? How does that work?

A. So —— you're talking about the meals rather than the redistributed food?

Q. Yes.

A. So we also have kitchens because we try and teach people to cook because, if you can cook and budget, you're more likely to maintain a tenancy. So we had this resource. So we needed to turn that domestic training kitchen into a production kitchen, so we had chefs who were on furlough and they came in in teams along with some of our staff. So we had three chefs go in and we produced somewhere between 80,000 and 100,000 meals over that period of time, using that ——

Q. What period of time?

A. The first lockdown. We then had a whole bunch of other people who were on furlough and volunteered, who distributed that across the city, and we partnered with a number of other organisations for that distribution method as well.

Q. You were also talking about, before I rudely interrupted you ——

A. Possibly ——
Q. —— about distributing non—cooked food.
A. Yes. So we were distributing about 40 tonnes. We ramped it up to 250 tonnes a month during lockdown, the first lockdown, and into the second lockdown, and were able to support about 250 organisations with food that they wouldn't have otherwise been able to access, and actually, because we were purchasing that food, some of that food was able to go free to those organisations, or they were paying the fee but, as I said, it was only a fifth of the cost so their money could go further. So we distributed in that year the equivalent of 4.2 million meals worth of food.
Q. Right. And at paragraph 20, moving away from food, looking at your wider service, and you talk about your volunteer supporters. Tell us about those.
A. So at the heart of what we do, it's built on volunteering. So last year we had about 460 volunteers, gave us about 66,000 hours. That's about 40 staff, but actually that's a huge range. There are people who come and live in our residential communities for about six to nine months from all over the world. So at one end you've got that. We've got people who have gone through tough times in their life and actually the best way of them flourishing, because they're never likely to get

back to work, is volunteering with us on a regular basis. You've got people who just want to give back and then you've got corporate volunteers. So across the board we've got a wide range of reasons for coming to volunteer with us, but it's huge for us and makes a massive difference. During COVID, that went through the roof and it was incredible to see. We were literally turning people away.
Q. At paragraph 24 you talk about funding from a variety of sources but in particular —— well, just a difference in approach. In the final sentence you say:
"The dynamic moved from funders deciding what should be funded to asking us what was best to fund."
A. Yes, and this is one of the more extraordinary things that came out of that experience. Usually what happens is funders say, "We'd like to fund this thing or that thing and it should look like this", and then you apply to that and say, "We can do that". But the decision about what is needed to be funded is made by the funder rather than ——
Q. The provider?
A. It's not uninformed but it is a decision that's been taken away from those who are in the front line or the people actually experiencing the issues that are there.
What was happening is we were getting calls from

funding organisations and, directly from and via those funding organisations, the Government and from funders —— grant—giving funders and from corporates, saying, "What's the best thing we can give you money for?", completely changing the conversation. Frankly I think they were able to spend their money better because they were asking that question before they gave it to us. We still needed to say what we'd do and they'd go, "Oh, that sounds good", and then do it. But changing how we have a conversation about what's the best thing —— essentially, what will produce success from the people who hold the money to the people who are experiencing the challenge I think is the best way of us doing things in the future.
Q. You say something about that at the end of paragraph 25, where you effectively quote from another funder.
A. Yes.
Q. Could you read that? Just the quotation, "'... forget what you thought ...'".
A. Yes, so this was a funder who said, "We'd given you that money for this". They said:
"Forget what you thought you were going to spend this money on, if you need to spend it on something else ... because of the pandemic, do that."
And that was extraordinary. Funders literally were

saying, "And it doesn't matter if it's nothing to do with the group of people we were supporting. If it's what you need to do, do it".
What's underlying that is an enormous sense of trust and, because of that trust and because they leant into that trust, we were able to do things that actually needed to be done.
Q. At paragraph 26 you say:
"The system for funding became much more efficient."
Then further down in that paragraph you're talking about pre—pandemic you spent more time accounting for money than spending it.
A. Yes, it would be true to say that sometimes it appeared to be, the smaller the grant from the Scottish Government, the more you have to account for it. But literally you have to give detail every quarter, whereas actually they were saying, "Go and do this and then, when you've done it, tell us what you've done". And they did manage to find ways of getting money out quickly and, as I referenced earlier, they would say to organisations like Expand in Scotland, like Foundation Scotland, like Corra, funding organisations who had a wide range of relationships with a wide range of third sector organisations —— so in a sense their relationships were the due diligence and through that

they trusted that that due diligence would work for this new set of circumstances. And they would say, "Go and have the conversation and, if you're happy, then give the money out". They started with smaller sums and then went to larger sums. I have to say that, if we could do more of that now, we would be in a better position in terms of the impact of how we spend money.

Q. How did that come to an end after lockdowns? How did they put the brakes on that freedom you had?

A. The money that was given to those organisations to distribute went back to the old set of rules of somebody decided what was the right thing to be done and us having to make applications under the old system. I mean, there are grant funders, who have more freedom, who have continued some of this stuff. I mean, the money that I referenced earlier for the green skills stuff was a lot more about a conversation with a grant-giving trust than it was a grant application, so some people have learnt. But in terms of public sector money getting to the third sector, we've gone back to where we were before, which is a shame.

Q. You talk about, at paragraph 30, Scottish Frontline Network. Tell us about that briefly.

A. So this is funded actually by a London organisation, St Martin's in the Field, and it's one of the ones right

across the country. But basically it's to try to provide peer support amongst front-line workers but also learn from front-line workers, who in many ways are the bridge between people with lived experience and the organisations and the systems. So this network will take an issue and folk from all over the country -- this is one thing we did digitally -- kind of tend to have a conversation about that. But it's specifically for people who work in the front line, who work directly with the people we support, so people like me don't get to go. That's a good thing because it gets me out the way. And out of that then things are raised and then fed into the system in terms of trying to change the way the system works.

Q. You talk about that being online --

A. Yes.

Q. -- for understandable reasons.

A. Yes.

Q. You also talk about your veteran service also being online. Why are those two in particular online?

A. I just gave them as two examples, but what they both were examples of -- having started running them, the Frontline Network was in Edinburgh and the veteran support for families was in Edinburgh and the Lothians. But we discovered quickly that we could start providing

a much wider reach of service by doing digital stuff, which we had not done before, and, of course, people were up for the digital thing in a way that they weren't because they were forced into it. So quite quickly we were providing counselling support for the veterans' families. The principle of the veterans thing is they go in with huge -- often huge PTSD and all that kind of stuff and the family around them becomes impacted by that negatively and that breaks down. But if you can keep the family as an asset by them understanding what's happening and, through that conflict resolution stuff I was talking about earlier, actually help them through it -- and we discovered we were able to do that online in a way that we probably didn't realise when we first set the service up. So we were literally supporting people in the Islands and things like that that we would never have done previously and we're still doing work in that area as a result of that.

Q. All in for Change you refer to at paragraph 31.

A. Yes. So All in for Change was set up as part of the Ending Homelessness Together programme, which was signed in 2019, a collaboration of the Government, local authorities and the third sector to end homelessness. This is a group of people with lived experience, front-line workers and academics, and they're a sounding

board and an assessment of new policies and of new services and they're a way in which you can really bring those voices into that space and it's funded by the Government. Again, we were doing that in person, but we've started to do it online and were able to involve more people more often as a result.

Q. At paragraph 32 you talk about family support and five secure units.

A. Yes.

Q. Tell me about that.

A. So there are some -- randomly five secure units for young people. It's not prison. It's where young people, for their own well-being, need to be in a secure context. The challenges -- what happens to the family relationships when they're in that context -- because often they're in that context -- the family relationships have been damaged on the journey to them being in that context. So we work with the units and with the families to try and keep those relationships strong, so when the young person comes out, they're coming out to a different set of relationships than before, because we know that, if those relationships can be strong, the chances of the young people getting to a better place are far higher. It's that old thing: when can you intervene in a way that's going to change

things rather than the system continuing the problems because those relationships don't get repaired?
Q. Your organisation has a finger in a great many pies.
A. Yes, that would be true to say, but the journey to homelessness starts in many, many places and is different for every person, so we need to be in lots of places to be beside people so that they can get the support that they need on their terms and get to decide what success looks like for themselves.
Q. At paragraph 33 you start to talk about lockdown and you say that Cyrenians locked down on 16 March, about a fortnight before most -- or a week before most other places. You say:
"In hindsight it was one of the best decisions I took ..."
A. Yes. Well, in the end --
Q. Tell me about that.
A. In the end, as the chief executive, you're the one that has to take responsibility for a decision as big as, "We're shifting everything, everybody is going to go home, we're going to find a way of delivering our year-round 24-hour services in a way that people can work on their own". And it was really, really hard because there was no plan for this, nobody had worked this thing out, so we literally had to just do it and

see what happened. As one of my colleagues said, the advantage was we got to have our melt-down before everybody else and learn from that so that, when it actually came officially, we were already in train and running at it.
Q. Okay. You say at 35 about a change in the questions that were being asked.
A. Yes, we'd started out saying, "Can we -- do we just have to shut everything down?", and we quite quickly moved to, "How can we actually make this work? How can we actually reach out to folk and continue the services?", because we realised our other -- lots of other services were just shutting down and we realised that that would be very damaging for the folk we support, if they became isolated from their support. So we had to shift our thinking quite rapidly and in the end we managed to keep pretty well every service going in some form or other, which was quite an achievement.
Q. You talk about things shifting more online. Tell me about the difficulties.
A. Well, to start off, two or three things. There's just getting people used to using a completely different way of communicating, so there's that whole IT stuff. One of our problems was that we realised our brand-new IT server wasn't geared up for video calls so we had to

work out how to do video calls separately to the rest of our work. We also had to just -- people had to work out how to manage that whole process and we had to make sure that they had the hardware to do that. But we did -- that was okay.
However, because our work is based primarily on building trust and relationships, and as we all know, relationships built through digital are very different to ones in presence -- so we had to work with folk, saying, "How can we do this differently? How can we help folk do that differently?". And then we had to give the right hardware and access to wifi to the people we support, many of whom actually didn't have the skill set, so we also had to train them in that as well.
So I reference here -- this is a real example -- you know, somebody had got a chaotic, challenging life, with a whole series of difficulties in life, they'd got their house in Housing First just before lockdown and so they had a new support worker who was trying to build a relationship either talking through the letterbox or teaching them to use a smartphone. So, for staff, it was hugely challenging.
Q. You provide another example at paragraph 42.
A. Oh, yes. So the other one, it was an older lady whose cooker had broken and she was given a Baby Belling oven

by the council, but they wouldn't tell her -- they delivered it and left, but no instructions on how to use it. So one of my staff had to, on the phone, watch a video of to work a Baby Belling and translate that into ways that the old lady could understand it but not be present with it. So it's not like you could show her. You had to talk her through it and then make sure she'd understood it and was confident about it so she could use this new bit of kit she had so she could eat because there wasn't -- she couldn't go to the lunch club that we normally ran that she attended.
Q. And she was one of the users of a lunch club --
A. Yes.
Q. -- that you operated?
At paragraph 44 you say that it was "difficult (for staff) and emotionally draining".
A. Yes.
Q. How did the organisation deal with that?
A. So we tried to do a lot of little things like -- because a lot of this is about permission. You know, when people are in the caring service -- I don't mean to say that people who are not in the care service aren't like this -- but people who work for us tend to be passionate about what they're doing and are driven and they find it quite hard to give themselves permission to look after

themselves. So one of the things we did was just constantly say, "It's okay for you to take a half—hour break". We introduced a second half—hour break in the day. It was almost like you had to officially say to people, "It's okay to go for a walk", you know. So there was a mindset thing in there that we had to do that.

We also introduced additional support packages through, you know, online counselling and so on that people could access. We have a tool called "reflective practice", where we encourage people to talk about how they're feeling. There's a permission thing in there as well. Since COVID we've actually significantly increased that as a way of just letting stuff out because they were carrying a lot of trauma.

But I think one of the hardest things was, particularly when your way of supporting people is through relationships and its relationships where you're saying to folk, "No, you decide. You've got agency. You can believe in yourself", and then we were saying, "But, by the way, you've got to obey these rules" —— and there was a real conflict there, a tension that they had to manage, that was really, really difficult. And usually they'd be doing that in a staff team, but now we were asking them to do that on their own and that was ——

that added to the challenge that they were facing.

Q. Okay. Paragraph 46, you talk about the difficulties in accessing PPE.

A. Yes, that was —— to begin with you just couldn't get hold of it and you had this situation of —— you know, the national message was "This virus can kill you", and we were saying to staff, "But we actually need you to go into a situation and you've got an apron and a mask", and trying to reassure them, so that's a stress level. There was also contradictory messages about who could get it, so if you were Care—Inspectorate—regulated there was a route to get it, although it was quite complicated. But you would also have that situation where a service could be part Care—Inspectorate—regulated and part not, so could you get enough PPE, but it was very difficult, particularly early on, for us to get access, partly because they needed to give it to other people, like the Health Service, and we just felt we were at the back of the queue.

Q. You also —— you will have had people at the back of the queue, as you put it, who work in regulated services ——

A. Yes.

Q. —— but you would also have people who weren't working in regulated services but might well have desired PPE.

A. Yes, yes.

Q. How did you deal with that as a manager?

A. So it was really difficult because you were saying to folk, "We think there is a risk because of the virus but there is also a risk of not engaging with these folk and we need to be able to support them". So sometimes it was, "Well, you'll just have to work out how to have the conversation in a safe way because you haven't got the PPE", so you're having quite personal conversations from one end of the garden to the other, you know, and sometimes it was saying, "Well, yeah, you've got a mask and an apron so you can go into the house but only so far". And in some cases, where we eventually did get quite significant PPE, we were also going in and that —— and the PPE also was a barrier because it was how can you have a relationship because there's this thing that appears to be a threat in front of you in that space as well.

Every service is different, so we had to have different conversations with each service to work out what they felt was safe and what they were willing to do, and sometimes we had to make judgment calls about whether or not we could do something and, if we couldn't do something, we had to say, "Well, we'll have to try and do this digitally. It will be difficult but

actually that's actually less of a risk than doing it the other way".

Q. You say that during lockdown you continued to innovate, and I'm looking now at paragraph 51, where you talk about your employability programme.

A. Yeah.

Q. Tell me about that.

A. Yes, so, as we know, one of the biggest challenges was people either getting jobs or —— keeping jobs or losing jobs and needing new jobs, so we had an employability programme and we were able to move that online and get it accredited by Skills Development Scotland, which allowed us to access at that point a particular stream of funding. And because we got that accreditation, as I understand it, we were the first organisation to be able to do that and we were actually able to get people back to work and, during the first lockdown, somewhere between 35 and 40 people we got jobs. It also meant that staff in that context could do it from home. Normally that would have been done in rooms with —— in small groups. The big change was we were doing it individually rather than in small groups, which, again, was a challenge because we needed to redesign the courses so they could be done on a one—on—one basis, but oddly enough it allowed some other people who normally

couldn't have done the groups to access it because we could deliver it at different times, like twilight and so on, which we hadn't done previously. So there were swings and roundabouts with it.

Q. At paragraph 58 you talk about young people and the increase in anxiety and depression.

A. Yes. So I think this is probably the biggest problem out of COVID that we are going to face and it's going to be around for a long time. So you first of all had schools having to shift completely what they did and how they did it. You had young people having to engage in education in a completely different way. You had the limits, the digital limits, where they only had a smartphone or they didn't have the wifi or there was only one laptop between three or four siblings or there wasn't a space to do that work, so all those logistical things that were there. So we knew that young people were not engaging. We saw that through our mediation services, where we were getting more referrals, where that lack of engagement was causing stress to the family, so we were trying to help the families work through from that side of things.

But what we've seen since is the impact it had on young people and their ability to socialise and be in relationships. So you had the transition, the group

that went from primary school to high school and then that mid—teens group as well. We build up confidence to be in relationships through —— about ourselves and our ambition through the relationships we create. If you're in a situation where you don't learn how to make relationships —— that's what a lot of teenage years are about and in particular points of transition —— the impact on your own self—worth will be enormous. If you then, as a consequence, because you're struggling with that, disengage with the place where you might get those relationships and that experience, which is school, it's going to perpetuate that.

And we're now seeing, as I indicate here, young people coming to get support from us who haven't been to school for two or three years. One of my staff said to me this week —— he said, "We're getting referrals from schools about young people that the schools literally do not know because they haven't seen them for two years". So they don't know how —— they were 14 when they last saw them and now they're 16. A lot of change happens in a child's life at that space. So they don't know actually if what we're providing is what they need and that means that that is a challenge in itself.

I think the tail of COVID, by "tail", what's going to continue, will be around for a long time. Around 40%

of those people we support haven't been to school for two or three years. It used to be about 10%. There's numerous studies that have shown that attendance at school is dropping on average. It's now about 90%. When I was, as you indicated earlier, convenor of education, the average attendance was 95%. This was a trend that was happening, but it's getting much, much worse, as well as that lack of socialisation.

Q. Okay. At paragraph 62 you talk about the third sector stepping in. Why did you need to step in?

A. So the public sector was in a huge number of challenges and part of the problem with the public sector is it needs, generally speaking, to take a one—size—fits—all approach, so it had to say, "Right, everybody has to go home". I mean, that's a broad generalisation, but, generally speaking, that's where it is. So it felt like a lot of the services were being withdrawn, some mental health services, you know, the LEAP service that I referenced earlier, that stopped happening because it couldn't happen online or they didn't know how to make it happen online. A lot of mental health services, a lot of criminal justice services —— community justice services were struggling or weren't available. A lot of services for older people weren't available, as I referenced earlier, the employability services. So we

had to say, "How can we continue to support the people we're supporting without the additional support that we used to get from public sector services?". You know, homeless presentations, where you present as homeless, went online and didn't come back to face to face for months and months. So you already have a very difficult set of circumstances which are made more difficult because you need to access them digitally with tools that people are not used to using.

So we found ourselves again having to step into spaces where the public sector ... Again, I have a lot of sympathy with where the public sector is at because it's called to account in a radically different way to everybody else and that accountability means that you have to get everything right the first time and you cannot make mistakes and, as a consequence, it becomes frankly more risk—averse than it needs to be and, as a consequence, it makes choices that is about managing that risk rather than thinking about the risk to those that they are there to deliver services for. My words are not to be critical of them, I'm trying to be cognisant of the context in which they're in, but the context created a vacuum that we had to step into.

Q. I'm now looking at 81. Yes, you're talking there about putting people into hotels.

A. Yes, so this —— one of the things —— COVID was awful, it was absolutely awful, but there were things that came out of COVID that were good and I think the only way we're ever going to process this is by paying attention to both. This is one example of where things were actually —— a good outcome came. So we had to get people who were either on the streets or in congregate temporary accommodation where they couldn't be safe in the way that you could be in your house, where they weren't households or where they were sharing kitchens and sharing bathrooms, all that kind of stuff, we had to get them into safer places. Of course there was no tourists so we had hotels. So a partnership was created between the Scottish Government, the local council and five organisations, including my own, and we got 700 people into hotels across the city.

Now, what was really interesting about that was that, when we were providing support and asking to talk about what they might do when that time was over, we got a far greater level of engagement. That's because, instead of being in temporary accommodation that wasn't very nice, they were in a place where, at a point of crisis, it was actually quite nice so it felt like they were being looked after. It was en suite, they knew when the food was coming and we, who provide the

services, were coming to them rather than them having to go to others. So at the end of this we were able to say to the council, "Actually you'd get a better result by continuing this", so that continues to this day. We no longer have a night shelter in Edinburgh, nor in Glasgow. We now block—book rooms in a hotel and ——

Q. Can I take you to paragraph 82?

A. Yes, so it still exists. The Bethany Christian Trust are the ones who manage it as a collaboration. It's still funded by the council, who still —— despite the restricted financial circumstances that we're in, still realise it's a better way of spending money.

Q. It's a better way of spending money because the outcomes are better?

A. The outcomes are much better because you're able to pay attention to what people actually need. People don't —— it used to be you came out the night shelter —— you couldn't get in until 9 o'clock at night, you came out in the morning, you didn't know where you were going to get your dinner, you had three appointments on three different days —— three different days in three different places with three different groups of people, so you were going to have to retell your story and you weren't sure where you were going to sleep that night. Now they were able to say, "Well, you can stay here for

as long as you need, your dinner's coming, and the folk you need to talk to are going to come to you, and then they'll talk to each other and we'll work out a plan for you".

Now, there's a huge challenge with the housing Emergency we've got in Edinburgh so people are less able to get into temporary than they used to, but that's a separate thing. The level of engagement is significantly increased because we're paying attention to the person's needs on their terms in a place of dignity. If we do those basic human things, we get good results. In some ways it seems blindingly obvious and it's a pity it took a pandemic to get us there, but we have got there, and this is a good example of something we haven't lost. I'm kind of laying it on thick, but I want us to make sure that we hear that loud and clear, that there are good things that we need to keep here and hang on to because the human outcomes are really positive as a consequence.

Q. Does that form part of the Public Health approach to homelessness?

A. Absolutely, because if you grab folk at that point and they get into a better place, they are less likely to be traumatised by the experience of homelessness. So one of the other interesting numbers —— and it references

the number that I removed previously —— is that in last year, 50% of the people who presented at the Welcome Hub had never used homelessness services before. Now, there's a whole number of drivers for that, economic drivers for that, but if —— often people end up in homelessness for Poverty or trauma, but actually my staff are now saying that they're now dealing with people who are traumatised by the experience of becoming homeless.

Now, if we can grab that early, we can get that at a point of intervention where we can lessen the impact of that and people are more likely to recover well from that difficult set of experiences. We need to understand the journey from exclusion to inclusion is always primarily an inner journey. If you get to that point of crisis, you feel hellish about yourself and your recovery starts in there, and us engaging with people in a way that pays attention to that, which the hub does, means it's going to be more effective.

Q. The next main section in your statement is about guidance and policy. The guidance and policy evidence that we've heard so far from organisations such as yours might be summarised by saying, "It changed very frequently and it wasn't designed specifically for us".

A. I think that would be a very accurate and diplomatic

description.
Q. Do you need to say anything else about it?
A. It was really hard to know where to start. I mean, I could watch the things on the telly and so on, but it felt like there wasn't an understanding of what we were endeavouring to do. Of course we were running at full capacity so we were also dependent on folk like SCVO and CCPS to do stuff, and both SCVO and CCPS, SCVO in particular, distilled it well so we used their website a lot. But, no, it was really, really hard.
Of course, as I referenced earlier, if you're saying to folk who live chaotic lives, who struggle with rules as it is, "Actually you've now got to start obeying rules", where I used to say, "Actually, you can make the decisions and we will support you", and then those rules keep changing, it just gets worse and worse, so ——
Q. You also provide familiar evidence in relation to PPE ——
A. Yes.
Q. —— about the difficulties that third sector organisations had accessing it. I'm not asking about that. What I am asking about is something that I haven't seen before, and that is, when you get the PPE and you've used it, you're not given advice about disposal.
A. No, no, not at all, or when we did, it was completely

contradictory.
Q. Contradictory from where?
A. Well, sometimes you got different instructions from the provider as opposed to the public sector or the Government advice. So we were often struggling to work out where it was to go and how it was to be disposed of and how much was our responsibility and how much we had to make sure to give to other people for it to be their responsibility.
Q. You bring things up to date at paragraph 118. Can you say something about that?
A. So the number of people sleeping rough during the first lockdown in this city was small single digit —— never happened before. And actually, for the rest of that year, out of the first lockdown, into the second lockdown and going forward, those numbers stayed really, really low. One of the reasons for that was the collaborative effort that was made with the council, getting folk into hotels and all that kind of stuff that I've referenced earlier, and that's good and people should be pleased about that.
One of the other reasons for that was because Public Health regulations trumped immigration regulations. People who had no recourse to public funds could get accommodation. So there was a period of time

when there was several hundred people in accommodation that normally would not have been able to access that accommodation, and a number of organisations, my own included, spent a lot of time —— and the council too, to their credit —— then engaging with people in accommodation that they wouldn't have otherwise —— but, as I referenced earlier, that's sometimes taken out of context for a different type of conversation —— to work out what they were going to do next because you had a space and time to do that. You had a context. The Public Health regulations came into context for a different type of conversation. And we were able to help people actually get a status because they didn't know they could or, in some cases, actually get people eventually voluntary repatriated because actually they were able to do that. Part of the problem was they didn't know how to do that, things having gone not as they hoped when they came to this country.
Those regulations have ended and, as the economy has got much worse, as we know —— and I referenced earlier the number of people who have experienced homelessness for the first time —— the numbers on the streets are back up at the three—digit level, 100/125, and about half of them would be —— fall into that, people with no recourse to public funds who previously we had in

a context in which we had conversations. Now, it's a very complex area that I could spend a lot of time on, but just to see the difference when you have a context for a conversation that you don't have now.
Q. I want to ask you about a couple of other distinct areas of work. I'm looking now at 132 and the information about the visitors' centre that you run at Addiewell.
A. Yes.
Q. We've heard evidence both from the Prison Officers Association and from SPS about visits, so we know. But I'm interested in why the Cyrenians are so involved in the family visitors' centre and I think you answer that at the end of paragraph 132.
A. So we know that families —— people who are in prison, if they are visited by whatever they call family on a regular basis, they are six times less likely to re—offend. That is rock—solid research that's been reviewed and reviewed. So we're part of the Prison Visitor Centre Network because we know that, if we can support those families, they would be less likely to re—offend and therefore less likely —— more likely to make wiser decisions which means homelessness is less likely. It's also a place we can engage with families because the demographic of families who end up with somebody in prison largely —— not entirely but

largely —— falls into those areas where people are experiencing poverty and other forms of discrimination and exclusion. You just can see from the SIMD data that that's the case. So it gives us the opportunity to engage with whole families in provision of support at a point at which they're looking for help, so it allows us to be in that space and that's why we're part of that network.

Q. Tell us about the Randolph Crescent Centre.

A. The Randolph Crescent Centre was a really interesting thing in terms of the changes it offered. So the Randolph Crescent Centre was normally used for the LEAP —— part of the LEAP programme I referenced earlier. Because the LEAP programme was shut down, it was empty, and at the time we thought that we need a space for people who have —— who are homeless, who have COVID and need to isolate but don't have accommodation in which they can isolate. So we said we would create something like that and the Government funded that. And that was good. One of those funds I referenced earlier, it was —— we went with a short proposal, they said, "That sounds really good. Crack on with it". So that was an example of what I was talking about previously, and we're talking significant sums of money to put this together because it was a 24—hour programme that needed

to be put in place. And we were able to turn it round really quickly and we got the building because it was a council building —— the access quickly.

Now, actually there weren't many people who fell into that category of presenting as homeless with symptoms, partly because of the other thing we'd done, which is get people into hotels, because the other really amazing thing about that period of time, the first lockdown, those 700 people who were in hotels, there was not one case of COVID in all that period of time.

However, there was a requirement for people who needed to get emergency accommodation because at that point we didn't have the Welcome Hub. So we shifted what was required because we saw that demand —— that need that actually we thought was there isn't there, but there's another need that this could provide, and we said to the funder, the Scottish Government, "We think this —— we could shift", and they said "Yes" really quickly; again an example of paying attention to what's happening, rather than saying, "This is success and, if you don't get that, it's a failure". So between July and September we supported 77 people who otherwise would have been, again, on the streets.

Q. I've almost finished, I've just more thing that I want

to ask you about, and that's something that you talk about at 156, where you talk about shifting your employability away from adults and into children and then a particular example you provided.

A. Yeah. So we were asked by CAMHS, the Children and Adolescent Mental Health Service, to see if we could engage with a group of people who were on their list, and the numbers had increased on their list, and that was the key thing on the data. So that was young people with eating disorders had gone up by 200%. Now, the assumption is —— I'm not an expert in these matters, but the assumption is this is that group of people we were referring to earlier, a high level of anxiety, the one thing they can control is the food they put into themselves, so there appears to be a connection with those things. So we'd been asked to —— we work with that group as part of our Creative Natives programme, which is a programme for people using the creative arts to get them back on to a pathway that will help them get into a space —— a better space and a better set of decisions.

It's also an attempt to engage again earlier than a clinical service, which is what CAMHS is, because, you know, it's a four—year waiting list for CAMHS in Edinburgh. There's a whole bunch of people that

actually, if we can get engaged with them and find out what they really need, we might be able to sort it before they get to the clinical bit, which in itself is a challenging process. This has proven to be very successful as a result of that and we were able to build on something we were already doing to provide that resource as a ——

Q. Now, as is traditional, the final part of your report talks about lessons learned and hopes for the Inquiry. I think all of the lessons that you want learned you've already referred to and that also deals with hopes for the Inquiry. I would also say that those sections are particularly closely looked at before any conclusions are drawn.

Those are all the questions I have for you. Is there anything important that I've not addressed?

A. So I think the one thing that I'd want to say is about how the third sector is treated as a participant in how we make decisions as a society. So we were able to step up at this point and say, "Here's the things that we need to do to get through this", and we've learnt a lot of stuff from that. Then we were asked to —— well, we asked —— they were talking about, "How do we get out of this politically?", and there was the Advisory Group on Economic Recovery and so on, and we were asked to give

information and to evidence that. We met with the chair, we put in a submission. That document came out, it was supposed to be the pathway out of COVID for Scotland, and there was not one reference to the third sector in that entire document. Not one reference.
Q. Do you need to say any more?
A. I don't think I do in many ways. Just there are three —— there's the public sector, there's the business sector and there's the third sector, and I would like our voice to be heard as a result of this, as a consequence.
Q. Thank you very much indeed. I don't have anything further for you.
A. Thank you.
MR CASKIE: Thank you for your help.
A. Thanks a lot.
THE CHAIR: Yes, thank you, Mr Aitken. Very good. I think we can start at 3.15 with the last witness. Thank you very much.
MR CASKIE: Thank you, my Lord.
(2.59 pm)
(A short break)
(3.14 pm)
MR GALE: My Lord, the next and final witness today is Jennifer Ewen.

MS JENNIFER EWEN (called)
THE CHAIR: Good afternoon, Ms Ewen.
A. Good afternoon.
Questions by MR GALE
MR GALE: Ms Ewen —— it's Jennifer Ewen, isn't it?
A. Yes.
Q. You've provided the Inquiry with a detailed statement. The reference for that is SCI—WT0062—000001. I think you're agreeable that that statement be published and that the evidence you give today will form your evidence to this Inquiry?
A. Yes.
Q. You're here as the director of adult and community services for Voluntary Services Aberdeen?
A. That's right, yes.
Q. You tell us at paragraph 27 of your statement that that's a role that you've held for nine years ——
A. Yes.
Q. —— albeit that you've been employed by that organisation for 28 years.
A. Yes.
Q. I think that organisation is a registered charity.
A. Yes.
Q. You do tell us a little bit about —— we'll call it "VSA" for shortened purposes —— tell us a bit about its

structure at paragraphs 10 and following of your statement.
We can see that VSA is an organisation that's been in existence since 1870 ——
A. Yes.
Q. —— and, as such, it's one of the oldest social care charities in Scotland.
A. Yes.
Q. It's important obviously to note that you now cover supported services to all ages in the Aberdeen locality across four core areas. Can you tell us about those, please?
A. Yes, so as well as my directorate, which is adult and community services, we also have a director of children and family services, so we support children and families in residential schools for children with additional support needs. We also have placements for adults with learning disabilities on a working farm and supported accommodation. We support adults with mental health diagnosis and older adults in residential care homes and very sheltered housing services as well.
Q. How many residential care homes do you have?
A. We have two for older adults and we have more for adults with a mental health diagnosis as well.
Q. I think you also have support accommodation as well.

A. Yes.
Q. Now, your support for children and young people will be considered by my colleagues in the other —— one of the other portfolio teams, but for my purposes and for today I'm going to concentrate on the adult services that you provide.
A. Yes.
Q. I think at paragraph 15 we can see that, as you've already alluded to, that includes people who have dementia, people who have poor mental health and learning difficulties.
A. That's right, yes.
Q. I think you also provide support for those with addiction problems.
A. Yes, people that are in recovery from addiction, yes.
Q. Do those addiction problems cover both alcohol and drug use?
A. Yes.
Q. I think geographically you are centred in the city of Aberdeen.
A. We're centred in the city. We recently were awarded the contract for carer services in Aberdeenshire.
Q. What has that —— has that involved in a widening of your services geographically or has it involved greater pressure on the services that you already offer?

A. Well, for the carer services, we only took over that contract on 1 April this year, yes.
Q. So a little early?
A. A little early, yes.
Q. You do provide us with some information regarding the financial impact on your organisation of the pandemic, and that's at paragraph 20 and following of your statement. It may be that my colleagues in Portfolio 2 will be discussing that further with you, but just for present purposes, I think we can note that in February your trustees approved —— this is February of 2020 —— your trustees approved the designation of £750,000 to cover PPE and other infection control measures.
A. Yes.
Q. Now, that was very early in the pandemic?
A. Yeah.
Q. Could you explain why you were able to do that?
A. So I suppose as our EMT or executive team under our board of trustees, we were sort of keeping an eye on the news, I suppose, and part of our business continuity plan, we try and prepare in advance as much as we can. So, you know, to prepare for the readiness of the pandemic, I suppose we were quite early in securing PPE for our services. We have 13 registered services and hundreds of service users, so we knew that we would need

a vast amount of PPE, so we purchased that early on, I suppose.
Q. And you were able to anticipate that?
A. Yes, and sort of pre—pandemic and during the pandemic and after, we always had a three—month supply of PPE in hand.
Q. Yes. I was going to come to that and I'm grateful to you for mentioning it. You as an organisation —— I think you have a large building in which you can accommodate that amount of PPE and it was your tradition to have at least three months' supply of PPE that you thought you would need ——
A. Yes.
Q. —— in storage, as it were?
A. Yes, so we have an activity centre which, pre—pandemic, was used for activities for older adults but obviously during lockdown and during the pandemic it couldn't be used for that purpose, so we used it to —— for storage for PPE and then we started using it actually as a testing centre, so staff and family members could come and get tested before visiting services and working there. So that took a lot of stress off the managers and seniors in the services. They weren't having to do any PCR testing. We could do all that from one site and we dedicated staff to that as well.

Q. You've also told us in your statement —— I'm just going to take this very briefly —— about the financial impact on your organisation of the pandemic. You tell us that, over the course of the pandemic, your organisation incurred a total additional cost of about £3.7 million.
A. Yeah. I mean, that statement there actually comes from our chief financial officer, so yeah.
Q. And I think 50% of that was associated with staffing and agency costs which were needed to cover COVID sickness and also isolation and also protection measures associated with attending to residents who had to isolate in their own homes.
A. Yeah, so again a lot of that was preparation in readiness for that. So we quite early on —— we work with a nursing agency and we've agreed to a relationship with them, so we block—booked agency staff, one, to cover for any sickness absence during the pandemic, but, two, that we could also get the same staff coming to the same services as well, so that meant there was less staff coming in and out of the building, it wasn't different agency staff every day, but also for continuity of care for our service users, it's helpful for them if they've got the same staff coming in. So we block—booked for three months at a time the same set of agency staff to come to services.

Q. Just completing the financial impact, I think you were able to recover —— the figure is £2.369 million, but you were left with just short of £1 million that was irrecoverable?
A. Yes.
Q. You've mentioned staffing. Can I ask you a little bit more about this? One of the areas that you were able to —— as well as your agency agreement, one of the areas you were able to rely on, I suppose, was that there was obviously an adverse impact on the hospitality sector ——
A. Yeah.
Q. —— in Aberdeen as a result of the pandemic and, as a result of that, the pool of available workers was increased.
A. Yeah, so I think we're —— health and social care recruitment has been a real struggle, even pre—pandemic, over the last few years, but when hospitality sectors were closing or putting their staff into furlough, I suppose we benefitted from getting those staff into the health and social care sector. There are pros and cons to that. I suppose a lot of those staff had never thought of a career in health and social care before so we kept some of those staff after, following the pandemic, but then the downside was a lot of staff did return to those sectors, so yeah.

Q. I think, as you say, that influx of staff did fall off as the pandemic ended.
A. Yeah.
Q. And I think one of the other things that you observed was that —— I think this is at paragraph 65. It's not necessary to look at it, but for the reference it's 65 —— you found that a lot of people were burnt out, as you put it. Could you give a little explanation of that, please?
A. Yeah. I think during the pandemic we found that there wasn't a lot of leavers. There was, as I stated there, quite a healthy retention of staff. I felt like staffing felt that we were all in this together and there weren't a lot of leavers during that time. We found it was post—pandemic when —— I suppose reflecting on what the front—line staff had been through, that's when we noticed the most burnout of staff. I mean, it was a really stressful time for them, trying to keep themselves safe and their family and look after the people we support as well.
Q. Obviously we can perhaps understand and perhaps to a certain extent speculate on what burnout is ——
A. Yeah.
Q. —— but was it your experience that there was an impact on staff morale and/or concern about staff well—being

and their mental health?
A. Yeah. I mean, we've always had a dedicated occupational health department anyway, but during the pandemic and following, to this day, we offered our staff access to counselling services and there was a lot higher of a take—up during and post pandemic and a lot of staff going off with either work—related stress or mental health issues.
Q. Have you experienced much in the way of long COVID impacting on your ——
A. There's been a few cases, yeah.
Q. Now, I think interestingly you tell us that, almost coincidental with the first lockdown in the UK, you were flying out.
A. Yes. So actually on 20 March I flew out to Jamaica and arrived there and actually the flight I was on, someone on that flight took COVID into Jamaica and it was all over social media, you know, if you were on flight BA whatever it was, and I thought, "Oh, God, that was my plane", yes —— so, yes, and I found myself stuck there for four and a half months. And, you know, people say, "Well, lucky you", but it was quite stressful not knowing when I was going to get back.
Q. I think you say at —— you tell us about that at paragraph 89 of your statement. I think at paragraph 97

you make the observation, which is obviously interesting, that when you returned it was like coming back to a totally different world.
A. Absolutely. Obviously I hadn't experienced anything in Aberdeen at that time until returning during the pandemic and just everything seemed to have changed. There was hardly any cars on the roads. You know, my employer had to give me validation that I was a front—line worker and I could actually leave my house to go out and support people. The shopping was totally different. Yeah, so it was like a totally different world.
Q. What engagement did you have or were you able to have with VSA while you were in Jamaica? Were you able to do any work or ——
A. Yeah, yeah. Yeah.
Q. And how difficult was that?
A. For me, personally, it was really difficult because, you know, obviously I'm the director of quite a lot of services and I did feel —— there was a level of guilt that staff back home were going through this really traumatic period and I was stuck there in Jamaica. And although I could give support over the phone, it's not the same as actually physically being there, so I do carry a bit of guilt around that.

Q. Four and a half months?
A. Yeah.
Q. Why so long?
A. There were just no flights back. Jamaica was in lockdown so there were no flights going in and out. They eventually put on special flights for people to get back to the UK.
Q. Okay. Now, can I divert slightly off to ask you a little bit about testing ——
A. Hmm—hmm.
Q. —— which you do tell us about. You do this at paragraphs 106 to 108 of your statement. This obviously is from your knowledge once you'd come back.
A. Hmm—hmm.
Q. You tell us about the testing regime that your organisation set up for both members of staff and also for other service users.
A. Visitors —— yeah, visitors of ——
Q. Visitors, I'm sorry.
That was done in your own accommodation, as I understand.
A. Yes.
Q. Was this the big room that you ——
A. It was the big hall we have in the activity centre, so rather than each service having to test all their staff

every week and test visitors before each visit, we did it in that centre, which took, as I said previously, all the pressure off the managers and team leaders from having to —— they were busy enough, you know, trying to stick to all the guidance and support people as best they can without testing staff every week and testing visitors every time they came in. So we seconded two staff full—time to do all the testing for the whole agency and for visitors.

Q. I probably should have asked you this. How many staff do you employ?

A. It's over 500.

Q. Right.

A. Yeah.

Q. And I think what you've indicated is that staff required to be tested three times a week with a lateral flow test.

A. There was —— yeah, twice a week with the lateral flow and then once a week for the PCR, depending on which place they worked in. It was different for each case.

Q. I wonder, when did you institute that? Can you remember approximately?

A. It was quite early on because we just thought this was a lot of added stress for managers and team leaders on each site, so we thought, "We've got this hall that

we're not using, not able to use, so let's use it for this purpose". So quite early on, yeah.

Q. As you indicated, you had a dedicated team ——

A. Yeah.

Q. —— who were carrying out the testing?

A. So two carrying out the testing. We also had an admin worker who would liaise with the visitors and book in all the visits as well because they had to be timed so you didn't have lots of visitors turning up to one service at any one time.

Q. Can I just ask you a little bit about what the arrangements were for visitors? Can you indicate what category of visitors you were testing and why you were testing them —— it may be obvious —— and how frequently that was done?

A. Yeah, so it was predominantly for our older adult services, so two care homes and two very sheltered housing. They tend to get the most visitors anyway. So the visitors would book a test with us at the testing centre, get tested and then they would head to whichever service they were visiting and the admin person would book that visit into each service, let the service know the person had tested negative —— hopefully —— and then they would go and do their visit with their loved one.

Q. You've mentioned that there was at least one person

associated with or in charge of the admin work that was ——

A. Hmm—hmm.

Q. Was that quite a considerable amount of work that was required? Perhaps you could just explain to us what that person would be doing.

A. Yes. So they booked in all the testing, they organised the visits, liaised with the services themselves as to visits, but also we had to record all the results of the testing as well, and for the PCR testing, all the specimens had to be gathered and then taken to the doctor's surgery at the end of each day as well for processing, for the PCR tests.

Q. It's again probably an obvious question, but if a member of staff failed one of these tests, what was the consequence of that?

A. Well, they just had to go right home because they couldn't obviously work in the service if they were positive.

Q. And that would put a burden on your staffing level and presumably on your need to access alternative staff?

A. Yes, so that's why our line(?) kind of block—booked the agency staff, so we were always kind of over the safe staffing level, so if anybody did test positive, we'd have a bit of contingency there with our staffing.

Q. One might think, from what you've said first of all about the amount of PPE that you had in stock and also the block—booking of agency staff, that you were in perhaps an advantageous position in the amount of preparation you had in place for the pandemic.

A. Yes.

Q. Would that be correct?

A. Yes.

Q. Can I ask why you were in that beneficial situation?

A. I think VSA have got a really robust business continuity plan which we've always had, even pre—pandemic, so that deals with critical incidents to minor incidents. Anything that will affect service delivery is in this plan and it's constantly reviewed. So we're always looking at the horizon to say, "Right, what could affect the business?", and I think we're pretty well prepared for any eventuality.

Q. Was one of those eventualities the possibility of a pandemic?

A. Yes.

Q. Right. Now, just on the question of PPE, you've told us that you had a three—month supply of PPE for the 12 services that you provided, and I think inherent in that is that, because you provide a variety of services, then you needed a variety of PPE.

A. Yes.
Q. That put you —— probably you can infer from my earlier question —— that probably put you in a more advantageous position than other care providers, and I think at paragraph 117 you say that you think that some other care providers left it too late to source large quantities of PPE.
A. Yeah, I mean, obviously I can't speak for other providers, but I think being well prepared was —— certainly left us at an advantage. You know, we did have some providers that we helped out with PPE as well, people that were struggling.
Q. You also mention that your organisation was impacted financially in this context —— that's paragraph 119 —— because, as you put it, manufacturers predictably put up their prices.
A. Yes.
Q. On that regard, while we may say it's market demand, do you feel that you were being taken advantage of?
A. I think it's wrong that people were benefitting financially from a pandemic, yes. That's a personal opinion.
Q. Yes. And I think also you were able, as you've just said, to provide support for other care providers because of the preparations that you put in place.

A. Yes.
Q. Were those other providers within the —— you don't need to name them but were those other providers within the same locality or ——
A. Yes, so we —— yes.
Q. Can I just ask you a little bit about the provision of PPE to service users?
A. Hmm—hmm.
Q. Obviously we know from what you've told us that your service users were across the board of individuals and would include people suffering from dementia.
A. Yes.
Q. Was that a particular challenge in communicating with such a person, particularly if it had to be insisted that they wore some PPE?
A. Yeah, it was really difficult, I suppose predominantly for our care at home service, where we had staff going into people's houses ——
Q. Yes.
A. —— because obviously, you know, we couldn't insist on any kind of standard of cleanliness in people's own houses. It can be really hard for people with dementia even knowing what PPE was or masks and things and it made communication a lot harder as well, you know, for people we support who might lip—read support workers ——

you know, they couldn't do that anymore because staff had masks on and aprons and so on, so, yes, it was really difficult —— or getting them to correctly wear the PPE was really difficult as well. Sometimes it was difficult to get staff to correctly wear PPE let alone people with support, so yes.
Q. Similarly I suppose it was also difficult not just for lip—reading but also expressing by being able to see somebody's mouth and a smile, for example, pleasure ——
A. Yeah.
Q. —— and enjoyment or perhaps criticism even through the expression on somebody's face. That couldn't be done?
A. Absolutely, but, you know, we've got some elderly service users who are non—verbal so you're relying on facial expressions, even to be aware if someone is in pain or not, so, you know, that did add a difficulty if people were wearing masks.
Q. For those who weren't suffering from dementia or perhaps some other impairment, was it easier to ensure that they wore PPE?
A. Some people were quite happy to wear it and sort of were glad that we were supplying people —— service users with PPE. For others, they didn't understand why they had to wear it or point blank refused to wear it.
Q. I think probably —— and it's something you mention in

your statement —— some of the people that you provide services for are people who have perhaps somewhat chaotic lifestyles.
A. Yes.
Q. Was that a particular area of difficulty?
A. It could be, yeah, for our younger people we support with a mental health diagnosis and perhaps a dual diagnosis, where they're in recovery or they're actively using drugs or alcohol, and they were going out into the community, even in lockdown —— you know, we can't keep people inside. You know, we don't have locked units. So they were free to come and go, and even though the country was in lockdown, if they were going out, our difficulty was we didn't know where they'd been, who they were associating with, you know, so I suppose coming back and putting staff and other service users at risk because we didn't know where they'd been and they probably weren't sticking to any guidelines.
Q. Is that inherently —— let me put it this way —— risky for your own staff?
A. Yes.
Q. And how did you cope with that?
A. I think it's just giving constant reassurance to staff and making sure that they did have PPE and we could protect them as much as possible. But, you know,

there's also a risk in working in an older people's care home where people were contracting COVID and staff were working during that time as well.
Q. Did you have any kick-back from any of your staff about that situation?
A. Actually, no. We were very, very lucky. I think staff were really conscious of the fact that a lot of our service users weren't getting to see families for quite long periods of time so they were happy to come in and provide that service to service users.
Q. A point you make in paragraph 125 of your statement is that none of your homes is a nursing home --
A. No.
Q. -- and that, as a consequence, prior to the pandemic staff wore their own clothes in the home.
A. Yes.
Q. Once the pandemic struck, however, everybody who was a member of staff wore scrubs?
A. Yes.
Q. And I think that's something that continued?
A. It has. Staff have actually chosen to remain wearing the scrubs and actually our service users, especially some of our service users with dementia, find it easier to identify the staff now that they're in a uniform rather than in their own clothes, so yeah.

Q. Can we turn on to another matter that you address? At paragraphs 133 and 134 of your statement you say -- and I'm summarising -- that the greatest impact on the people that the organisation supported was the denial of visitors.
A. Yes.
Q. Obviously this is something -- if you've been following our hearings, this is something that the Inquiry has heard a lot about, particularly from the viewpoint of those who were the relatives of --
A. Yes.
Q. -- persons within care homes. There's two matters I'd like to ask you about from the perspective of someone in charge of an organisation providing residential care. Firstly -- and again this is something that we've heard about from several witnesses, and that's a constant and rapid change to guidance.
A. Yes.
Q. You make this point at paragraph 136 and I think you say that it was difficult for you and your managers to provide any level of consistency. Now, obviously there are various people that you would have to convey the guidance and its implications to. One would obviously be to your managers and to your staff.
A. Yes.

Q. Others would be to the service users themselves and, where appropriate, to visitors to the service users.
A. Yes.
Q. So with the, as you put it, conflicting advice, can you explain how difficult that conflicting advice made the situation for you? Perhaps just in that context, perhaps you could explain where conflicting advice may have been coming from.
A. Yes. So we were obviously getting advice from lots of different organisations, so whether that be the Care Inspectorate, Public Health, local authorities or Government, and because we run a variety of services as well, it was trying to look at that guidance and see what was the best fit for each service. There was quite a lot of guidance for older people's care homes but our mental health services, some of those are registered as a care home as well, so that guidance was meant for all care homes but didn't really fit with a younger client group.
And you had families looking at that guidance and I suppose it's different interpretations for different people. So, you know, if we were saying something, families would say, "Well, that's not what the Government is saying", and we were saying, "Well, this is what we feel it is saying", and I feel like in quite

a lot of occasions, visitors' families were saying, "You're just trying to stop us from coming in to see our loved ones". So providers were kind of getting the brunt of -- I think they thought organisations were just keeping them out and actually not that we were following guidance to protect everyone as best as we could.
Q. Talking about conflicting guidance, did that problem that you just identified put you into conflict particularly with visitors and family members?
A. Yes, it could. Families were really angry and, although their anger was directed at us, I think if they reflected back it probably wasn't at us, it was at whoever was coming up with the guidance, but we were front-facing, so yes.
Q. I think we've heard people operating care homes and other institutions being described as the "gatekeepers".
A. Yes.
Q. Is that something you recognise?
A. Pretty accurate, yeah.
Q. Paragraph 80 of your statement, you do tell us, in relation to the conflicting advice, that this led you to having, as you put it, to strike a balance between I suppose two interpretations or possibly more than two interpretations of that conflicting advice, and just taking it a little further, you mention, if possible,

not being too risk-averse. Can you give us a little context to all that, please?
A. Yes, I think, as I said before, there was a lot of guidance about care homes for older adults and we've got two residential care homes for older adults but we've also got two very sheltered housing complexes, which are pretty near the care homes, and the client group is not that different. And because we had visitors coming to the testing centre to get tested, they would speak to each other, so you had to strike a balance between -- you couldn't have, "Right, we're following the guidance for this care home but we're not going to do it for the very sheltered housing", because -- in theory we could have probably said, "Right, visitors can go into the very sheltered housing, they just can't go into the care homes", which wasn't really fair. So we had to strike a balance between, I suppose looking at some kind of risk/benefit analysis, what was the best for the people we support.
Q. You've told us a little earlier in your statement about the structure of VSA and that you have a board of trustees.
A. Yes.
Q. I think you do actually say that perhaps the board of trustees were more risk-averse than perhaps you might

have been. I don't want to put you in a difficult position, but would that be correct?
A. Yeah, I suppose I'm employed to take some of that risk and make decisions for service provision so they're relying on me to make the right call, the right judgment, so yes.
Q. One of the things, quite interestingly, you do mention is that, when construing the advice, you had to be mindful that it was possible -- and I'm quoting from you here. It's paragraph 80 -- that you might have to stand up in court "and justify why I made a decision, then I had to be content with that".
A. Yeah.
Q. Can you just explain why that was in your mind?
A. I think because there was so much conflicting guidance from different regulatory bodies. You know, there wasn't just, "This is what you must do". So you're interpreting the guidance, you know, you're speaking to your peers and they're maybe interpreting it differently to you as well, so at some point you've got to make a decision based on what you think is best for the person you're supporting. And I suppose, for me personally, like I said, if I think I'm making the right decision for that person and I can justify that, then, you know, that's something I'd be content with.

Q. To a certain extent, the buck fell with you?
A. I think for all managers of care services, yes, especially when there was threats at times of, "You might have to stand in court if someone has passed away due to COVID", yeah.
Q. Did you have any deaths from COVID within --
A. We had one.
Q. Was that in --
A. It was in a very sheltered housing complex, yeah.
Q. I think again, interestingly, you said that the trustees were looking for peace of mind and that you were dealing with things correctly.
A. Yes.
Q. Again something we've heard -- and I think we heard this as I was listening to the evidence of the witness who has just given evidence from Cyrenians -- what you say at paragraph 113 of your statement is that the same guidance did not necessarily fit all of your services.
A. No.
Q. Can you explain that?
A. Yeah, so the guidance was predominantly for older people's care homes and, like I say, we have registered care homes but they're not for older people, but they are registered with the Care Inspectorate as a care home but you could have people in there from 18 up to 60-odd,

so the guidance for an older person over 55 had to fit a younger client group as well, so that was really difficult. And adding in that that younger client group also have enduring mental health problems made it really difficult.
Q. Yes. Did you feel -- again I'm asking for your opinion on this -- that it was either an error or a -- well, a mistake to have a system of guidance that was not in some way specific to the type of services that were being offered?
A. Yeah. I think obviously there was a lot of scrutiny in older people's care homes, but I think it should have been taken into consideration the vast amount of services that providers support people with, from children to outreach services to care at home, and it did seem to be a focus on care homes.
Q. Yes. The second matter I'd like to ask you just about guidance is the communication of it. Now, first of all, who are you communicating with in the sense of those who are providing the guidance? Obviously we've heard quite a lot about it coming from various sources and that's perhaps inherent in some of the problems of it being conflicting. So who are you getting your guidance from, if I can put it that way?
A. Yeah, so obviously we were getting things sent through

from Government to care home managers, but our local Public Health nursing team set up weekly Teams meetings with providers across Aberdeen City and all care home managers were invited to that. So we would get information direct from Public Health and their interpretation of the guidance.

Q. Is this what you refer to at -- I think it's at paragraph 167 where you're talking about the Health and Social Care Partnership.

A. No, that's --

Q. That's something different?

A. Yeah.

Q. Okay, we'll come to that in a little then. One of the points you make subsequently in your statement in relation to the lessons to be learned is that you personally and your organisation were not, as it were, consulted on the guidance.

A. No.

Q. Do you feel you should have been?

A. I think from the point of view that VSA does deliver lots of different types of services, yeah, and obviously each provider has got their own area of expertise, whether that be addictions, learning disabilities, Cyrenians for homeless and things, so, yeah, I think the Government could have benefitted from partnership

working in relation to guidance, yeah.

Q. Do you know if any sort of partnership working was done with Government at that time?

A. I think for CCPS, yes, so people speaking on behalf of the third sector, yes.

Q. Just going back to the guidance, providing guidance to your staff, how did you actually do that? How frequently were you having to give guidance to your staff, particularly if guidance was changing?

A. Sometimes it could be several times a week. You know, it was changing so rapidly at times. So I would convey it to my managers and they would take that to their teams and then, obviously, we've got a marketing department as well, so they were tasked with putting out communications to families as well because they obviously needed to be updated every time the guidance changed as well.

Q. Also communicating with families --

A. Hmm-hmm.

Q. -- I think at paragraph 138 you talk about that and you say it was appreciated --

A. Yeah.

Q. -- if you were providing your interpretation of the guidance to families. Would that be even if it was restrictive of their entitlement to visit their

relatives?

A. I think so. I think they appreciated that we were keeping in touch with them, so whether that -- every time guidance changed, we would write out to family members and, as I refer to in this statement, we also had Zoom calls with family members as well, and we adapted that to be mornings, afternoons and late at night, so people could attend that were still working during that time. But I think, you know, like I said earlier, they might have interpreted guidance differently from us, so just that explanation of, "This is what it means for us as a provider", kind of gave them a bit of reassurance that it wasn't just VSA saying, "No, you can't visit". It was, "This is why".

Q. I think at paragraph 161 you say that there could be difficult conversations with family members.

A. Yeah, I think in particular people who were on palliative care and end-of-life care -- having to say to those people, "You can't come in and spend that last time with your loved one", was really difficult, yeah.

Q. I think that's something you give a fairly forthright opinion on at the end of your statement, and we'll come to that --

A. Yeah.

Q. -- in a moment. Now, one of the things you did manage

to do throughout the pandemic is that you were able to keep your services running.

A. Yes.

Q. Was that -- one of the things I've obviously noticed in what you've said is that, because of the services and the range of services you offer, you were effectively always full.

A. Yes.

Q. And how much of a demand was it on you, both personally and on your organisation, to keep services going throughout the pandemic?

A. I think -- I mean, there's always been a high demand for our services anyway. That didn't really change pre or post pandemic and we always operate pretty much at full capacity. The staff -- I think because we were so well prepared with staffing and PPE, we managed to deliver our services to the same high quality as we always have done.

Q. Now, you tell us a little bit at paragraphs 153 and following about what you've termed as "Disaster Planning Strategies".

A. Yes.

Q. You've touched on this a little bit and you've said:

"... VSA have always had a robust disaster management plan in place, for pandemics or

major fires ... "

Now, I've also noted in your statement that you go back to your work in a psychiatric hospital ——

A. Yeah.

Q. —— presumably in Aberdeen at the time of the Piper Alpha disaster.

A. Yes.

Q. Can you just tell us, in relation to pandemic preparations, what did you particularly have in mind?

A. I think —— I mean, we had pandemic as part of our disaster planning, but I suppose in our minds we were referring to a major outbreak of norovirus or —— the things that hit care homes quite regularly. Nobody could have predicted a pandemic, I suppose.

But it's just making sure that we've got plans in place for any eventuality and, in the past, we have had fires. We do support people with mental health issues that smoke indoors when they're not supposed to or light candles. We've had floods. We have really robust sprinkler systems and things in place for our care homes in case of fire, but we had an incident where somebody threw a bunch of keys and it knocked the sprinkler and flooded the whole building. But we're always kind of prepared for, I would say, pretty much every eventuality and we do hold regular table—top exercises of that

disaster plan and regularly train staff so that everybody knows. And we've got flow charts in every service, so if something happens, this is the process.

Q. Since the pandemic, have you updated your strategies to take account of what has happened in the pandemic?

A. Yeah, it's a document that —— I suppose it's a live document, so it's always under review, yes.

Q. And I think I've asked you if you would be good enough to share that with the Inquiry and you've indicated that you will.

A. Absolutely, yes.

Q. Just a couple of other matters and something that I referred to I think erroneously earlier. You talk about guidance and policy notification, paragraphs 167 and following, and you say that the Health and Social Care Partnership set up a group called "Provider Escalations".

A. Yes.

Q. Can you tell us a little bit about that and in particular whether it was geographically confined to Aberdeen?

A. So, yeah, this was an Aberdeen City group and they do actually still meet. So they meet over Teams and it's a group of senior staff or managers, and it's not just —— there's a residential Provider Escalations group

and a non—residential for supported living groups, and during the pandemic personally I thought it was a really good peer support group for other people that were going through the same thing and, you know, we would speak about guidance, we would speak about any difficulties we were having, and it was really a very supportive environment for other care home managers.

Q. Do you know if such groups were rolled out beyond Aberdeen?

A. I think there was some in the central belt as well, yeah. I don't know if they're still going, but I know there certainly are in Aberdeen. It's something that has continued post pandemic.

Q. Again, something I've touched on already. You do observe that you were never approached for your input.

A. No.

Q. And probably a difficult question to ask you and I probably have to ask you it from two different perspectives: if you'd been asked at the time of the pandemic, what particular advice or input would you have wanted to give? And then, secondly, now with the benefit of hindsight, what would you have wanted to give?

A. I think —— it's probably towards the end of my statement —— I think —— you know, I was asked during my

interview on reflection what I would change, and I think one that I alluded to earlier was businesses profiting from PPE and hand gels and sanitisers and things like that. For me, the visiting —— I mean, it was really heartbreaking, people not getting to visit loved ones. In particular, some people weren't there for their family's end—of—life care and they'll never get that time back, you know.

Q. No. Paragraph 176 of your statement, you observe that there were significant gaps in the guidance —— again you've probably mentioned this —— because it was predominantly written for older people's homes.

A. Yeah.

Q. What particular areas of guidance would you have liked to see in relation to residential accommodation for younger people?

A. I think for younger adults —— you know, there wasn't really any sets of guidance for children in particular and for —— although we were operating as a care home for that younger client group, it was all about infection protection and control, you know, the visiting —— no visitors allowed and things, and that doesn't fit for every service. So, you know, I think there should have been —— we've got care standards for every different type of service, so really there should have been

guidance for different services as well.
Q. At the end of your statement you make some comments on lessons to be learned and I think, rolling together paragraphs 212 to 214, you are, as I think I've already observed, quite forthright in your opinion on the necessity for restrictions on families visiting their loved ones, particularly at the end-of-life care.
A. Yeah.
Q. Now, we've heard obviously a lot about that from various perspectives and I'd be interested just to understand your rationale behind the view that you express.
A. And this is a personal opinion, so --
Q. I appreciate that.
A. -- it's not me speaking on behalf of my employer, it's a personal opinion. I think, in particular, for older people's care homes -- you know, we're dealing with people who can be anything up to 100 or over 100 years old. And if they're at end-of-life care and the family were willing to take the risk by going in and visiting them, I think who were we to actually say, "No, you can't do that"? I think if the family were happy with that level of risk, I think it should have been allowed.
Q. I think we get the impression from your statement and some of the decisions that you perhaps took during the pandemic that you were sympathetic towards that

approach.
A. Absolutely, yes.
Q. Ms Ewen, that's all I want to ask you specifically from your statement. We have a tradition of asking anyone who gives evidence if there's anything further that you would like to say having regard to what we've discussed so far and also having regard to your experience in your particular role during the pandemic. If there's anything you'd like to say further, can you indicate that at this stage?
A. I don't think so. I just want to thank you for the opportunity -- for giving VSA the opportunity to take part in this Inquiry, so thank you.
MR GALE: Well, we're very grateful to you, Ms Ewen, and thank you very much indeed.
THE CHAIR: Yes, thank you, Ms Ewen. I'm grateful.
A. Thank you.
THE CHAIR: That finishes today's proceedings. 9.45 tomorrow morning.
MR GALE: Thank you, my Lord.
(4.10 pm)
(The hearing adjourned until Wednesday, 17 April 2024 at 9.45 am)

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