Scottish Covid-19 Inquiry

Witness Statement

Stephen Finlayson and Jane Cumming, Penumbra
Witness Number HSC0148

Statement taken at 0900 hours on Friday 24 November 2023 on Microsoft Teams

Introduction

1. My name is Jane Cumming, my date of birth is Personal Data. I am Personal Data. I am director of programmes and innovation for Penumbra Mental Health and have worked for Penumbra since 1995. Penumbra's headquarters is based at Norton Park, Albion Road, Edinburgh EH7 5QY.

2. I have met today with witness statement takers from the Scottish COVID-19 Inquiry team and am happy to provide a statement about my experiences as director of programmes and innovation for Penumbra during the Pandemic. I am willing to provide a statement, have my information within reports and, for my statement to be published. I have completed the consent form provided. I am content that this interview is recorded.

3. My name is Stephen Finlayson, my date of birth is Personal Data. I am Personal Data. I am head of innovation and improvement for Penumbra Mental Health and have worked for Penumbra since 1995.

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Overview of Penumbra Mental Health

5. JC-Penumbra was founded in 1985 by a small group of social work professionals who were working in the Royal Edinburgh Hospital with people who had long stay mental ill health. They felt that there were people who were cared for in hospital who did not require inpatient treatment and were, essentially, cared for in hospital because there were not alternative services available. They established what was to become

the first supported accommodation service for people with mental ill health in Scotland. That was located in Dublin Street in Edinburgh.

6. What they wanted to do was to offer community-based care for people who had long stay mental ill health, and the organisation grew from there. The origins of the organisation were in Edinburgh in a very small centre, that one house in Dublin Street but it very quickly grew, and we opened more supported accommodation in different parts of Scotland.

7. The organisation was very small until we had that wider policy move towards community care in the mid 90's and, at that point, the organisation really expanded. By the time I joined in 1995, we had around 100 staff.

8. The organisation continues to have the same ethos and we continue to offer services to people who experience distress, who experience mental ill health. The purpose of our organisation is about providing services but continues to be about improving responses. We are keen to keep driving, trying new ways of working, making improvements, campaigning for better services, more services, depending on what is required.

9. Penumbra operates in Scotland, but we have connections beyond Scotland. We have partnerships internationally. We have approaches we have developed that partners in other parts of the world use but in terms of actual service provision, we only provide our services in Scotland.

10. We have 77 services across 23 Health and Social Care Partnerships in Scotland. We also have national programmes that cover the whole of Scotland. The 'Self Harm Network', which is a fairly new service, covers the whole of Scotland. It is an online portal, there is a website people can access to get information, resources; anybody. It is set up to reach people who are at risk of self-harm, but there is also an area to cater to friends and family and an area dedicated for professionals to get information.

11. If you are intending to self-harm or looking for support with your self-harm, you can access that through the portal and we have a team, a live chat function so you can talk to a team of staff and volunteers or you can leave information and one of the team will get back to you. It is provided by peer practitioners, people who have lived experience of self-harm. It can be accessed anywhere in Scotland, including the Highlands and Islands.

12. We have suicide prevention services, but they are separate. We do have a dedicated suicide prevention service in Angus. The suicide prevention services came about after the pandemic.

13. Penumbra are the strategic outcome lead for outcome three of the Suicide Strategy that the Scottish Government released this year. There are four outcomes within the strategy and there are different organisations that are the strategic outcome leads. Outcome three is about improving responses for people who are at risk of suicide.

14. We have a range of face-to-face services. We tend to think of our services in terms of home services, community services and distress services. During the pandemic we had five supported accommodations. Although when we started as an organisation, supported accommodation was the core work, that has changed over the course of the history of the organisation. We have far fewer supported accommodation services now because the work we do is far more community based, which is a good thing.

15. We still have five supported accommodation services which are registered as care homes. They are not large; I think the biggest is for 12 people. We have two in Glasgow, one in Edinburgh and two in Aberdeen. Three of them provide 24-hour support for people who are experiencing mental ill health and two of them are for people who experience alcohol related brain disorder (ARBD); people who have been impacted by long term problematic alcohol use. As they are categorised as care homes, they were subject to care home guidance during the pandemic.

16. We have a team of staff that work there but they are not working with older people specifically, they work with people with mental ill health providing emotional and practical support, not generally personal care in that sense. They are registered as care homes which was an emerging issue.

17. The core of our staff are mainly employed in services. We provide support to people in their own homes, or we provide services that are based in the community. We might provide groups or community-based activities that people come to so not all the community services are visiting support.

18. The other part of what we do is that we have quite a few services where people have their own home, they are the tenant in a block of flats, but the block of flats is set aside for the purposes of community support. We will have a staff team who provide support to all the people in that block. It is more akin to sheltered housing. For many of them, one of the flats in the block will be set aside for staff support. The staff can sleep over at night, so they are available 24-7.

19. The properties are often provided by a Housing Association and the local authority pay for the support.

20. Penumbra is a registered charity. Most of our funding comes from Health and Social Care Partnerships, the services I have described are mostly commissioned by them. They will tender a programme of works, services that are to be provided and we will offer how we will do that. The contract is awarded and, if we are successful, we will take on providing the service and support the people who are referred in to it.

21. Some of the more national programmes are funded directly through the Scottish Government and we get grants. There are some separate smaller pieces of funding that we might get through grants to do specific pieces of work.

22. In terms of my personal background, I did a Social Policy Sociology degree at Stirling University and, when I completed that, I did mental health nurse training. I worked for a couple of years as a mental health nurse, then I joined the third sector working for a small mental health association in Elgin.

23. I came to Penumbra in 1995. I knew of Penumbra, I liked the work that they did, it connected with what mattered to me. The opportunity was there to be the area manager in the North services, they were just starting to work in that area, in Aberdeen, and that excited me as it was starting something from scratch.

24. SF – I joined the third sector in 1995 or 1996 with an organisation called Thistle Foundation. That was almost straight from university, although I had done some voluntary work with a disabled man in London prior to that.

25. Thistle Foundation are based in Edinburgh, and I worked there for 20 years. I was a front-line support worker and then moved through a variety of roles, including team leader and manager roles, eventually managing the supported living services that the Thistle Foundation provides. I did work in equality and improvement, on the training side as well, training around things like adult support and protection and person-centred working training. I also completed a secondment with Penumbra somewhere between 1998 and 2006 so was quite familiar with them. I joined Penumbra just under five years ago as head of innovation and improvement.

26. 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 the 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.

27. I am very involved with all our services through our quality evaluation frameworks which we use very regularly through our engagement with our services. My team and I team lead on the feedback processes of gathering evidence and data from people we support, from our partners and the wider statutory sector.

28. One of the fundamental parts of how we do what we do is the important involvement of peer workers, people with their own lived experience of mental health on our workforce. Last year, 26% of our frontline people were employed specifically to bring their lived experience of mental health to the role; the aspiration is that this will increase in the coming years. That is part of the work that my team and I are involved in, how we support the peer workers in the organisation to bring their lived experience and use that experience in the way they deliver support.

29. There is no clear line between "these are the people with mental health problems" and "here is us in the organisation". We see it as a much more equal partnership and that all of us have mental health which, at times, can have a spectrum of experiences. We explicitly bring that into the organisation in terms of peer workers. There is a very direct expectation that they are bringing that experience to the support they provide.

30. JC-Penumbra is almost exclusively paid staff and at the time of the pandemic we had a handful of volunteers in a couple of our services but not actively in front line delivery; they may have engaged in telephone support. We have more volunteers now than we did then.

31. The reason for this is probably indirectly as a result of the pandemic. The Government had their recovery and renewal fund and we applied to that fund. It is from that that the Self Harm Network came about, it didn't exist prior to that. It is primarily because we have a team of volunteers there that we have increased so much.

32. SF- We would signpost people to other organisations if we were unable to help them. Penumbra works very collaboratively with a number of organisations, and I don't think we would have any sense of preciousness about it having to be us who provides services to people who contact us.

33. For example, we have a new service that wasn't around during the pandemic, Hope Point in Dundee. It is a 24-hour community wellbeing centre which is really for people experiencing crisis, distress and suicidality. They have a very strong signposting model so that if people come in, they receive immediate support addressing what is affecting

them at that time, but they have a directory of organisations they can connect other people with.

34. It is much more than just giving people a leaflet, they will make the phone call for people if appropriate and, as much as possible, try and be alongside people to connect with those organisations.

35. JC-Penumbra don't really run big National campaigns and PR events, I would describe it more as around influencing improvement in things like people's rights, better services for people, listening to people who have lived experience, raising awareness. Trying to help people see that if you take a rights-based recovery approach you really can achieve good outcomes for people.

36. Penumbra host the Scottish Recovery Network so that they have a role in promoting recovery focussed approaches, we would see it more as influencing and advocating.

37. Scottish Recovery Network are a semi-autonomous organisation, they have their own grant funding. They are a small team of network officers and network coordinators. Their role is to promote recovery approaches in Scotland, so they develop resources, run events, develop support in communities. We host them within Penumbra as a way of administering their grant effectively.

38. Referrals to Penumbra's services depends very much on the individual service and how that service is commissioned. The supported accommodation requires a referral from a community mental health person, for the Distress Brief Intervention (DBI) you need a referral from a first responder such as police of Ambulance Service; other services like The Crisis Centre in Edinburgh and Hope Point in Dundee, can be accessed straight away, where anybody can turn up or make a phone call and they will receive that immediate support.

Penumbra - Pre-Pandemic

39. Prior to the pandemic, Penumbra services were working well, feedback we had was really positive, we had very good feedback from the care sector, and we were involved in some exciting new programmes like DBI which was moving forward. We probably had a turnover of about 10-11 million pounds. It felt like we were in a good place.

40. We had just finished a really big IT project, a mobile office project. We had invested in a new end to end IT system for all of our processes which meant that staff could do all their record keeping etc., while they were on the move. It meant they would basically be able to do all of their work at any location on a mobile phone. It wasn't just a support plan, it was our

finance systems, HR systems, all of that. The project went live in February 2020, and we were looking forward to a bit of a breather after all the work it took to get it up and running.

41. It was incredible what happened with that because we had just gone live with it, when everybody got told to pack up everything and go home. If we hadn't done that, I dread to think what would have happened. It was massively positive but coincidental. Although, it was a new system for us all and there were quite a lot of things that weren't working quite right, things to be tweaked.

42. SF-The thing for me that seems the most significant in terms of what then happened (pandemic) is the DBI programme. That had been a really significant part of the newer work. I had only been with the organisation for about one year prior to the pandemic but in the three to four years prior to that the DBI programme had started and had been a fairly significant piece of work.

43. That probably was one of the things that helped us to be in quite a strong position in terms of thinking about actually responding to the mental health concerns that the pandemic threw up; the distress and isolation and the emotional impact of that. I think it was very fortuitous that Penumbra was already involved, significantly, in the work responding to people in immediate distress and were able to build on that when things started to develop.

Penumbra's Service Delivery - Impact Relative to Scottish Government's Response to the Covid-19 Pandemic in Scotland

44. JC-During the pandemic, I was the services director. I am the programmes director now. One of the impacts of Covid is that this organisation grew, and my role was split. As the services director during Covid, while I wasn't frontline, what I did have was an overview of the impact on the services as a whole; I was line managing the managers.

45. We set up a task force really quickly, so we had a lot of information getting fed into people like me and Stephen so that we were getting all the information that we needed and were able to manage the Scottish Government guidance and things like that. So, although I wasn't out delivering the actual service, we were collating the information, we were paying attention to what was happening, so we had that overarching organisational view.

46. The task force which was largely senior managers in the organisation including Finance, and HR function. HR fed into that task force daily, information on staff who were sick, staff who were isolating, staff who were shielding.

47. JC-I think Penumbra are quite a 'connected to our emotions' type of organisation and the thing that sticks in my mind when the pandemic hit was the emotional impact on people who were providing, and responsible for services and therefore responsible for people. There was an incredible fear. For example, what it would be like if Covid ran through one of our supported accommodation services and the people that were there, how would staff live with that? How would we support staff who have that responsibility through something like this? It was horrendous.

48. Then you just go into a zone; what needs to happen here? What do we need to do? Practically, the fact that we had done what we had done with the IT meant that we were able to continue to provide a lot of support. We didn't stop providing any of our services at all, although we did some differently, for example, people who previously had visiting support but who could cope with telephone or video support, we did that instead.

49. The other thing that the new system allowed us to do was to have a digital record of the risk assessment for every single person we supported so we could very quickly say 'these are the high-risk people that we support, and these are the people who can manage with a phone support'. We have been able to apply that in every single service so we could know who the people were that really needed a face-to-face visit.

50. Services would have been able to do that themselves, but it meant we had a coherent system and process to do that across the entire organisation.

51. It also meant that the information was shared. If we had a lot of people, staff as well, who got Covid or were isolating it meant that the information could be accessed by others, the information was available to those colleagues and supervisors that needed it.

52. We went very quickly into guidance mode and what we needed to do. Translating that to 'this is the situation, this is a summary of the guidance, what we need you to do is x, y and z'.

53. SF-I don't think people were redeployed as such, but for people like me a lot of the more day to day stuff stopped for quite a long time. There was a significant period where it was primarily dealing with Scottish Government policies, trying to translate them in to guidance we could share. It was more the focus that changed rather than redeployment.

54. In terms of managing the guidance, we had the lead on translating the vast swathes of policy and guidance and what that meant operationally. That was a very dynamic process. We were putting out updates but obviously that involved a huge amount of backwards and forwards

between our services and staff on what this actually looked like in practice.

55. At the time of the first lockdown, March/April 2020, nationally, there was still that sense that it might all just be for a relatively short period of time and that, for the next three or four weeks we might have to do things differently then we will get back to normal. At that point in time, we didn't know that this was going to be a constant theme for the next two years. For all of us there was the sense of actually never quite knowing – is this this going to be for another month, another six months?

56. JC-The biggest challenges were in our supported accommodation services because these are services where we categorically have to be working with a good staff level. When we had people in the staff team who were isolating or whatever, it was a huge challenge keeping those services staffed appropriately.

57. If someone was sick or isolating, some of the other staff would share their work between them. We did have an amount of agency staff who would come in and we had staff from other of our services who would cover if required; sometimes it was easier to have their work shared so they could go in simply because we had to prioritise these residential care services. The managers also did a lot of direct support as well.

58. All of that has a short term and a long-term impact. It was a real challenge, a real struggle for staff in those services. If we had stopped some of our other services, we would have had more capacity; but we didn't. All of our services carried on one way or another so we didn't have that bank of staff freed up that we could redeploy, they were still doing their jobs.

59. SF-We can think about the service delivery impact in three ways. The supported accommodation services probably had the biggest impact partly because people are living together and the fears of a potential outbreak among the supported people and the staff. Anxieties about staff teams being decimated due to an outbreak and struggling to deliver a service and also the complexities of the guidance around care homes.

60. The visiting support services we provide to people in their own homes, that continued but probably not quite to the same level. By definition, people were seeing one person at a time, so some of those anxieties were not quite so elevated. The service remained really complex to deliver, the risk assessment process of who do we continue to see and who do we not and the practical aspect of staff physically getting to see people.

61. Our distress services, like the DBI services were probably the ones which we could most easily pivot to deliver remotely, delivering digitally by

video calls, telephone calls and were most easily adaptable to delivering that way.

62. JC-In terms of delivering support to individuals who were high risk and needed face-to-face support, I don't recall that there was ever a situation where we couldn't do that, if that person needed support. We never stopped.

63. SF-That could be for a variety of reasons in terms of people's mental health and concerns that people may be at high risk of self-harm, of suicidality. Also, some pragmatic things; many of the people we work with have long term mental health conditions which might mean very practical things like shopping, having access to food, medication; if they are not seeing somebody it is unlikely they would manage these things on their own. That was part of the prioritisation and risk assessment.

64. There were occasions when staff would literally knock on a person's door and maintain a distance or drop off food. Support with medication was probably the primary reason why we would be there because, although it's not a lot of what we do, sometimes we have to administer people's medication, not just mental health medication but physical health medication as well. It was very much a case of in and out as quickly as possible or supervising self-medicating service users, having the least contact possible.

65. We undertook a risk assessment for every person because we were supporting people who were obviously at risk; so, what could we do to minimise that risk? We did have people that we were concerned about, who did refuse visits because they were anxious about seeing somebody. That would be a worry because, where you have a concern about a person's mental health, but they refuse any contact at all, there is no way of knowing if they are okay. That had an impact on staff too. Quite a lot of people we support don't engage by video or phone.

66. There were almost certainly differences in the impact on the services Penumbra provided, depending on geography. We have fairly extensive service in the Borders where public transport is pretty poor at the best of times. I don't remember the details, but it must have been extremely difficult for our staff in the Borders, certainly the ones that weren't car owners, in seeing people.

67. The supported accommodation we have is all in cities so that limits the impact geographically. The services we have in the more remote areas tend to be less support intensive. I think the themes were fairly universal, I don't think there was a huge variation geographically.

Impact on Penumbra's Supported People - Relative to Scottish Government's Response to the Covid-19 Pandemic in Scotland

68. JC-In terms of the impact on our supported people, we had this conversation last week with a cross section of people from the organisation and the issue about the lack of access to other services was a major factor, particularly things that people relied on around their mental health. Things that they relied on to stay well – statutory services, community groups – all the things that people put in place to try and keep themselves well.

69. Being cut off from family and friends, having that social and personal network is really important to people struggling with their mental health. When that wasn't available that was an issue.

70. Digital poverty, there was a reliance on accessing services through laptops, phones, things like that. Not all the people who use our services have smart phones, or mobile phones in some instances. That was obviously an issue because if that was the main way of engaging with people, then they were excluded from that.

71. Conversely, sometimes you can be in a situation where if people are in receipt of support, it becomes almost their routine. But if, suddenly, like in Covid, it's not there, people's self-reliance and their own individual resilience and ability to manage becomes clearer; they are able to do things for themselves, not holistically, just things like, for example, getting a pint of milk because they really need it. It kind of levelled the playing field that everybody was in this together so there was an upside to that.

72. For people who were really anxious because they were isolated, being out and about became easier but conversely, as we started to emerge people who had been isolating and stuck in their homes found it difficult to come out and be around crowds of people again – a whole range of impacts.

73. The physical health impact, I don't think was any more or any less for the people we support than the general population other than the fact that physical health issues are often connected to long term mental health issues. I don't remember anything hugely specific in relation to that.

74. SF-Seeing people doing 'okay' was a double-edged sword at times. The fact that people have had the resilience to get through this period without that broader range of support they had pre-Covid, is different from them demonstrating that they are thriving and have good mental health. I think there was a temptation for the people holding the purse strings to think that maybe some service users never needed the support in the first place.

75. One of the things I felt in relation to the loss of access to statutory support services like psychiatric nurses and occupational therapists was that it took a very long time to start getting back to any sense of normality. Many months after we were got back to some kind of normality, staff were still saying that people were not seeing their psychiatrist. Even going back to the start of 2022, an awful lot of services were not actually seeing people.

76. JC-Part of the feedback we had from people who had visiting support was that sometimes the Penumbra worker was the only person they saw. If you were not able to see your family, that's your only contact. And that would be true for people who provide care and support from other care organisations.

77. For the people we support, that contact became more important. As a manager, when you are struggling with staff and resourcing, knowing that this rare contact has that level of importance in people's lives, you do feel a huge weight of responsibility to make sure that that person is still getting the visit that they need.

78. The people we support were also amazing, they were often concerned for our staff as well, making sure that they were safe. As managers across the organisation, we tried to be very on top of recognising the work that people were doing, how hard it was, how much it was appreciated.

79. A lot of the people we support are people who need emotional support, but they work and have families and they would have been affected by all the financial issues that hit the general population; for example, people would have been furloughed, businesses closed, people were losing their jobs, trying to do home schooling, taking time away from work, dealing with those kinds of pressures.

Distress Brief Intervention Service (DBI)

80. Part of our DBI service is about people in distress. It expanded in the way that it did because of the impact and levels of distress in communities. To try and provide a response to the fact that people were dealing with these very real issues around employment and finance and the impact that has on their mental health.

81. Our organisation expanded remarkably in that period trying to provide that kind of support to people who were experiencing those very real issues which were having an impact on people's mental health.

82. DBI is about providing a compassionate response to people in distress. It is a national programme and, prior to the pandemic, along with some

other service providers we were piloting the model funded by Scottish Government.

83. How the model works, you have first responders which could be police, ambulance service, primary care, A&E, unscheduled care. Those first responders are trained in what's called a level one response, so they provide the immediate response to someone in distress. They can then make a level 1 DBI referral to an organisation like us.

84. We are a level 2 responder, so we will respond to the level 1 referral within 24 hours, contact the person who has been referred and talk to them about what they are experiencing. As a level 2 responder, we can provide up to two weeks support to that person who is in distress.

85. Sometimes people don't need the whole two weeks, they have the initial conversation or another couple of conversations and that's all that's required. Sometimes it's about reaching the end of that two weeks and making the connection on to another service; maybe one of ours, maybe something else in the community. That's how the model works.

86. We were piloting this service, but there were some partnerships who weren't part of the original pilot and wanted to apply this same model, so they set up what was called an associate programme. I think we had a couple of them.

87. The initial evaluation of the pilot model was positive and Scottish Government released more funding, so an NHS 24 pathway was set up. The five existing level 2 providers became level 1 responders and were allocated localities based on health board areas. For calls coming through NHS 24 and the mental health hub, an onward connection could be made to the level 1 responders. This meant that there was the DBI service throughout NHS 24 available to anybody. That NHS 24 pathway is still there but the associate programme for DBI also moved forward.

88. The DBI service delivery started in about 2017-2018, it was a collaborative model with Scottish Government and Glasgow University. There was a collective established that comprised Scottish Government and some key organisations in terms of progressing it and moving it forward. Penumbra were providing a service called 'First Response' and there were elements of that taken forward into the DBI model.

89. First responders would often be responding to a distress situation, somebody who has maybe self-harmed. The police for example would take them to unscheduled care or to a psychiatric hospital for assessment but after the assessment the person isn't admitted so what happens next? The DBI is for when somebody is in distress, but they don't necessarily need mental health care and treatment at that moment in time.

90. It doesn't have to be about mental health either. Everything is related to mental health but as I said before, linked to the pandemic, it could be about finances, relationships, employment concerns – distress is obviously linked to mental health and that became significant.

91. It would be difficult to say whether there was an increase or change in the number or nature of referrals to DBI during the pandemic because the programme had just expanded, and we were doing so much more of it. There isn't a baseline to say this is what it looked like in 2018 and this is what it looks like in 2023 because the whole thing was growing through that period, we were opening up new pathways for referrals, training up level 1 responders.

92. DBI has now crossed the 50,000 number for people who have been supported by the service and the ambition was to have DBI across Scotland by 2024; but the NHS 24 pathway was there because of the pandemic; to respond. Because we had the structures in place, it got off the ground incredibly quickly as a response to the pandemic. DBI felt like a positive action, a good response to what was happening.

93. From the DBI reports there are a lot of people who are talking to DBI practitioners who are discussing thoughts of suicide. There was a marginal increase in suicide rates in Scotland reported in September (2023) but over the period of the pandemic there isn't really evidence to say that the suicide rate increased. There is a study going on in Scotland just now to see what extent approaches like DBI have a positive impact on people's risk of suicide. But there are a lot of different factors that come in to play with that.

94. SF-As well as the emotional, it is also the pragmatic support. A lot of the causes that people will come to DBI with would be the pragmatic stuff like being furloughed, the financial worries and that is what the DBI structure is about, trying to really drill down into what is underneath this distress and what are those very pragmatic steps we can support you to think through that would start to address some of those things that are causing the underneath distress. When people get to that point, it's often about that sense of losing control of things, whether it's financial, relationship. So, trying to have something that helps you bring a sense of control back over everything that's happening.

95. JC-Everyone that accesses DBI gets a distress management plan so there is a clear process to do exactly what Stephen is describing – this is where we are, and these are the steps that we can take, so people have that ta take away and use after their engagement with the service.

Impact on Penumbra Staff Relative to Scottish Government's Response to the Covid-19 Pandemic in Scotland

96. JC -The immediate impact on staff was mixed as some staff were working from home but others were going out. Our staff were awesome, not just in terms of going to work but being flexible, plugging gaps when people were isolating. The commitment that our staff showed to ensure that people who needed support still got support was incredible.

97. There was also anxiety both in terms of the risk to themselves, their family, "if I'm out mixing what if I take Covid and give it to other people?"; a whole mix of stress and anxieties. 'Why am I going out to work when the person working in the DBI service is sitting at home quite safe?" Some staff would express that, and these were realistic, genuine anxieties. But the bottom line was that they were amazing. When push came to shove, nothing stopped.

98. SF-My memory is that people did have anxieties, but we didn't have significant issues of people saying I'm not doing things, or this is outrageous or unfair. I think a substantial number of our staff were proud to still be delivering support, particularly when other supports and services were disappearing. There was an incredible sense of commitment and pride that we were continuing to see people and support people.

99. Staff in the social care sector do tend to be one of the poorer paid sectors in our society. Home life for example, they are probably not living in a four-bedroom house with spare bedrooms and garages you could set up as an office and I think that was a very significant impact on those people who were homeworking. Trying to juggle childcare but also living in flats or places where they just didn't have the ability to set up a clearly dedicated, quiet workspace.

100. It was a really big impact for the staff but also complex for us as an organisation; how do we support staff? When people were delivering video or telephone support obviously it is really important that it is confidential. How did we support staff to think through, how you have a home working space that is both appropriate in terms of confidentiality but minimises as much as possible the impact of your home becoming your workspace?

101. JC-Because of the mobile office project we had just completed, the financial impact on Penumbra in terms of IT wasn't such an issue. People could go and visit somebody then update a record of that visit on the phone, but to do more ongoing work they would come in to the office. So, we had to buy more laptops for people. We were also buying desks and chairs, things like that so people had a decent, safe workspace at home. Normally you go to work and walk home at the end of the day, leaving

your work behind. But if you are there and your laptop is sitting on the kitchen table that is not ideal? We probably invested more in that aspect than the actual resource element because we were fairly well set up for that and we had invested a lot in the mobile office project which minimised some of the financial impact on us.

102. In terms of the impact on anxiety and stress, we pivoted quite a bit onto staff wellbeing, connecting people who were at home so that there were spaces that people could come together. One of Stephen's team started doing yoga sessions; we developed wellbeing resources to support people who were working from home, just in recognition of the fact that those anxieties were there and to address the risk of our people being or feeling isolated.

103. SF-Significant numbers of our staff did continue to go out and see people to deliver face-to-face support and there were some very practical challenges that impacted on them; for example, trying to find a public toilet because they were all closed, all the shops were closed. This was a really big issue. Transport was also a challenge as many staff rely on public transport.

104. JC-A lot of our staff did rely a lot on public transport, and we actively encourage people not to use their cars at work for a variety of reasons, for example our carbon footprint, but that became very difficult. We heard stories that because there were a limited number of people allowed on buses, occasionally our workers couldn't get on the bus, because maximum numbers of passengers had been reached. Our support worker was left at the bus stop. So, we did put out a communication that if the only way you can get to people is by using your car, then do that.

105. One of the really significant impacts, mental health impacts actually, was on our first line managers arising from the fear of "getting it wrong"; that huge sense of responsibility. In the midst of this, really complex, often changing guidance, particularly in the registered care homes, it all added a real pressure. If there was a Covid outbreak, that real sense of responsibility, of getting it wrong but also of being held accountable, of being blamed. This was a real worry for our residential care staff and managers.

106. We did not use the furlough scheme for any of our staff.

Guidance

107. SF-A lot of what I and one of my colleagues were doing was trying to keep on top of the guidance coming out from Scottish and UK Government. It was often very complex, particularly when trying to filter it down to the parts that were relevant to us. What we did do quite

quickly, and it felt like it was effective, was produce a weekly bulletin where we were trying to synthesise 'this is what the policy says, this is what we need you to do'. We tried to get to a clear 'actions you need to take' basis through that bulletin.

108. That was really challenging, there was so much guidance coming out at that time and if felt very difficult to keep on top of. There was that sense that it came out at four o clock on a Friday afternoon saying, "on Monday morning, you need to do this". That is certainly my memory. So, we would have bulletins that said 'remember what we said last Monday? Forget about that because that's all changed'.

109. In terms of the care homes, I think this was one of the things we found most challenging. It did feel like the guidance was being written by people who did not appreciate the breadth of services which places that are registered as care homes actually provide and how those services look in practice. It felt that there was a presumption that when referring to a care home, it is all about care of the elderly, or about people who are largely immobile, or who have physical infirmities or disabilities.

110. It was quite striking, reading the guidance, that there did appear to be this implication that you could manage people because there was an assumption that these were mostly people who would not be able to physically leave their room or get out of a chair. The guidance was very much written in a way that often was about keeping people in their rooms, keeping people separated. This was interesting in terms of the some of the wider questions around the human rights of people in care homes.

111. The people we support are able to get up and leave the accommodation if they want to and they have every right to do so. We have no powers whatsoever to tell people that they can't do so. We don't really have anyone for whom powers under the Mental Health Act (or other legislation) would allow us to restrict their movements.

112. We were trying to operationalise all this guidance that was primarily written for the care of the elderly in older people care home settings. It just didn't feel well designed for our sector.

113. I am not aware of us having any senior level influence over policy, or capacity to feedback to Government regarding the guidance but I suspect if those conversations were being had, they would have been with our former Chief Executive, **Name Redacted**. He has now moved on.

114. We did have regular meetings with the Care Inspectorate. We had a relationship manager with them, and I used to meet with her quite

regularly. She was incredibly helpful and we could feedback through that route.

115. There was a discrepancy that we experienced between the Care Inspectorate and Public Health Scotland (PHS). We would sometimes ask PHS questions, describing the service we provide. I remember one conversation when I was talking about the guidance in relation to our service and asking what do we do here? The PHS advisor said, 'we don't consider you a care home'. But then the Care Inspectorate did, we were registered as a care home, so it felt like there was a distinction but also a contradiction. You've got two bodies who are offering guidance to you as an organisation, but they don't have the same view as to whether your residential service is a care home or not.

Care Inspectorate

116. Later on in the pandemic, I'm not exactly sure when, the Care Inspectorate started publishing reports, publicly, when they were visiting care homes. In my personal view this felt like a 'naming and shaming', it didn't feel supportive. I think there would have been a way to publish lessons learned, it was useful to understand what was working well in other services and where there were identified issues for improvement.

117. I think this could have been done by way of a thematic report in terms of what they were seeing so that everybody could benefit from the shared learning without saying 'we went to this particular service, and this is what we found'. I felt the reporting could have been done differently and in a way that felt more supportive and about improvement rather than shining a light on a particular individual service.

118. SF- A lot of that was when the political pressure started to ramp up in terms of infections in care homes, so the Care Inspectorate were having to deliver reports to Parliament or Scottish Government. It felt like they were under enormous political pressure because of the infections and deaths in care homes so there did start to become this report saying, 'this care home is failing, it is not doing this', 'this care home is adequate, but it needs significant improvement'. I can see that being a useful report for people who needed to know but I don't see that being a useful report publicly available.

119. More positively, many of our managers also experienced local Care Inspectorate in a very supportive way, people proactively phoning up to see how things were, was there anything they could? So, there was good local support from the Care Inspectorate and our managers really appreciated that, it felt like there wasn't that sense of being abandoned by them.

120. JC-It was that difference between the Care Inspectorate, the organisation, liaising with Government in contrast to the Care Inspector, the individual, on the ground care inspectors.

121. SF-On the emergence from Covid when care inspections re-started, they effectively re-started on the same criteria as before and inevitably there were things, when people had had their focus on keeping people safe, complying with the Covid guidance that they were not as on top of the other areas and there didn't seem a lot of leeway with that. It did feel to me that there should have been a different framework for emergence.

122. It is important again to distinguish between the inspector's themselves, their views, compassion and empathy versus the Care Inspectorate system and its lack of flexibility.

123. We are members of Coalition of Care Providers (CCPS), and we absolutely would have been feeding our experiences in to CCPS. They were asking us what were the themes, what were our experiences, what were the challenges we were facing? So, we were working with other care providers to give them feedback.

124. SF-There were times when I would email Scottish Government officers just to clarify points in guidance because sometimes, they felt contradictory or did not make sense. I think that only happened three or four times, and most of the time they would reply "good point, I will come back to you" and by the next time it had changed and made sense.

125. JC-People were doing their best and, individually, always trying to be helpful when you contacted them. It was just hard to try and navigate who it was that was the arbiter.

126. SF-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.

Shielding

127. SF-For the people we were working with I suspect shielding was less of an issue compared to many physical disability organisations for instance. With it being mental health, a large amount of the people we work with don't have another kind of aggravating physical health condition. So, I don't think it was as prominent an issue for us as it might have been for others.

128. JC-We have some shared houses, some of them being older so there is not that place where everybody has en-suite rooms, it's a shared space, shared bathrooms and things like that. The idea of the care home

guidance, stay in your room and don't come out, it's not possible. People are not with us because of a physical health condition.

129. The bit about shielding that caused tension was where we had staff who were shielding. That was an issue. I think for them, the guilt of not coming to work but also the issues around emergence and people still being very anxious, understandably, for their own health. As the guidance was changing to say you can come to work, people's own personal anxiety was that, actually, I don't feel safe to come to work.

130. We took a pragmatic approach to support people to come back to work, we would have conversations around what they were anxious about, was there anything we could do or put in place to alleviate that anxiety? It would be an ongoing conversation and also considering, if you can't come back to that role, what role could you do? We had roles that people could do from home; they didn't necessarily need to be out. The conversation would be about 'How can you' as opposed to 'You will'.

131. I don't recall a lot of questions in our Covid mailbox about shielding. When we talk about guidance, the guidance in relation to shielding did always feel clearer cut and I think it was where you had the grey areas around the guidance that it was a bit more challenging. That is probably why we weren't getting questions so much in relation to that, because it felt clearer. And even though that presented its own challenge in some circumstances, it was clear what was expected, and you knew what you needed to do.

Funding

132. JC-Some of the grants that we have are dependent on activity. For example, we will give you a grant for £100,000 for one year's work if you deliver x amount of support, we will pay you per the hour of support you deliver. That is massively time consuming and, also, if we are not delivering that face-to-face support and that is what we are contracted to do there's a massive sustainability issue for us. But one of the things that did happen during the pandemic, although I can't remember at what point, was a directive that we would be funded for the whole amount of what we were supposed to do.

133. We couldn't do a lot of what we had planned to do but it was agreed that we would still be paid on the basis of what we would have planned to do. Effectively, this meant that organisations like Penumbra wouldn't go under. We were able to continue to apply our funding to employ the staff because they were still working, they just weren't doing the same kind of activity. That was massively helpful.

134. Because of this, the financial impact to Penumbra was less than it might have been otherwise. The practical part was that we knew we were going to have the money but also, we didn't have to do the reporting attached to all of it. The reporting we were having to do at that time was significant and, had we had to continue to do all the other types of reporting we would have had to have brought in a whole other set of managers. The reporting we were having to do was off the charts.

135. We were able to claim back additional funds that we had spent in our response to Covid. If we had to spend additional funds on Personal Protective Equipment (PPE) for example, we could claim that back from the sustainability fund via Health and Social Care Partnerships. Some partnerships were more proactive in enabling this than others.

136. The private sector was really good in coming forward and offering sanitiser and things like that for free. They were making it and saying we could have it because we couldn't get if from anywhere else. That was fantastic, in terms of being able to have some but also that people were thinking about the fact that we may need it.

Personal Protective Equipment (PPE)

137. JC-PPE was a massive issue practically and emotionally in terms of short term and longer-term impact on our staff. This was probably the bigger issue because I think it said something about how health and social care staff were placed and valued.

138. Because we are a support organisation, we don't provide care and treatment as such, we didn't have our own stocks of PPE – masks and sanitiser and things like that when the pandemic started. I think we had some in Aberdeen, but we weren't set up for that and all of our people spent numbers of hours trying to contact various suppliers and we couldn't get it.

139. Our staff were making masks at home with sewing machines and sharing them. Obviously, the masks weren't fit for purpose, but that was literally what was happening. They were sewing their own.

140. When we were trying to source PPE and hand sanitiser as an organisation, we quite often got a message from those suppliers that did have it, that it had been reserved for the NHS and they couldn't give it to us. The first, biggest supplies of hand sanitiser we got were from local distilleries who had pivoted to making sanitiser. It was a massive challenge.

141. We had to finance it, to buy PPE but that aspect of it didn't cause us an issue. It was the getting of it in the beginning that was the real problem for us.

142. SF-I don't think it was clear cut in the first two to three months or so whether as a service delivery provider we were expected to use masks. I remember, more widely, there was all those debates about whether masks were effective or not, whether they were adequate or not; that probably didn't settle down until several months at least. It was quite some time before that simply settled down and something felt clear – these are the situations where masks must be worn, and these are the type of masks that must be worn.

143. For some supported people it was very difficult engaging with someone who was wearing a mask. We provide emotional support to people and to do that while you are wearing a mask is really difficult. But, on the whole, people accepted that we were in a pandemic, this was the right thing to do.

144. Some staff did wear visors, particularly in the supported accommodation when they wanted people to see your face. We would have had aprons, gloves and cleaning agents available too because there may be some occasions when staff would apply cream or clean up bodily fluids. What we didn't have though were the specific surgical type masks or the higher-level masks (FPP3).

145. SF-On the whole, we don't provide personal care but life and supporting people isn't always black and white and there are people we support who do need help with practical, physical aspects of personal care at times, people have accidents or are sick, things like that.

146. JC-Technically, supporting people with medication, actually administering it is defined as 'personal care'. That is primarily why so many of our services are registered as providing care (registered care homes), it is not because they are providing personal care in terms of taking people to the toilet. Just actually helping people to take a tablet at night it is defined as personal care. This not only happens in supported accommodation but in visiting support services too.

147. JC-We had a bit of a refresher reflection session with a cross section of people from our organisation last week to help us remember and get their reflections of the use of PPE and what they were saying was that, on the whole, everybody was watching the same news, everybody was in the same situation so people were accepting and understood that we were in a pandemic, this was an issue and that if we took these steps it would minimise the risk to ourselves and others.

148. People felt they were doing the right thing. They felt they were doing a good thing and that would be the main overarching theme of it, the last thing our staff wanted was to be the person who brought Covid to people

we support or to their colleagues. If the way to minimise risk was to use PPE, then people were very happy to do that.

149. For some people though, it did have an impact physically, it affected their skin. Also, psychologically, if you are wearing a mask all day every day at work the impact of how that made you feel.

150. I would emphasise the impact of being an employee of an organisation, a health and social care worker out there, a defined key worker in the pandemic and being told that you are less of a priority in terms of accessing PPE than other professionals. Rightly or wrongly, there was a sense of you are not a priority in terms of accessing PPE and that has a lasting impact in terms of how people feel.

151. One of my manager's had a conversation with an Occupational Therapist (OT) on the phone who asked that one of his staff to go and visit a particular person as she was concerned about them. The manager explained that they had been in touch with the person, they were okay, and we did not feel like a face-to-face visit was required. The OT said, "I would like you to go because I work for the NHS, and we have to be protected". That was just one instance.

152. This is a third-party story which was shared with me yesterday and my interpretation from what I thought I was hearing was that "I work for the NHS so I can't go. Because I work for the NHS, I can't do a home visit so you go". If you were to ask our staff, they would say that a lot of statutory services stopped home visits.

153. SF-An important thing across the third sector and voluntary sector was the flexibility and the willingness to be more risk enabling. We did see the statutory sector going into a slightly bureaucratic one size fits all, 'this is what we are doing. I can't go and see anybody'.

154. About a year into the pandemic, we had a series of suicides amongst people we had had contact with and supported in the Scottish Borders, about five or six people died over the space of a few months. A meeting was called with various partners from Local Authority and NHS. It was framed as a supportive meeting but there was a sense of 'this is us, the statutory sector checking up on you'.

155. What was striking was our managers were able to present clear data that we had continued to see these people, continued to support them but all the statutory support had almost entirely disappeared - Community Psychiatric Nurses, psychiatrists, psychologist visits – and our staff were the only paid people in their lives they were seeing. For the people in the meeting that was quite profound, there was a sense of shock on their part

and recognitions that "well if Penumbra are seeing people, why are we not"?

156. SF-I think it was more widespread than that, that sense of you are a key worker but you are not as significant. Things like the access to supermarkets, if you were a nurse, you could get priority access and I think that caused real frustrations for some of our staff. They were out there doing this work, but it was very difficult for us to obtain ways that would be accepted that showed that our staff were key workers and essential workers, and we would have that parity of treatment.

157. JC-It did take a while for things like that to come. Eventually we were recognised as key workers, but it felt like it was fought for rather than factored in.

158. If you are working within the public health, NHS system then that is your focus but there are services that are commissioned through Health and Social Care Partnerships that are absolutely vital to keeping people safe and which are an extension, a part of that National Health Service. Maybe it is the way these services are commissioned and that is part of the conversation around the National Care Service.

Lessons to be Learned

159. JC-The recognition of Health and Social Care Staff as key workers is hopefully a lesson that will be carried forward in terms of how those staff are recognised, valued and regarded. We can't forget that during the pandemic they were absolutely essential to the response and the idea that they were less of a priority is a mistake we can't make again.

160. In terms of reporting, we 100% recognise the need for reporting and completely understood the need to provide information to the people managing the logistics of the Covid response. However, managers were being asked by many different sources to provide reporting information, sometimes with unrealistic timeframes which was challenging. Although the information was needed, I would say the increased reporting processes continued for longer than was necessary.

161. SF-In relation to the reporting, I think there should have been a single point of contact instead of organisations having to provide reports individually to many different statutory bodies – for example local authorities, Care Inspectorate, Public Health. That was incredibly time consuming and confusing. In my mind there should be a single point of truth and a single point of contact. I do not underestimate how difficult and complex that would be to implement.

162. There were also frustrations that people writing the guidance or providing advice didn't have a clear understanding of the sector concerned. I think the people responsible for that single point of truth should have the relevant breadth of knowledge and understanding. I understand that would also be a challenge.

163. JC-In terms of the guidance and how it is approached in the future there are obvious questions about how services are registered and how that registration leads to follow up action in a particular way. I think that needs to be reflected on. It is not fair to say that the guidance that would apply to people living in one of our services registered as a care home would equally apply to people living in the Thistle Foundation (for people with physical disabilities). It is not needs led. One size does not fit all.

164. That has been a problem since before Covid and there is something more nuanced about being more person focussed – 'if you are working with a person who needs this' rather than, 'your service is registered this way, this is what you have to do'. I think it is something that needs a lot of thinking about, a person-centred approach.

165. We, as an organisation, are very focussed on people's rights and the guidance was telling us to do something that, if we applied it, meant we would be breaching people's rights. These were discussions Stephen and I would be having.

166. We were getting guidance that we were to keep people in their rooms; it was just not going to happen, and how did that fit with people's rights? We don't have the right or authority to do that in any circumstance. If a resident approaches a worker and says they are going to visit their mother as they have done every day for years, we can't stop them.

167. This led to anxiety of staff who knew they couldn't stop it, knew it was right that they didn't stop it but were asking 'if Covid goes through this home, is it my neck that is on the line because we've been unable to implement the guidance? Are we going to be in one of those reports that are sent to Parliament that I spoke about earlier'?

168. SF-One thing about guidance that was very confusing was when the Scottish Government and UK guidance started to diverge, organisationally we had staff coming back confused saying wait a minute that's not what I'm hearing on the news. That was complex to manage at times and what was being reported on the national news may not have reflected Scottish guidance. It did settle down eventually.

169. JC-On a positive, some of the other processes and bureaucracy we deal with all the time shifted and people reflected on that, because of that we were trusted to do the job that we do. When you create that

environment, we are all in this together, we have to trust each other to do our own part of it, almost exclusively, people will do that. We spend an awful lot of time convncing people that we are doing the job we are given to do.

170. It is right, it is public money, we are dealing with real people but there were many processes that were very quickly set aside, you don't need to do that anymore. We had quite a lot of discussion about if we can put that bureaucracy to the side right now, what is the point of it in the first place? Reflecting on this and learning from it - what do we actually need and what is just good to have but not necessary or isn't necessary and isn't serving any purpose whatsoever? I think we have pretty much gone back to where we were before in regard to this.

171. There were also issues for us around testing, getting tests and managing testing. We also had an ethical dilemma about reporting testing on staff who were vaccinated. There was confusion at one point about whether staff who hadn't been vaccinated could work in registered care homes. We struggled with whether we had a right to know if staff had been vaccinated. There was a real confusion about that. Staff could voluntarily provide the information but that whole question went on for quite some time and repeated.

172. SF-We did look at recording it at one point because we did actually come to the conclusion that we could not follow some of the guidance unless staff told us whether they were vaccinated; we had to ask. That guidance did eventually disappear but there was a while when that became difficult and was a complex issue at points.

Hopes for the Inquiry

173. JC-I hope that we reflect on what worked and what didn't so that if we are ever in a situation like this again, we do what worked and do it well. And for the things that didn't work, that we put measures in place to make sure they work the next time.

174. I would hope that the role of social care staff in the response is recognised.

175. SF-I would hope that the role of the third sector is recognised because, looking back now, had the third sector closed down, I think the situation across the country would have been even more catastrophic. I feel there was a substantial difference in the flexibility and willingness of the third sector to continue to operate in ways that a lot of the statutory sector was unable to do. I hope it is recognised that the third sector was a hugely significant part of, as a society, getting through this.

176. JC-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 service. We are not talking about the 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.

177. SF-This is much more about recognising the systemic issues, overarching governance frameworks that operate in statutory sector that means it is more difficult for them to have the flexibility and nimbleness that the third sector bring.

Signed Redacted

Date 28/2/24

Signed Redacted

Date .....1/3/2024.....