Scottish Covid-19 Inquiry

Witness Statement

Statement **of Alexander CUMMING**

INTRODUCTION

1. My name is Alexander **CUMMING known as ALEX**. I am 41 years of age, and my date of birth is Personal Data

2. I am the Executive Director of Operations for Scottish Action for Mental Health known as SAMH. I was appointed Interim Director in February 2022 and permanently in February 2023. In my current role, I have responsibility for the leadership of our 70 plus services that cover health and social care across Scotland. This includes community-based services, employability, children and young people services, staffing, health and safety, quality assurance and sustainability.

3. I also have overall responsibility for service infrastructure projects and development of new business, strategic development.

4. I have been with SAMH for 4 years (since September 2019) and worked as Assistant Director before taking on Director role. During the pandemic I was the Assistant Director of Operations for the East of Scotland. This covered the area from Moray in the north to the Scottish Borders in the south. I was also responsible for our distress brief intervention and children and young people's work.

5. For over 20 years, I have worked in the statutory and charity sector covering portfolios of youth services, community safety, youth justice, education, and mental health.

6. My contact address is c/o Scottish Action for Mental Health, Brunswick House, 51 Wilson Street, Glasgow, G1 1UZ. My contact telephone number is Personal Data My e-mail address is Personal Data

7. I am willing to provide a statement, have my information contained within reports and willing for my statement to be published. I agree to recording the statement. I am prepared to provide evidence at the Inquiry. I am aware that I can withdraw my consent at any time. I am available to attend an oral hearing in February 2024.

Overview of the Organisation

8. Scottish Action for Mental Health known as SAMH is a charity registered in Scotland (SC008897) founded in 1923. SAMH has just recently celebrated its

100th anniversary. SAMH pre-dates the NHS. It has been supporting and representing those with mental health problems and illness since that time. Our aim has been to encourage people to live well and recover and lead as independent lives as possible.

9. Since the late 1980's, early 1990's SAMH became a large deliverer of mental health services across Scotland. This was due to the care in the community act coming in and institutions and psychiatric wards closing.

10. SAMH currently operate over 70 services in communities across Scotland, providing mental health social care support, addictions, and employment services, among others.

11. We have 26 registered services (regulated by the Care Inspectorate) from Moray to Edinburgh across the central belt to Glasgow and Inverclyde. Out of the registered services we have seven care homes, housing support and support services. We also have a range of community-based services and primary care services. An example of this is a community link worker service in Aberdeen. We have drop-in peer services and therapeutic horticultural services. We also have employability workers namely Individual Placement and Support (IPS). This is a specific mental health employability program to get people back to work or maintain them in work when they have mental health problems.

12. We have a growing Children and Young People portfolio. This was started before the pandemic and has grown since then. We have a physical activity and sport team that deliver a lot of physical activity programs. In addition, we have a strong suicide prevention team, with a focus on campaigning, capacity building. Most of these services and staff who work in these services sit within my portfolio.

13. SAMH also delivers online services. These include our information line and access to online psychological wellbeing services. The psychological service was launched during the pandemic. The information line includes phone, email, and webchat messages services. In the last 12 months we have supported 6,500 people through the information line to access services.

14. Other services include our high-profile work such as our public affairs and campaigns. We have a strong public affairs team who are constantly responding to Scottish Government consultations. What that allows us to do is feed on all the challenges and issues that we're seeing within our services onto that public affairs team to hopefully make strong cases for change. Also, when Bill's or legislation are being developed, we make sure the voice of those with mental illness or problems are appropriately reflected.

15. Our national programme of work including See Me, respect me, suicide prevention, and physical activity and sport inform SAMH's policy and campaign work to influence positive social change.

16. SAMH has a workforce of over 550 members of staff. That number changes each month and year as services start and end. This number slightly increased during the pandemic as several new services were commissioned.

17. About 450 members of staff work in the operational area of business. I have responsibility for these employees. From a public facing perspective, we are most known for our service delivery within communities. In addition, we have a small number of volunteers. They primarily work on media. When we deliver new services, we ensure that they are co-produced with young people, parents, or existing service users. Other volunteer roles include peer volunteers so someone looking to engage and support and use their lived experience as part of that service and support for that service as well. Our hope and aspirations are that the volunteers move into paid roles within SAMH.

18. In my role I report to the Chief Executive of SAMH. We have a board of ten trustees. We meet four times a year as part of the Governance arrangements of the organisation. This is when the finance and risks are discussed and monitored. Our Trustees have a range of specialisms and backgrounds.

19. We also have a separate audit and risk committee which is a sub-group of the board of trustees. I also attend this committee.

20. SAMH is a member of the Coalition of Care Providers Scotland (CCPS). They were a good support network through the pandemic. We are a member of the Scotland Mental Health Partnership. This is a collection of 17 different organisations that come together to try and collaborate on a whole range of different issues mainly from policy and public affairs perspective but looks at other areas as well.

21. We are currently the secretariat for the Scottish Parliament Cross Party Group on Mental Health. That meets at least three or four times a year. We have been the secretariat for four years. I do not sit on any Government advisory groups.

22. During the pandemic SAMH were a member of the Children and young people programme board. This board has now changed into something else. This was around children and young people's mental health. On an ad-hoc basis we are involved in several different programme boards for Government.

23. Other work that we were active with during the pandemic was the national suicide prevention leadership group. Our Chief Executive was a key member of that group. The group aimed to drive the national suicide prevention action plan. That strategy has since been replaced with a new one. That was launched in 2022. SAMH is one of the strategic outcomes leads for suicide prevention activity in Scotland.

Impacts of the COVID-19 pandemic on the Organisation

24. Towards the end of January 2020, SAMH as an organization were aware of COVID and that working arrangements would require to change. At that time, we tried to put as many things in place as possible to ensure our business could operate as best it could.

25. One of the impacts on us was around Information Technology (IT) and infrastructure. As an organsisation we did our best to get the technology to the staff that needed it.

26. The first 18 months of the pandemic were challenging for SAMH. An example of this included how government guidance or legislation would change regularly sometimes daily.

27. The challenge was to disentangle the guidance or legislation especially if we had to stop doing something or do something differently. This was particularly challenging for our care homes. We would have to communicate that guidance to a workforce of around 450 frontline staff. This became time consuming especially if we had to decide what the best approach would be for our staff.

28. The pandemic was challenging for our workforce. I was so impressed with the resilience of our staff. Some of our challenges included communication to staff. This included at the point when everyone was to be working from home the reality for SAMH was that we were not. Unless the staff member was shielding.

29. At the start of the pandemic, we reviewed all our service users using a risk assessment tool. We had a duty of care for our service users. SAMH were a lifeline to a lot of individuals especially if they were on medication support. In some cases, required our support for day to day living. I also had to ensure that our staff were safe.

30. The risk assessment of services users allowed us to put them into red, amber, and green categories of risk. A red category would include an individual that needs to be seen face to face and for us to provide the appropriate support.

31. Our staff also went online to communicate with service users in addition to making more telephone calls. Hundreds of people across the country were getting direct support from SAMH services during the pandemic.

32. During the pandemic we got more effective and put better processes in place. We became more effective at supporting our service users remotely using the internet and Microsoft teams.

33. The reality during the pandemic was that SAMH were still delivering face to face services. The feedback we received was stark about statutory services. For most of our service users we were the only service that they saw during the pandemic. Particularly where someone had less connections with friends and family. I guess statutory service were recalled centrally to be managed for health and social care partnerships. Our staff were a lifeline for individuals at that time.

34. Another challenge was trying to manage staff expectations and anxiety. Examples included Government messages informing us not to use public transport however, if our staff did not use public transport, we would not be able to deliver frontline services. Staff would contact me and say that they have been told they cannot do something as the rules had changed. I would then explain to staff that they could perform their duties. I also made sure that staff were properly equipped with the correct PPE and with technology and support.

35. Where some of our services prior to the pandemic had been operating in G.P practices these had to be stopped as we were not allowed to operate in these premises.

36. In Aberdeen our staff were re-deployed to support the shielding helpline. This helpline was set up by health and to support people after receiving a letter or who were worried that they were to shield.

Care Homes

37. SAMH has seven care homes for adults. These are not like traditional large care homes. These are smaller units. These are registered and still classed as care homes. Our homes are supported 24 hours a day seven days a week. Five of our homes are Glasgow based and two are in Forth Valley. They range from a five-person care home up to an eleven-person care home. These are all mental health care homes mainly through the commissioning of mental health services.

38. One of our homes is classed as a homeless service. Many individuals are placed within the care home following exit from a psychiatric ward. The aim is to move these individuals on to their own tenancies. Four of the homes are all in the same building. There are communal areas where service users can interact with each other. The communal areas were challenging during the pandemic as we had to support our service users to understand that four or five people could not be in the kitchen all at the same time.

39. We had to comply with the guidance around visitors to care homes. Depending on the guidance we complied with the rules. This ranged from having no visitors to care homes or when the guidance relaxed putting in different processes to allow visits to be safe. Having no visits or reduced visiting did have an impact on the mental health of our service users. We tried to encourage different methods of visiting including meeting outside and in different places but the restrictions on the care homes were challenging. Challenges includes no meeting indoors and forming bubbles.

40. We saw little of the statutory sector during the period of visiting restrictions. I don't know the reason for this.

41. If anyone did test positive at our care home, they were properly managed. This included staff who would then work from home and not come into our care home buildings.

42. The seven care home managers were a good peer support for each other. Especially about sharing information about what was happening locally and how things were changing. That information and practice spread to a wider group of managers.

Infection Prevention Control

43. All our staff must complete mandatory training. Included within this is Infection Prevention Control and the disposal of equipment after use. This training is an online module and was in place prior to the pandemic. The module was later enhanced with additional guidance and videos. We also encouraged topics like Infection Prevention Control to be discussed at team meetings.

44. During the pandemic our management team had to spend an endless amount of time reviewing guidance and legislation. This then had to be distributed and provide support calls explaining what the changes meant. Sometimes we were online having meetings eight hours a day just trying to answer questions.

45. At the start of the pandemic the private sector was trying to give donations for certain things. I can recall that at that time some of our staff had to buy their own hand sanitizer and would have to pay £10 a bottle at a corner shop. Some of our staff were going out and buying what they could from a local B and Q store. There was a lot of pressure on managers to get masks, aprons, and gloves. That took a lot of time also. It also took a few weeks and months for local public health teams to build up stock of PPE at their hubs. After about six months these hubs did work well. There were also some challenges around communication including who could and could not get provision of PPE i.e., care homes only or all health and social care services.

46. There was large expenditure on buying PPE which could have been made available to us sooner. Different local public health processes also hindered us as we would have to communicate this across our workforce. Some of our managers also created enhanced measures for staff or service users because they were hearing what others were doing. It was difficult for us to communicate due to the breadth of services that we have and the constant changes to guidance.

47. Since then, we have made improvements to our contracts and procurement. We have a better understanding of how we can distribute goods like PPE to staff.

48. Overall, the COVID outbreaks within our services were minimal and we did not have any service user deaths related to COVID. I know we had a different environment to health settings, or the larger older people care homes however, our challenge was the often-chaotic nature of our service users. Our staff were

doing the right things to protect themselves and others there was no guarantees that our service users were doing the same. They may have been going out and meeting up with several individuals. That was an anxious period for our staff.

49. Within our care home Infection Prevention Control was always part of what we did however, the pandemic was another level all together. That meant that things needed to change including staff roles. Additional tasks around cleaning and infection, prevention control was installed. Most staff were ok with the changes but there were a few that would say they were not cleaners so why were they having to clean. The guidance dictated what we had to do. This also included the Care Inspectorate guidance.

50. We had challenges with the Care Assurance Teams. These teams would conduct visits and spot-checks at our care homes. That was challenging and frustrating as it was not communicated effectively well and was also not implemented effectively. We were under a huge amount of pressure and then a mixed team would come into buildings demanding things. Some of our service managers did not know what they should and should not do as part of these inspections. It felt like a reaction to the horrendous mortality rate that there was and this pointing the finger at care homes. We found these to be difficult and challenging. We did not appreciate the way it was done.

51. There was feedback provided through CCPS about the way these Care Assurance teams operated. We did not know the checklist they were using and considering this our managers were put under a huge amount of pressure.

Testing

52. The testing of staff and reporting the results were challenging to us an organisation. Once we were over the initial challenge of the pandemic testing became established. There were challenges around how that was implemented. Local health and social care partnerships information along with national information became a challenge. As an organisation we had to join the dots. On occasions some of our local services knew of information about testing procedures prior to us at the centre of the organisation.

53. We had to spend lots of time reporting on the testing. This included recording the positive and negative tests. We had to log every PCR test for staff twice a week. We had to devise a process to make this work especially if staff were on different shifts. Some of the practicalities around this and how this worked day to day was a challenge. We on occasions had extra enquiries from staff who were asking if they would be paid for coming to work half an hour early so, they could carry out a covid test.

54. A further challenge for our frontline staff was if they had dependents at home who were relying on them. We had to quickly put in place plans so staff could deliver services online. Some other challenges included staff asking managers why other staff members were being allowed time off work. Our resource

allocation and continuity plans were tested to the maximum limit during the pandemic. The risk assessment model helped us at this time. We also combined our services dependent on geography. An example being the areas of Fife and Tayside supporting each other and all the Glasgow services working together.

55. The reporting of staffing levels to the Care Inspectorate was also a challenge. This additional pressure on service managers meant that they could not do other duties.

56. In summary the constant changes in practice and additional scrutiny were really challenging to staff and management. The care assurance teams did not go down well. We were all at our limit after the first 6-9 months of the pandemic and for to have that extra layer of scrutiny added did not sit well. Especially if a dental nurse was part of the scrutiny team telling a care home manager what is right and wrong. This was well documented through the members of CCPS.

Finance

57. In respect of furlough most of our staff were working in services where they still had a job to do. Maybe we could have made better use of the furlough scheme as we only had a handful of posts subject to this. Our staff were still required to do a range of supports for people. Our concern was that we were working legally and ensuring that we claimed for the right things. When we found out we could apply for additional resources or funding that process was tricky especially as every health and social care partnership had delivered services differently. In some cases, there was endless amounts of information required and in others there was very little. All had different governance arrangements.

58. Our Fundraising took a bit of a knock and flat lined during the period of the pandemic. A few of our regular supporters who made a monthly contribution stopped. There were pockets of central funding for new initiative and new support. We felt we never got as much access to that as we felt we should have. On one occasion we had to go to another trust for funding for a service. On a plus side there was a few corporate businesses that made donations at the start of the pandemic. That helped with the purchase of IT equipment.

Services

59. The pandemic had an impact on several of our services. One of these was on our horticultural services. Prior to the pandemic we had four horticultural services in Scotland. This is now down to three. They are in Edinburgh, Fife, and Dundee.

60. The restrictions surrounding public transport had an impact on individuals attending. Some services moved online for several months at the start of the pandemic.

61. We also supported our service users with online workshops and wellbeing sessions. Some of the staff were working in the garden to keep it going. Where a

service user absolutely needed the horticultural service as part of their mental health journey, we managed that accordingly with the appropriate risk assessments. Some of our gardens are big with lots of space. Once restrictions were lifted, we could quickly welcome people back to this service. With two and a half hectares of space in some cases people could work on their individual projects.

62. We have peer support workers as part of our staff. They are embedded in a range of services. Once the restrictions were lifted during the pandemic these support workers were allowed to deliver services face to face or a mixed mode of delivery (including online) as and when required.

63. Our National Employment Team deliver our Individual Placement and Support Service (IPS). We have a team of 15-20 staff mainly across the central belt covering Glasgow, Edinburgh, and Fife. They delivered one to one support in a range of community settings. Either one of our offices or a community mental health team office or GP practice.

64. During the first six to nine months of the pandemic our National Employment Team delivery had to change. That team was a little ahead of our other services at the start of the pandemic. They were not working in care home settings but were supporting services users. This team were using technology prior to the pandemic so when lockdown happened, they were able to move things online quickly. They had been doing online support prior to the pandemic.

65. SAMH has three homelessness services. These are all in Glasgow. All of these are registered services. One of them is a care home. The other two are care at home housing supports. They came under the same guidance and challenge as our other services. Managing these staff and homeless services users during the pandemic was challenging. They were badly affected by the pandemic. The nature of the service users could make this challenging. Especially as some had chaotic lifestyles.

66. Our suicide prevention team were also affected. That team had to change rapidly at the start of the pandemic. Prior to the pandemic a big part of their remit was training including face to face training. We are one of the main providers of Assist training. This training is licensed by Scottish Government, and we were commissioned to deliver two-day training courses across Scotland. The impact of the pandemic meant that this had to be moved online. We also had to pause the delivery of face-to-face training and develop new methods to support training in workplaces and communities. We know that during that period lots of people became more connected using technology. On the other hand, others did not and were in fact isolated. Even in the media there were messages about reaching out and supporting others. As restrictions were lifted in the autumn of 2021, we tried to re-establish both face to face and mixed mode training courses. We used the good practice we learned during the pandemic however there was still a lot of anxiety from the public and staff. That period was peak vaccination period however we could not stipulate that our staff had to be vaccinated. Most of our

staff jumped at the chance to be vaccinated but this could not be mandated. We did have a few staff members who did not wish to be vaccinated.

67. SAMH has a concentration of suicide prevention work in the northeast of Scotland. This is commissioned work and we have done this for over 10 years.

68. Our physical drop-in services closed at the start of the pandemic. One of our key services was on the grounds of a hospital and that had to shut. Most of our drop-in services moved online. Our staff provided online and phone support. When community venues were happy for us to start again then we were able to do that. We tried to amend our delivery and add any value we could as part of our service delivery. This could involve us conducting online workshops, peer support forums to encourage people to connect, webinars, seminars for existing service users and local communities. Once it was safe to do so we returned to delivering face to face drop-in services.

69. In respect of referrals for our services that was different across the country. In some cases, practice continued as normal. An example of this was our employability services. They continued to pick up referrals from community mental health teams or GP's.

70. Our self-referral services such as our horticultural services or drop-in services are all self-referrals. We kept these services open and ensured that we had clear communication so that people knew what services were available and what were not. For us as an organisation there was less movement of individuals during that period within commissioned mental health space i.e., from psychiatric wards to our after-care services. Where individuals were moved it was complicated. This included having to conduct additional checks and multiple negative tests. There was also less referrals to Child and Adolescent Mental Health Service (CAMHS).

71. SAMH created a coronavirus mental health hub. This was designed by our communication team and was within our website. We also worked with our sister charity in England 'MIND' to collaborate on a different range of resources for the public. We pulled together as many of our mental health resources as we could so that we could help people that were reaching out. This included information on financial matters, relationship issues. An example of this was that we produced material to help a single parent manage three kids at home whilst also was having to work. We know from research that mental health deteriorated during the pandemic for most people. Our mental health hub provided the public with trusted information. Our information line was also open five days a week. Our website had a resource available to the public called 'mood tracker'. This was aimed at assisting people seek help and manage when they are struggling and in need of additional help.

72. From a financial perspective it is very challenging now for us at SAMH and recruitment and retention of staff remains a key priority

73. It was probably not until the start of 2022 that organisationally were we talking about getting back to main offices.

Impacts on the COVID-19 pandemic on the Organisation's membership

74. The pandemic did affect our service users. Quite often we were the only organisation engaging with our service users and offer a range of supports for these people. That changed depending on the risks and vulnerability of the individuals. Where the risk was high, and a service user needed more support we would meet face to face. Other service users would receive online support and check in wellbeing calls.

75. During a survey of service users most of them said that they did prefer face to face support. These were mostly the service users with severe and enduring mental health problems. This was within our registered services. That service could see people three or four times a day or three or four times a week. This depended on the type of service that they were engaging in. Changes to this service provision was massive and had a big impact. Especially as reduced face to face contact meant that some were isolated especially if they never had many other contacts with family or friends. Once again, our view was that there was little engagement with these service users by statutory services unless there was a crisis or an emergency like someone having to be re-admitted to hospital.

76. Our peer support and community resources closed at the start of the pandemic or moved online. Some of our service users were supported and had the ability to engage digitally but some of our users were also digitally excluded. A lot of our service users didn't have the IT equipment, or they never had the skills or knowledge to access our support. This had a huge impact on our service users in addition to not being able to see their friends and family on a regular basis also.

77. Where we could we tried to deliver a high level of support based on the needs of the individuals. These had to be provided safely. This included taking on extra duties such as fielding shielding calls in Aberdeen. We were also asked to increase our support for medication administration in some areas as some statutory teams didn't have the resources available to deliver it. From a financial point we were being funded to provide services so we would flex when asked to do so.

78. Every one of our services has a slightly different referral pathway. The impact for SAMH following the opening of services was an increase in demand. This also included referrals made from statutory services.

79. We have a children and young people team. This team has about a dozen members of staff. This team is primarily focused on work in Edinburgh, Glasgow and one other area. Part of this team's role was to give advice to young people, parents, teachers, and support staff working in schools. There is no doubt that the communities or households that are most disadvantaged struggled the most during that period. This impacted on the children and young people.

80. Following the pandemic, we have seen an increase in requests for help and enquiries. Since that time, we have increased our delivery in several local authority areas.

81. During the pandemic the number of referrals to specialist mental health support for children and young people reduced. This was because young people were not in school and so teachers were not able to make referrals. Young people were not visiting GP's so there were fewer referrals made there also.

82. Our coronavirus mental health hub was accessed 76,534 during 2021. This information is contained within our SAMH Impact report 2021.

83. We also have an online learning module for teachers about how to identify and have conversations about mental health. In April 2020, that module was accessed over 4,000 times. At that point of the pandemic teachers were having to work online and how could they identify pupils who needed support. Our website and wellbeing tool were accessed massively. I believe our website collectively in 2021 and 2022 was accessed over half a million times.

84. We also published our strategic report 2021/22. This outlined our official objectives and activities for that period. Our report includes a section on the pandemic response which indicates that our contingency planning continues to evolve. Our business continuity processes have all been enhanced during this period. We have also invested in an additional resource to support our risk management, business continuity and contingency planning making sure that we have more fail safes across the organisation.

85. There were two pieces of research conducted following the pandemic, the aim of which was to understand the impact of the pandemic: 'Forgotten' research focused on experiences of people with pre-existing mental health conditions. This report summarised key findings from a longitudinal research project undertaken by Name Redacted on behalf of SAMH. The two key research questions were: Q. In what ways has the treatment and care that people in Scotland receive for their mental health changed due to the coronavirus pandemic? and Q. How have these changes been experienced by people in receipt of care and treatment, and what effect have changes had on their mental health?

86. Over 1,000 people took part in the research, through three surveys which ran in August, October and November 2020, and a series of 15 interviews which took place between August and December. To take part people needed to: live in Scotland; be over the age of 16; and have been referred to or received treatment from a professional (such as a GP), organisation or service for their mental health.

87. The 'Forgotten' Research (Impact of the pandemic) has a lot of information and highlights that those people with poor mental health are often those furthest away from the support that they need. Through that research and through our

own internal research with service users we identified the lack of access to face-to-face support during the pandemic was critical and had a massive impact on people.

88. As we moved through 2021 into 2022, pandemic related restrictions changed, and the NHS began to remobilise. A further piece of research was conducted and is named 'Still forgotten'. This was commissioned to better understand how the delivery and experience of mental health care and treatment changed as restrictions eased.

89. What we have learned from this research is crucial for helping inform how mental health care is delivered in the future as we tackle the short- and long-term legacy of the pandemic. The research was timely, coming as the Scottish Government was preparing a new mental health and wellbeing strategy and new suicide prevention strategy. We hope the findings will help shape these important national plans and ensure people living with mental health problems can access and receive the care and support that they need in a way that works for them.

90. Structural changes to mental health care and treatment, such as a move away from face-to face care and treatment, which were introduced due to COVID-19 persisting into year two of the pandemic.

91. As COVID-19 restrictions eased over 2021-22 and the NHS began remobilising we would have expected to see a return of face to face support, this has not happened for the vast majority of participants.

92. GPs remain the predominant point of access and deliverer of mental health care and treatment before and throughout the pandemic.

93. There continues to be higher levels of satisfaction than dissatisfaction with mental health care and treatment across a range of indicators such as treatment quality and the ability to discuss treatment options. The lowest levels of satisfaction – both for treatment from GPs and specialist services – was with crisis care.

94. Slightly higher levels of satisfaction with specialist services than with GPs were found, and may in part be due to more consistency of practitioner, length of appointment, tailoring of support and more face-to-face delivery.

95. In 2021, just over 5,000 people sought support from SAMH. That is now looking like over 7,000 people seeking support in 2023. This is the amount of people contacting our information service.

96. In 2022-23 over 20,000 people received direct support from SAMH. This was in respect of an intervention, programme or service.

Lessons learned

97. We have better policies and procedures in place to support a network of services than we have ever had before. We have better infrastructure around Information Technology (IT). Through that we as an organisation have had a focus on digital inclusion for staff and service users. This allows people to make decisions about what works for them.

98. The focus on Infection Prevention Control, Business Continuity plans has meant that people now know the real understanding of such matters. This will allow services to adapt quickly to situations.

99. If the worst was to happen again people now have the devices and the knowledge. I believe that we would be in a better place. The worry is that currently we are still recovering from the pandemic. Everyone's resilience is going to be factor. Our services are at breaking point about mental health. We are constantly having to change and adapt our delivery models. This includes our timelines and effectiveness of support. As an organisation how do we keep delivering more for less.

100. Our national contracts are better now so I believe we would be able to do things more effectively. We also have improved relationships with organisations such as Public Health and Health Improvement Teams. We have stronger relationships with the Care Inspectorate also. That has been important.

101. 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 the 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.

102. I believe that the facts stated in this witness statement are true. I understand that this statement will form part of the evidence before the Inquiry and be published on the Inquiry's website. By typing my name and the date below, I accept that this is my signature duly given.

STATEMENT CONCLUDES

Signed - Alex Cumming

Date 29/1/24