Scottish Covid-19 Inquiry

Witness Statement

Statement **of Vivienne DICKENSON.**

INTRODUCTION

1. My name is Vivienne **DICKENSON**. I am Personal Data. I am the Chief Executive Officer (CEO) for CrossReach. My c/o address is CHARIS House, 47 Milton Road East, Edinburgh, EH15 2SR.

2. 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 this November/December 2023.

3. CrossReach have previously provided information to the Inquiry. This was a rule eight response.

4. I have worked for CrossReach for over twenty years. I have worked in most areas of social care in CrossReach including Children and Families Services, Mental Health, Homelessness, Criminal Justice Services, and essential support services. I became the Chief Executive Officer in 2017.

5. In my role I had connection prior to the pandemic with the Scottish Government (SG) through individuals in the civil service. I was not on any Advisory Group, but I am a Board member of the Coalition of Care and Support Providers in Scotland (CCPS). This Board provides support and advice to non-statutory care and support providers.

6. The Coalition of Care and Support Providers in Scotland membership comprises of around 90 of the most substantial care and support providers in Scotland's third sector, providing high quality support in the areas of community care for adults with disabilities and for older people, youth and criminal justice, substance use, homelessness, and children's services and family support.

7. The Coalition of Care and Support Providers in Scotland represents about a third of all care provision in Scotland. It was an ideal body to represent concerns about the effect of Covid-19 guidance on the third sector and to promote a shared understanding of these issues given the diversity of social care services represented, including children's services. The voluntary sector has a wide provision in respect of social care but does not have a wide representation from nursing or residential care home providers.

8. Scottish Care is the largest membership body for the independent care sector, covering private, not for profit and charitable provider organisations. It

represents the majority of the care home Providers in Scotland so many of the concerns shared by care home and care at home providers were raised through Scottish Care. We also raised questions and concerns that way.

9. The work done by both of these organisations was invaluable as they were able to distil the essence of Provider concerns to Government and seek clarification and solutions, allowing Providers to get on with the immense task of delivering services on the ground during this time.

Organisational overview: CrossReach

10. The Church of Scotland Social Care Council is accountable for the work of CrossReach. Its remit is to provide social care services and specialist resources in Christ's name to further the caring work of the Church to people in challenging circumstances. It also helps to identify areas of need and guides the Church in new approaches to relevant problems in society as well as responding on issues arising in the Council's areas of concern.

11. The Church of Scotland is the national church in Scotland and has been in existence since the Reformation in 1560. It is the parent charity (Scottish Charity No SC011353) of approximately 1,000 individual congregations, each of which has separate charitable status, its charitable purpose being the advancement of religion.

12. CrossReach sits under that charity number and offers care and support to people of all ages across a wide range of different needs, in locations all over Scotland. It is one of the largest voluntary sector care providers in Scotland, with services including homelessness, mental health, learning disabilities, criminal justice, substance use, residential care for older people, support for those affected by dementia in the community, counselling, care and education for children and young people and day care. In the context of the Inquiry, it represents both those in receipt of its caring services and its care staff, who were key to the delivery of these services.

13. CrossReach is unique in Scotland due to our geographical spread and range of services that we provide. We support people experiencing a challenge to their mental health in the ante ante-natal period and we support older people at the end of life. In our Children's Services we deliver perinatal mental health services, have a number of small houses where we offer home to looked after children, run our own school and work with children with disabilities. We have two prison visitor centres supporting families and run counselling services. Our adult services (18-65) offer support to people through services covering mental health, homelessness, criminal justice, learning disabilities, substance use. Our Older People Services include residential care homes (not nursing care), day care and heart for art groups which is community support for people with dementia. Although CrossReach has a large residential care portfolio most of our work is in people's own homes or in community settings.

14. CrossReach has services all over Scotland. Our most southerly provision is a Heart for Art group In Galashiels and our most southerly residential care home is in Ayr. Our most northerly care home is on Shetland. We have a supported living service on the Isle of Lewis for people with a range of challenges who are preparing to live more independently and an outreach service for those affected by substance use. Most need reported to us, however, is where the densest populations are within the cities of Scotland and, the majority of our services are based in and around the central belt.

Funding

15. CrossReach is funded in a variety of ways. Some funding is provided by the Church of Scotland, but much of the funding is commissioned funding coming through local authority tenders. We work largely with local authorities who are our statutory partners, and we would provide care on their behalf. Within our care homes there are people who largely pay for their own care (self-funders) as well as those whose care is paid for through the National Care Home Contract. We also have a fundraising team, so some funding comes through charitable fundraising and donations. About 66% of funding is contracted work through local authorities.

Membership

16. CrossReach employs around 1700 staff and benefits from the help of around 345 volunteers. We support over 11,000 direct beneficiaries a year.

Pandemic

17. As an organisation we could see what was happening in Italy in relation to the impact of COVID and the distressing situation in care homes in some areas. As early reports of the pandemic reached the UK, I wished to know more about what COVID-19 was and how we needed to organise at that time in order to manage the effects of it on our own people.

18. As an organisation, CrossReach already had procedures in place for infection protection and control and our staff were good at applying these. This was already critical activity for CrossReach services as we regularly dealt with norovirus outbreaks and seasonal flu outbreaks in individual services for example. This would require PPE and some stock was held in residential services. Our initial question was do we have everything in place to ensure that we could respond if several services had a difficulty at the same time , then as an organisation, do we have the resources in place to be able to perform our core functions?

19. CrossReach created a contingency planning group to think about and plan for what might need to happen. This group communicated with the services in a planned way rather than each service area having to do its own thing which could have led to significant confusion. We were keen to have a level of consistency of advice across the organisation.

20. At the time when the pandemic was coming into the country and the Government was raising the alert, most of our decision making was facilitated through that contingency planning group. On that group there were senior representatives from each area of the organisation. One example of how this worked early on is that we took a decision to lockdown care homes more quickly than the government were advising at that time as we were concerned about the risks. This was brought to the group by representatives of Older People Services, We were an early adopter of that advice. We were cognisant that something big and risky was coming along and that the people living in our care homes were often hugely frail. Looking back did we understand the scale of the pandemic to come? Absolutely not. Did we understand the likely infection rate? Absolutely not.

21. My role as CEO changed during the pandemic. Rather than concentrating on governance, and longer term planning I was asked a very large number of questions which I had never faced before on a daily basis. The balance of my time initially became internally focussed as we tried to make sense of what was happening and make the best decisions possible. The contingency planning group dealt with making the guidance accessible and manageable for services and dealing with the day to day questions coming from services. My role included taking all the anxiety and concerns being expressed from various areas of the organisation and feed these up to Scottish Government, Scottish Care and CCPS in order to try to find a way forward as well as gaining governanace approval where this was required. Questions would include concerns about safety for supported people and staff, levels of PPE supply, talking through emergency terms and conditions for staff, financial concerns, what IT support we could put in place to keep people connected, concerns being raised by families about levels of access etc.

22. Some of the questions I would ask of these representative groups or Scottish Government included, "what does this aspect of guidance mean in the context of some of our services, how can we apply that when it simply does not take into consideration the challenges faced by some of the people we support?" At other times I would be pointing out resource issues we had in terms of implementing guidance. My role at that point was to be the external face of the organisation in ensuring that we could apply guidance and were resourced correctly to do so. I was also a communicator in terms of supporting people; thinking through some of the experiences and deciding what CrossReach had to do next. I can recall one of my care home managers being in floods of tears about her experience and could see that it was overwhelming. I knew as an organisation we would have to do something very quickly to deal with the trauma that the staff were dealing with as part of their role. I would say I had a strategic oversight role for the organisation in terms of the pandemic.

23. At the start of the pandemic the guidance we received felt very scattered. We initially got communication directly from government, civil servants, or local health boards.

24. One of the issues was that local health boards would tell us something and this was later superseded by government instruction/guidance. Sometimes the government instruction would be analysed by local health boards who might take different views when we tried to apply guidance in services. In the beginning there was a lot of confusion, especially about the line of control and what guidance was pertinent. There were also directives directly from Jeane Freeman at that time (Health Minister). She would write out and we would interpret the evidence for services through a series of bulletins.

25. One difficulty for CrossReach was that we are such a large and diverse organisation and soon found that the guidance being issued did not fit all services. So, when guidance came out for care homes, we were looking for guidance which would be relevant for supported living services, substance use services, homelessness services and for our children and family's services. Unfortunately, some of that guidance never materialised and some was issued in such a way that the context in which we are operating was lost.

26. The role of the contingency planning group came into its own at this point. What we did as an organisation was take the guidance and examine this to ascertain if it had wider implications for the organisation. Did the guidance make sense in other settings? Sometimes the guidance did make sense to roll out more widely and sometimes it did not.

27. At that point each of the Directors would write local protocols. This meant that they would take the latest guidance and write a local protocol which could be implemented across a variety of services for their area. This really helped with consistency and avoided the issue of people just filling the gaps as they went along and potentially putting themselves, or others, at risk. I was most worried about this as in absence of good guidance there was a huge risk that people, faced with the overwhelming needs of the service users and others would fill that vacuum with decisions which would not reflect the evidence or based in good practice.

28. During the pandemic, the contingency planning group sent out 80 bulletins to services through services managers who then shared with staff. This was to ensure that staff could make sense of the guidance, understood best practice as things evolved or to give them a direct piece of information.

29. Bulletins were distributed to staff who would feedback with questions or specific implementation problems. That was where my role would become involved as I would ask the questions and request clarity on their behalf.

30. At CrossReach, we responded quickly when the pandemic started. We were aware of the frailty of the recipients of our care. This includes both physical and /or mental frailty. Many of our supported people would have been considered clinically vulnerable. (in terms of the interpretation of risk from Covid infection at the time)

31. Supporting staff was another key priority for CrossReach at that time. If staff are well supported, then they are much more likely to be able to provide good care. We were keen that staff support was as steady as possible, so they were not panicking in the situations they faced or simply leaving. One way that we tried to achieve this was to make the guidance as clear as possible and for the bulletins to be a one stop shop so that they could focus their efforts on the challenge of implementing.

32. At CrossReach we introduced an information tracker. This allowed us to manage all the new information and guidance we received. Once we had made sense of the information as an organisation, we also kept a record of the distribution of this to our staff and the questions/issues coming back.

33. The guidance was ever changing. An example of this was one day our Implementation Planning Group lead had written a bulletin ready to distribute to staff with new guidance issued that morning. At 4pm that afternoon the bulletin was ripped up and re-written. That was how fast things were changing.

34. The challenge we had was when Public Health advice was received, we felt that we had to respond as quickly as possible given that public health have the backing of the law behind them despite use of the word, guidance. The other problem was that initially new guidance would come out on a Friday afternoon to be implemented on the Monday morning. We did not have a hope of getting that out and well implemented on a Monday morning. As a large organisation we needed at least two good working days to communicate information and to ensure that staff were responding well to the change rather than weekend days. Some of the fast-moving guidance included withdrawing types of PPE. As I recall the type of gloves to use became an issue at one point. We were keen to ensure that change was understood and the implementation was done well and consistently.

35. The Coalition of Care and Support Providers in Scotland commenced a Monday morning clinic to allow care providers the opportunity to contact them and ask questions regarding the changes to guidance rather than do this piecemeal. That was helpful as it allowed us to share concern and understanding. Scottish Care organised a Tuesday morning clinic to provide a similar service for their members. This allowed for issues surrounding care homes and care at home to be picked up there too.

36. Where I needed advice quicker than the two clinics could offer, I would just pick up the phone to a Scottish Government official, or e mail and ask that way. That worked well for some queries.

37. CrossReach would feedback to The Coalition of Care and Support Providers in Scotland or Scottish Care. What I felt was difficult, however, was that I do not think there was a proper understanding of social care in the early days of the pandemic and that just made everything more difficult despite the efforts of these representative organisations. If the Scottish Government/Public Health had

consulted with the sector and their membership organisations earlier, we might have had less confusion about relevance of some of the guidance and less need for that guidance to come out in the way that it did. Just for the Government to understand that social care is not all about residential settings would have been useful and even then that residential settings can be very different. What they all have in common, however, is that they are there to support people to live as full a life as possible whatever their vulnerabilities and challenges. This is the same in residential and non-residential settings and includes work in community settings. There was a fundamental misunderstanding there, which started with thinking that somehow care homes were simply clinical settings and could be understood as mini hospital wards and not understood as people's homes.

38. My view is that Government did made a mistake there. That was where some of the frustrations came in. Making that assumption about care homes in the first place and then not recognising the variety of settings that social care is delivered in or the complex needs of the people we support meant that the guidance issued did not resonate with what we were having to manage on the ground. It felt like guidance was one size fits all whereas we operate in so many different types of services for example prison visitors centres or accommodation services for people who are homeless that there was quite a stretch to apply guidance in all of these settings. It felt like the guidance was coming down in an NHS directive model rather than able to take in the nuances of our different settings and allow a degree of flexibility. I saw this first hand as we were dealing with the guidance for care homes and some adult care settings and trying to pull out of that guidance for children and family services, which wasn't always appropriate. It was really complicated, and illustrated a misunderstanding of how social care is organised and operates across the country.

39. It was further complicated as some of our services would have been subject to advice covering other settings. We would have to work within prison service guidance for the prison visitor centres. We also run our own school so we would be subject to the education guidance. There was a lot of guidance being circulated by mid pandemic. This made our information tracker very busy as we were trying to capture everything that was relevant in all our settings and then make it comprehensible to staff who were understandably frightened and confused at times. Staff in addition to working were trying to look after their own families at home, and schools were closed so trying to oversee lessons too.

40. I fully recognise that all of this would have been complicated for Government. However, it was all hugely complicated for us as an organisation due to our size, geographical spread and diversity. The way that guidance came down from Government, often not suitable for our services made it difficult for organisations such as ours to ensure that we were getting implementation right at all times. This was one of the reasons why we became organised very quickly, so that we could help mitigate risk.

Care Homes

41. Before the pandemic, we had already started to be concerned about the move to making care homes feel more clinical. They are not hospital settings they are essentially people's own homes. Many people sell their home to come into a care home. This will be their primary place of residence and when you provide that environment for people you have a huge responsibility to make sure that it does feel as much like home as possible.

42. Pre-pandemic, we were always thinking about how we organise care homes. We run small homes with nothing over forty residents. The key thing was how do we organise to make people feel as much at home as possible? Examples include people decorating their own rooms, bringing their own furniture with them, doing activities that they might have done outside inside the care home or still taking part in lots of activities outside. If someone wished to go to the theatre once a week, they could still do that. We wished for people to live as normal a life as possible while having the safety or additional support that you do get in a care home.

43. When Covid struck it felt like we were being asked to turn our philosophy on its head and make our care homes into mini hospitals. An example of this was when a care home did have an infection outbreak, we were asked to move residents from their rooms and have people with the infection in one part of the building and people with no infection in the other part of the building. We could not do that. The Government were not fundamentally moving people from their own homes in streets or blocks of flats depending on whether they have an infection in that street or block or not. The fact is that the room within the care home was someone's home so we could simply move them particularly when the resident did not have the capacity to understand why and that it was temporary for their own or others safety.

44. About 82% of people living in our care homes have some form of dementia and some advanced dementia. For those residents following rules that do not make sense to them was a challenge. If someone does not have capacity to understand, then it is difficult for them to understand why you are disrupting their routine and why they can't access their lounge, dining room etc, let alone move them from their room.

45. The isolation policy was difficult for them. Followed through it could mean that a resident would be expected to sit in their room all day with a hope that the television is going to occupy them until staff members could spend some time with them. Many of our residents have a need to walk around and find occupying themselves by reading or other solitary activities impossible. That was never going to work in our setting, however, that seemed to be what was expected. There was also an expectation at some point that residents should wear masks, for someone with dementia that would be very likely to add to their distress so much more difficult than it sounds.

46. First, you saw that curtailment of visiting, then of communal activity, then an introduction of cleanliness and sterility which disrupts the very nature of home and feels more like a clinical environment so that there was a huge risk of people becoming more and more isolated as time went on. In addition to that, and while expecting staff to follow clinical standards there was an initial failure to provide the resources we needed to respond to the instructions coming down. It felt like we were a second-class sector.

47. As a result, we saw mental health issues or distressed behaviours due to increased isolation for with dementia particularly. The staff did as much as they could but could only do so much. Whilst people may be being protected, I would say some residents were not living life to the full during those times and some would die in those circumstances.

48. We understood early in the pandemic that the infection was airborne. That seemed to be the advice. We had experience of dealing with infection outbreaks, so our view was that PPE and face masks were going to be important in managing infection. It was clear that we had staff going in and out, so we were never going to keep Covid out forever no matter how careful we were.

49. Initially there was no consistent PPE supplies to care homes, so we had to rely on our own resources. Supply was drying up, so people were starting to panic. At one point I can recall we had one week's supply of PPE for the whole of the organisation. A week's supply was about 20,000 face masks for us.

50. On that basis you can understand that at CrossReach we needed a lot of PPE. Our managers were going to their normal suppliers who were saying that they were only providing to the NHS or that they could supply but had increased the price up to seven times.

51. I can recall a piece of guidance being circulated which said that the staff themselves should risk assess whether they should wear PPE or not. This was at a time of PPE shortages. The risk assessment option was tricky as if there was a highly anxious member of staff then they would always risk assess that they needed to wear PPE. The difficulty with that approach is if staff risk assess that they require PPE and you do not have a supply then you are doing them a disservice and making things worse. At that point we made it our mission to go out strong and loud on the need for a good supply of PPE. One reason for this was that hospitals were refusing to take people from care homes for treatment and we would be caring for very unwell people. Ultimately, we did this and provided palliative care through Covid until the point of death for some residents. We felt passionately that we needed to do all we could to protect our staff and their families as well as residents through the use of PPE and other measures at those times.

52. The PPE supply was not fully resolved until a government triage system commenced. There were still issues where care homes would have to wait three

to four days for supplies to reach them. I have further information surrounding this and a timeline which can be provided if required.

53. Adult Care settings (out with residential care homes for older people) were also asking for PPE. They were supporting people with learning disabilities, mental illness and in substance use services who were potentially clinically at risk and were finding it hard to access PPE. I can also recall there was no chance of our children's houses receiving supplies of PPE from the Hubs at one point. The children's houses were more relaxed with that as the staff felt that the children were like their own kids so if someone had an infection then you would not put a face mask on as you would not put a face mask on your own child, however there was a concern that this approach might have put them at odds with the guidance issued at times.

Restrictions on visiting

54. Restrictions on visits at care homes became such a point of contention especially as we were following in full the guidance from public health. This was one of the most difficult areas in terms of the emotions which were triggered and the upset for residents and relatives. However there was little, if any scope for doing anything differently given the strength of the guidance from Public Health, which, ultimately, does have the backing of law. CrossReach made the decision to allow essential visits from the beginning. So, if someone were at end of life or critically ill, then visits would be supported. About a third to a quarter of our care home residents reach end of life every year. Many people who come in to a care home are already very frail and elderly and need support. We are used to supporting families at the end of life of a loved one. We also know important it is for families to get together at the end of life wherever possible.

55. The challenge came when the guidance began to talk about essential visits also being something which care homes should consider depending on the needs/behaviours of a resident. Determining who was an 'essential' visitor given the anxiety held by relatives about their loved ones and the strongly held belief that if their loved one was not receiving visits then their quality of life was diminishing could have put everyone in the essential category at some point. This was really difficult and put managers in an almost impossible situation.

56. Some people were really frustrated during window visits as they could not communicate properly through a window. All of that was deeply upsetting for staff to watch but mainly for our residents and visitors. The lack of visiting was difficult too when visiting did come in because of the restrictions around testing, touch and locations etc. Our managers were dealing with the upset from visitors. Some visitors were also frightened and did not wish to risk bringing in the virus into the care home so it was a bit of a balancing act.

57. I would say that about 50% of the visitors to our care homes were upset at some point about the guidance for visiting and this had an impact on the managers. They were also dealing with infection control and staffing issues.

Where the managers were confronted with a difficult situation, from time to time I asked that family members call the Director of Older People services or me to discuss the matter. I wanted to take that additional pressure away from the managers when it became too stressful. I got very few of these calls from families as the managers or heads of service absorbed most of the matters and found a way through themselves.

58. Palliative care was impacted by the way the guidance was interpreted. Staff were having to do an awful lot more in terms of very ill residents than they would normally have to do, as residents were not being admitted to hospital and several could be unwell at the same time. We were not having General Practitioner's coming in as at one point they were refusing to visit. We were not getting nursing care delivered in the same way right at the beginning. Our front-line staff were supporting the end-of-life care and in particular palliative care. That was hard for the staff.

59. In respect of hospital admission more generally, we got a lot of push back from them in terms of admitting non Covid positive patients. I was aware that much of the focus was on not overwhelming the NHS, which was important and our residents were already in an environment where many of their needs were being well met anyway. However, people in care homes require medical attention also.

60. I can recall that I personally intervened in two cases within one of our care homes where I believed that people should be given hospital care. In one case someone had fallen and cracked their hip. NHS were refusing to assess and admit these residents to hospital. We escalated this through CCPS and had to work hard to ensure that our residents were not being disadvantaged.

61. Other matters such as dentistry and chiropody were stopped. The care home staff basically had to attend to any issues best they could. Dental issues are now prevalent in that population. The population that we have depend on these services quite critically. This includes access to dieticians where necessary and our residents were not getting good access to these services initially and at a very vulnerable point in their lives.

62. Personally, I think there was some discriminatory practice towards people in care homes at the start of the pandemic. The need to protect the most frail should have placed a higher burden of care on Scottish Government rather than their frailty being something which was overlooked in early decision making, for example discharge from hospital into care homes, or seen as a reason for deprioritising resources to care homes to keep people safe, for example PPE supply.

63. Our care homes tend to run with a high occupancy level, they are popular. Our occupancy level at the start of the pandemic was about 94% (out of 502 spaces) That high occupancy protected us a bit from the emptying of Covid positive people from hospitals into care homes as we were already quite full.

64. We also took a decision early on that we were not going to admit from hospital. We could see the discharge from hospital going on and thought there were risks so we were pretty firm with our decision. When testing came in, we said that we needed two negative tests before new admissions could come into a care home. That was important to us as Public Health guidance made the assumption that we could take people in and isolate them for a fortnight. We knew that would not always be possible for people with advanced dementia so took a more cautious approach. Although there was a lot of pressure to admit, the care homes operated under our protocol of two negative tests before admission was agreed.

65. The guidance was contradictory in places. It did not advise on testing for people coming in from the community. They might also have been exposed to Covid but there would have been no way of knowing without testing. In essence either way at different points there was a move to try to discharge people into care homes without appropriate testing taking place.

66. My view is that it was ill advised to discharge people from hospital into care homes from Covid positive wards at the beginning of the pandemic. We had an incredibly vulnerable group of residents and although we would not have been able to keep Covid out for ever, given the coming and going of staff, this policy compromised the first line of defence.

67. It seems particularly unfair in the context of all deaths in care homes now being examined by the Procurator Fiscal to see if care homes have been at fault or contributed to a death, but they are not applying the same examination to deaths in hospital, where the majority of deaths actually occurred. There does not seem to be the same level of scrutiny. We are now three years on from these deaths and the Procurator Fiscal is only just now following up on some of them.

68. As an organisation we have had one relative approach us to pursue a claim for damages but that has since been withdrawn based on the evidence that we put forward.

69. The decision to examine care home deaths also had an effect on our insurers. The insurers took fright and stopped insuring care homes for infectious diseases from October 2020. This was even though we had a very good long-term relationship with our insurer over many years.

70. As providers we reported this insurance matter to the Scottish Government through a number of channels and advised of the impact of the Procurator Fiscal inquiries in particular on Providers. I was involved in these discussions and we attempted to make the case that the government should indemnify social care like they insure the NHS. We felt that the indemnity must lie with the government as we were following the government guidance. That was never accepted so we were left without insurance and having to self-insure.

71. The Church of Scotland made the decision to insure CrossReach for infectious disease cover from October 2020 until 2022. It was only this insurance year

when we got the opportunity to go back in and negotiate some cover. Where cover was provided for other elements of social care provision we saw prices rise steeply.

72. My understanding is that the impact of Scottish law regarding civil claims increases risk for the insurer under the loss of society provision and this increased the risk to them to an unacceptable level.

73. Another area which impacted on care homes was the changing behaviour of the Care Inspectorate. They were very arm's length at first but when Inspections started again they concentrated on IPC and how well that was being done over everything else. This was a change in tack as prior to that the importance of how well the care environment was meeting the care standards and care plan for a resident was the basis for Inspection.

74. In addition to isolating residents, it was expected that many of the items that mean a lot to residents and give them comfort had to be put away as they were a potential conductor of infection. This missed the basic premise that care homes should be homely environments not clinical settings.

75. We also had to employ extra cleaning staff due to the additional cleaning that was required under the new cleaning schedules. Sometimes the chemicals used would affect wood on handrails etc and then we would be marked down on our inspection grades because handrails were damaged etc. At that point, poor grades were reported directly to Parliament on a weekly basis. The press would often pick up on that so it felt like care homes were under the cosh for not being able to behave like mini hospital environments and the actual quality of care became a secondary issue.

76. We would also be marked down if we had not replaced or fixed something within three days. As you will be aware, it was very difficult to get a contractor to fix something never mind within three days. Once again this was another example of the misunderstanding of how difficult our situation was. This demoralised the staff.

77. In respect of Do Not Resuscitate Orders initially that had an impact on our services. All care home were asked to have a conversation with relatives about these orders. We were asked to get people to sign them where possible. My understanding is that this information came from a health circular that was distributed to local practices and then the local health teams were asked to talk to the care homes about the orders. I can look to see if we have a copy of that circular.

78. The decision was made by families or the individual resident if they had capacity at the time. These conversations took place within all our care homes.

79. The managers would have these discussions either by phone or if families visited the care home.

80. In respect of supplies we had centralised our own PPE supply in Edinburgh and distributed these through our five regional Hubs (delivery points) across the country. The centralisation of supplies allowed for us as an organisation to drive to the care home with supplies when local supply, which was their first port of call, became challenging.

Rural Scotland

81. In my role I had to make sure that all services were well served by the organisation. We have a number of rural services but the hardest to reach, in terms of residential care homes is on Shetland. The reason for this is it would take at least 24-48 hours for anything to get to Shetland. I would say that Shetland organised well, and they did a lot locally so were less dependent on our mainland supply.

82. I can recall that we did not get much early upset within the Shetland care home. It was quite late into the pandemic before the infection reached Shetland. The care home could pull on the PPE that was stored in Shetland. I am sure that vaccinations had been established before Shetland got a wave of covid infections. The care home managed resources and infections well. It is a small care home with sixteen residents. The care home there is called the Walter and Joan Gray Care Home, 2 Main Street, Scalloway, Shetland, ZE1 0XJ.

83. In other rural areas of Scotland, we have the Lewis Street Project and Dochas (community addiction programme) in Stornoway, Isle of Lewis. We also had other services on the Isle of Skye and Dornoch in the Highlands. We had no reports of issues reported because of their rural location. In terms of supply specifically. If there had been a staff issue that would have been different and more difficult to resolve. Overall, we did not swap staff between services as you could see the cross-infection risks but it meant there were some challenges for managers in making sure they had enough staff available to meet resident's needs.

84. When infection first reached the Isle of Skye our service there remained without infection at that point. The staff working in the rural locations were taking extra precautions and being ultra cautious. They recognised that they were a long way from help if they needed it.

Impact on CrossReach

85. In relation to care homes I think that out of everything that happened, some of which was really challenging it was the blame culture which really affected morale.

86. Our managers everywhere were having to operate daily with different pressures from different places. The impact of this has been that several managers have walked away from social care as a result.

87. Staff wellbeing overall was badly affected. Our staff teams were exhausted at the end of the pandemic and after a huge disruption to the way in which they offered support then had to work out how to restore it or to adjust to a new normal. CrossReach have only recently made the decision to remove the risk 'wellbeing of staff' as an impact of the Covid pandemic from our risk register however we have left the risk 'wellbeing of managers' on the register.

Homelessness – service

88. We have several services in Scotland which support people who are homeless or at risk of homelessness. These include services in Edinburgh, Stornoway, Inverness and Glasgow. Some support people who are fairly stable and on the road to getting their own long term tenancy and others support those whose lives are less stable and who may also be using some sort of substance such as drugs or alcohol. Most of these services are all accommodation-based services.

89. One challenge was that some of the accommodation was technically a house of multiple occupancy with people who have tenancy agreements rather than a care home. Residents would have a tenancy agreement.

90. The pandemic period should have been easier there in some ways as residents in supported living services should have been following more general guidance. However, as the accommodation is regulated there was the added pressure of the differing guidance in these settings, along with new care inspectorate measures. This meant that the situation became very confusing for staff and supported people. What guidance were they to follow, how much mixing should there be and what cleaning measures should be put in place for example?

91. In the services where supported people were pretty stable in their lives there was a real desire expressed by those individuals to keep themselves safe with support from staff and there was a real understanding that it was a tricky time for everyone. We did our best to support people by keeping in regular contact throughout as there was a danger that that particular population could become very isolated which could affect their mental health.

92. One service in Glasgow was challenging to run as some supported people there are less able to follow guidance. Some supported people in that setting do not generally engage with statutory services including health services well. They found it difficult to follow the guidance and were less inclined to isolate. Just to keep that service operating and safe was difficult for our staff there and following guidance to the letter nigh impossible.

93. The Director of Adult Care would read the government guidance as it came down directly to him or through the contingency planning group and agree what care settings particular guidance applied to. We also have accommodation based services for supported people with a learning disability, mental health issues, in recovery, or supporting those who have been in prison.

94. The impact of this was that he would have been writing local protocols for all our services to try to distil the guidance for each setting. The initial guidance was concentrated on care homes did not really take into consideration different social care settings including houses of multiple occupancy. That was where it all became a bit confusing. The other complication in writing local protocols was attempting to react to local guidance such as the 5 tiers. The Director of Adult Care would engage with managers to try to work with them on what would and would not work in their setting and to feed back any issues. The aim of our approach was for staff to behave as consistently as possible but to feel supported in their individual settings.

95. We had staff on site at our homeless accommodation. There was a high level of support going on in these services including an office base and support staff.

96. We do not provide emergency homeless accommodation but it seemed that the Local Authorities did manage to get people who were rough sleeping off the streets at that time. That was something that we saw coming through fairly early on as Providers highlighted the issues. We recognised that the homeless population had to be taken care of given that many of them would have complex physical and mental health needs.

97. It was a difficult time for everybody but there were particular consequences for social care in trying to keep services running and support people in the best way possible. It tends to be local government, as our commissioning partners, that make initial assessments and get the information and finance together to help people access the services that they need. During the pandemic some people's jobs were changed; some were furloughed, some were working from home, some redeployed. As a result, the normal referral routes into funding and/or getting a stable residential placement were disrupted. The impact was that our services could be running light and / or people not getting the support that they need.

98. For example, we had residential rehabilitation places available at one point during the pandemic, at a time when we knew people were struggling and there was need for a service. The barrier was with local government at that time not being able to do the administration for someone to access or get the funding in place to access support.

99. There could have been more done to support people in homeless and addiction services. however, the infrastructure at local level was not in place as attention was being drawn elsewhere. Our experience was that some local authorities had people diverted from their core tasks. The impact was that some homeless people, people with issues of substance use and some experiencing mental health issues were unable to access the services which they really needed at that point.

100. Although I believe that if someone presented in an absolute crisis then they would receive a service, there were many people who remained quietly at risk.

Sadly, we know of the deaths of two people who needed more support from our services than we were able to give under the guidance in place. They committed suicide as they were unable to access the level of support that they needed. One was seeking additional mental health support and the other was known to our counselling service but was relying on remote support which was not sufficient for their needs.

101. The Covid tiers that were in place in Scotland, when these were introduced, were complicated for our supported people to get their heads around. An example of this was where someone living in the homeless service in Glasgow who had vulnerabilities and chaotic behaviours was living with lockdown restrictions. That person might have found out that their family from Renfrewshire for example were out and about and going to activities which were open while they could not. That did not make sense to our residents, and they would challenge our staff on this or just leave our setting. The tier system was hard in social care especially if our residents were not minded to comply with the rules or where some people could travel to visit care homes and see loved ones, and some couldn't. The latter was rectified and travel to a care home was eventually approved under the guidance.

Mental Health Support Services including Counselling

102. CrossReach provide a number of mental health support services. We have two residential services where people are being supported having experience of mental illness. One is in Glasgow and one in Alloa. We also have a day service in Kilmarnock. We also have a sizeable counselling service too, although this is not always recognised as social care provision and is not regulated in the same way. We understand that it would have been complicated for SG to understand what is managed under social care during the pandemic given that it is not well understood at the best of times.

103. Our mental health settings were relatively stable. We support people who come into our service following discharge from a long stay hospital or on a forensic order. These residents would be known to our staff and could be supported by our services for a long time. After guidance was issued it allowed us to have conversations with the staff at these settings to work out how we would implement the guidance. If staff could not manage the PPE supply system, we would support them with that. They might have been low on the government priority list, but they were not low on our list.

104. The impact for people living in or accessing our mental health services as well as for those living in or accessing support through our learning disability services was that all of their usual support activities suddenly stopped. Supported people who were used to going out to a day centre, support group, arts and crafts activities or sport centres for example found that those activities, which supported their greater wellbeing, were suddenly withdrawn because of the pandemic. Our staff suddenly had to take on as much additional support as

possible to those who needed it as so many of them were already vulnerable and the disruption to their daily routine could make them more so.

105. Our Heart for Art group service for older people was stopped for a while also. That had a significant impact on families as this support is a wellbeing/therapeutic support for people living with dementia and their carers. We did develop a way of contacting our service users and eventually doing online therapeutic online art classes but that took some time.

106. Our challenge was in revising care plans for supported people who had been regularly going out of the setting to activities which helped them stay well and resilient. That was a lot of pressure on staff to try to get that right for supported people at the time.

107. Where we were running day services ourselves these were also cut. Our service had to be completely turned on its head. Staff at the residential end were now working hard filling gaps for all the statutory or voluntary services that had been closed, for example their own day service provision which our residents might attend, but those working in the community also had to find new ways to connect that complied with guidance and this was often labour intensive 1:1 support.

108. At the day centre in Kilmarnock, we had about one hundred people accessing the service before the pandemic. The reason people access that centre is because these people recognise that they are vulnerable with their mental health in the community.

109. That face to face support being withdrawn meant that as an organisation we had to find a new way to support service users. Some would have been coping with the change better than others depending on family support networks etc. The challenge was how to recognise that and prioritise so that help was getting to the right people at the right time. We also wanted to ensure that others were not dropping off our radar. Our staff worked hard to organise themselves in a different way and use telephone or other virtual support methods. Some of the service users worked with them to provide others with peer support. We would support service users to support other people in the community and to get their own support from staff.

110. Our counselling services was no longer a face-to-face service. It moved to a phone counselling service and then on to a digital platform.

111. That was possibly one of the unexpected gains out of the pandemic, the way in which digital technology suddenly found a place in social care when we may have struggled to implement before. It was used extensively in most settings. The Government recognised the importance of that and released several funds to allow good implementation. This included the wellbeing fund. Our counselling services attracted investment through that route which allowed us to train staff to be qualified to deliver remote counselling online and to develop a good

platform for doing this type of support. We now have a digital platform for counselling services, and this is as effective as face to face for some people. It takes a different skill set to carry out counselling in terms of body language and recognition. The counselling managers developed a training course which over 80 counsellors accessed and gradually that service was brought back into operation also.

112. All of that change was disruptive. Some changes took place at huge speed and others took a long while. It was like turning an organisation on its head. We had all of the upset that was going on in the care homes while we were trying to continue to do our best to support people well in the community settings too. There were things we could actually support people better with by the end of the pandemic, such as reaching people in remote communities through digital counselling, and we were balancing that with the significant distress in our care homes where, for a time, it felt we were not able to support people with their wellbeing in a way that we would have done normally. That was hard.

113. As an organisation, we only furloughed fifty-six people in total out of 1700 staff members. This was because we made use of alternative work opportunities wherever possible. This might include staff manning the phones whilst the support workers were out for example. Some staff were re-deployed to design and deliver training courses and others concentrated on procurement and delivery of essential supplies for example.

114. We also worked with local authority partners to deploy staff in a way which would help meet the needs of the wider community. An example of that was at our school Erskine Waterfront Campus, Renfrewshire. The school became a food distribution site for families who we knew or were advised would be struggling. During the pandemic the school was used to support the local authority as not all of our children were in school all of the time. The school was open as the children and young people we support do have additional support needs and that was provided for within the guidance for educational establishments, which we also had to follow.

Learning disability

115. As mentioned above, CrossReach supports some people with a learning disability in small house settings which are the place they call home. We had to organise those settings as per the public health guidance, which is backed up by legislation so gives little room for adapting for the support of individuals, even when it might not be in their best interest. I can give examples of where the guidance did not always make sense for us, but was enforced by Care Inspectorate nevertheless. In one of the houses for example there is a service user with a specific feeding disorder. That individual has a particular trait where they try to take food out of a refuse bin and eat it. To prevent this from taking place our house had a locked bin. However, when the Care Inspectorate came to assess that service they were critical of the service on the basis of the Public Health /IPC guidance at the time where it was stipulated that you could only

have a particular type of bin within a residential care setting. This was not a registered care home but was being treated as one and had the staff implemented the guidance in the way it was laid out, they believed they would be putting the resident at a greater risk than Covid posed to them at that point.

116. There are other examples which illustrate the dissonance between the guidance and the practicalities of supporting people in social care settings. There was a need for guidance to allow some flexibility based on the professional opinions and expertise of staff and their knowledge of supported people.

Looked after and accommodated children

117. The challenge to provide a service for looked after and accommodated children was largely to do with a dearth of information coming through to us as an organisation for that group.

118. CrossReach has seven houses where a small number of children live in a homely environment. Each house provides care to a maximum of four children. These are located from West Stirlingshire to Ayrshire.

119. Within each children's house there are small groups of staff. About eleven staff between two houses. The houses are seen as family settings.

120. Initially at the start of the pandemic our role was to reassure staff and children at the children's houses. This was done in line with community guidance.

121. The advice was that most children were less at risk from the pandemic than others in the population. We tried to normalise things as much as possible for the children and young people, some as young as 8 years old, and did not apply the guidance in the same way as in adult care homes for the wearing of PPE or to limit group activities within the homes. However, we recognised that all of our houses were registered care homes and were concerned and that some constraints would be necessitated in an outbreak situation.

122. Our Director of Children's Services main concern was how to best care for children should that occur, given that all of the other guidance in place talked about isolation for children and for staff. She worked with the CCPS Children's Committee to try to establish what they could do differently.

123. It is widely accepted that children in care have experienced significant trauma, and we felt that making things up as the pandemic moved along and behaving inconsistently or too rigidly was not going to work for their wellbeing in the immediate or longer term.

124. One issue in particular was the guidance around self-isolation for staff if they had come into contact with a Covid positive person The impact of that was that we initially had droves of staff having to isolate where they had been a contact whether or not they themselves were testing positive.

125. So, whilst the government had not issued guidance specifically for children's houses the regulation about staff isolation did have a significant impact. Effectively there was a small team around a small number of children and were to all intents and purposes a family unit. Due to the staff isolation guidance if someone had a covid contact then the guidance meant staff who were in effect immediate family were being taken out of a child's life. In some cases where the majority of staff members were identified as a contact, it would have meant putting in almost a whole new team, and this would not have been appropriate given the complex needs of these children.

126. The government were not telling families to separate so random strangers could be brought in to look after their children if a parent/s were identified as a contact and there would have been outrage if that had been suggested. It was at that point that children's providers stepped in and advised government that the isolation guidance was fundamentally ill suited for that type of setting.

127. They proposed a bubble model to Government as a way of getting round this issue. Though we did go on to introduce the bubble model in our children's houses, which allowed for consistency of staffing in what we considered to be a family setting, with the backing of Care Inspectorate and the knowledge of Government it was never adopted into guidance which would have left us at risk had that been challenged.

128. Our children and young people also had a tricky situation to deal with as they come from different local authority areas. The tiered approach also had an impact on them. Where the children's support house and their family house were in the same tier then the child could have face to face contact with their family. Where the tiers were different then the child could not have the same access. That caused tension as it was difficult for some children to understand.

129. It was also confusing at the beginning about what level of access families and children could have. It is not quite a care home setting, so we were not shutting to visitors altogether, but we were unclear to what was to happen. This included how many people were the children allowed to see when they were visiting their family home at the weekend.

130. I do not think that Public Health really considered the full impact for looked after and accommodated children during the time of the pandemic.

131. Guidance relating to looked after and accommodated children did eventually come out, but it was long after the start of the pandemic.

132. I do not believe that we admitted any children into our houses during the height of the pandemic. Children were not being assessed or taken into care in the same way as before. This may have caused different problems for children in particularly vulnerable situations as the pandemic progressed, but some emergency provision was made.

Drug Addiction Services and Rehabilitation

133. We have two residential rehabilitation services. One in Inverness and one in Glasgow. We also have move on services so people who had been through the programme want to be accommodated by us for a while can take on a tenancy. We would continue to provide support in that tenancy. Hopefully that person will go on to get their own tenancy and be living a clean life by then.

134. A blanket approach was taken in respect of drug addiction services and rehabilitation. Again, one of the big questions at the beginning was around the classification of a residential rehabilitation service and how the guidance could be applied. Care homes for twenty-five vulnerable older people look different from a care home for four people with a learning disability and looks different again from a residential rehabilitation setting but they might all be registered as care homes for adults. That is where the one size fits all approach does not work.

135. Eventually the guidance did get there however in the beginning it felt like we were to apply increasingly clinical guidance to our very different care home settings.

136. During the pandemic our residential rehabilitation service kept working. We were also flexible as we could keep people for a little longer within the setting. We did not need to work within the usual programme, so service users did not need to leave after the usual time-period. This was good especially if the community rehabilitation service were not there to support them as their time in rehab came to an end.

137. We do not have many community services on the harm reduction end of rehabilitation services, but these were subject to the same sort of guidance as day centres and community support where face to face support was strictly limited.

138. Most of our services which were affected by closures, or limited in what they could do, are now back up and running and most are operating to pre pandemic levels. The reality is that in our residential settings things did not stop and operated in a very intense situation. We have lost a couple of services that never recovered.

139. Whilst we have opened back up that does not necessarily mean that all our clients immediately had a full range of other services available to them. Many of the services which we would refer people onto or where they got specific support were not fully opened. There remains a backlog to accessing services. Some of the local authority services were slow to re-start, some are lost altogether and the current staffing situation means that it is becoming more difficult to alleviate that backlog.

140. People who want to get support from CrossReach can do so in different ways. Some can self refer and some are referred from local authorities or other agencies. It depends on the contract we are working under. For an individual accessing a care home they can approach us directly although there is likely to be a social work assessment also.

141. Counselling clients would mainly refer themselves to our services. after discussion with their GP or health visitor etc. The decision to refer would be made in tandem with them.

142. If someone was under a contract for residential rehabilitation in Glasgow, then Glasgow City Council would be the route for assessment into that service. What we found during the pandemic was that if the local authority removed their assessment staff that was where backlogs were created. The impact was that some people were unable to access support or that services were disappearing altogether.

Financial Impact

143. The financial impact from the pandemic was significant. The government support that was brought in was helpful and we were able to sustain services because of that. Despite the fact that it was supposed to be a simple process to access financial help it was often more complicated and bureaucratic than we had originally been led to believe

144. The lack of insurance cover from our provider was a significant impact on CrossReach as were our rising insurance costs. I have referred to that above.

145. PPE supply was expensive and it was necessary to take on staff to manage the additional cleaning that was laid down in the Public Health and IPC guidance and then to comply with the additional testing needed for visits in Care Homes. That did eventually become a recoverable cost, but we have not recovered all costs.

146. Our Care Home income was impacted due to the pandemic. Normally around half of the residents within a care home are self-funders. During the pandemic we could not always take people in either due to an outbreak or because we felt it was unsafe to do so. We also felt that there was a kickback towards care homes towards the end of the pandemic because of negative publicity and because people were worried about their ability to keep in touch with loved ones. The impact was that our occupancy levels dropped. We were not able to recover the full loss of income there.

147. We went from about 94% occupancy pre-pandemic to 70% by the beginning of 2022.

148. In some of our non-registered services which rely on charitable income there was also an impact. We could not run all the community fundraising events which brings in essential funding. This meant we were continuing to run

services, albeit in a different way, and pay the staffing costs without the income to match. The impact there was on our financial reserves.

149. We have not recouped the full financial losses sustained. Each of our areas were impacted differently. Our operating figures over that time were in deficit and we continue to rely on reserves while income builds back up again, despite closing some services.

Membership

150. During the pandemic we did have excess deaths in our care homes due to covid we also lost two members of staff.

151. Some of the feedback from our staff and families during this time included a mixture of things like anger, sadness, fear, loss and frustration. It was a really tough time in social care and nobody was left unaffected whether staff members, supported people or their families. Our core task is to support people who can be facing significant challenges to live life as normally as possible and that was severely curtailed as it was in the general population. However, as restrictions were lifted for the general population it felt that social care was being left behind and that there was a lack of equity in the application of guidance in some settings.

152. There has been criticism for example surrounding the very slow opening up of care homes. At one point when they were closed it felt as if they were never going to open up again despite the representations being made by families and providers. It was a challenging time as some providers were highly anxious about opening up again given the negative view of care homes and the investigations by Operation Koper but could see that isolating residents from their families was disproportionate when so much else had been relaxed in society. Many families were upset and angry about that and there was little providers could do when the Public Health guidance remained in place, given the strength of that.

Testing

153. The introduction of testing was welcome but it did cause confusion given the diversity of our settings. We did try to keep things consistent as an organisation and had a predisposition to test as much as possible given the vulnerability of some of our supported people and in line with guidance. There was some initial difficulty accessing testing kits, but this did eventually resolve itself.

154. When testing was introduced, we felt strongly that our residents should have been tested for covid by a trained team of staff from the local Health Board. This was the case generally, but one or two Health Boards believed that this was a care staff function. That was difficult to manage and is one example of where health boards behaved in different ways, despite the same guidance being in place and which led to confusion and frustration.

Staff

155. There is little doubt that the impact on staff has been enormous and I am grateful and proud of the way in which they responded during this critical time.

156. The staff teams carried a lot of additional emotional strain. The impact of reduced family contact in all settings meant that we asked social care staff to take on much more in terms of emotional support than they were normally called on to do. Staff were anxious but more concerned about the people they supported some of whom were really frightened. The biggest strain was felt in the residential care homes where they were both supporting residents who were distressed because of a disruption in their routine and were also trying to alleviate the concerns of understandably anxious family members.

157. There was also a complete disruption of the staff routine. In residential settings where residents would normally eat at a communal dining room, staff were now deployed to see people in their own rooms. All of this had an impact on staff as they were stretched to the maximum and it took additional time and energy to spend quality time with people. Even though staff were feeling much more emotionally responsible for residents the time to support that was diminished. The additional tasks coming down as part of the guidance meant that managers were particularly overstretched as they were trying to accommodate so much change and take on additional responsibility while keeping their teams as steady as possible.

158. In addition, staff felt fear and anxiety. Some of our staff reported that they felt scared coming to work. Scared in case they caught the virus and the impact on their families, but also scared in case they passed the virus on given that they were in contact with others.

159. As the pandemic progressed and the rules changed regularly, as well as the shifting mood towards social care staff members reported that they felt supported well by the organisation but generally they felt unsupported. and undervalued. That captures for me the impact of the pandemic on managers and staff. Although there was the clap for carers in the beginning and a pandemic payment at the end, staff do not really feel valued or recognised for taking on the extra responsibilities that they bore then or the important service that is delivered through social care.

160. Staff also had to become very tech savvy very quickly. Suddenly they were operating digital devices and getting their heads round Zoom, Teams etc to keep in touch with each other and supported people. Technology was also needed to keep supported people in touch with their families. This was a different set of tasks and required a different skillset and mindset as we were all trying to do activities in a different way.

161. Staff had to read and implement hundreds of bits of guidance, some of it at very short notice in addition to their normal care tasks, which had become intensified.

They were also trying to get used to working in PPE at the beginning of the pandemic and to don and doff it appropriately. They were being judged on a new set of standards and much about that was confusing and scary.

162. As an organisation, we worked with our employee representative group to put in appropriate wellbeing support as we went along. We asked staff what was challenging and what would help. We spent a lot of time and energy thinking about wellbeing. We put in wellbeing supports and signposts. Some of the staff were young, potentially quite new to care and working in care homes doing a magnificent job. We can't underestimate the impact on some of these young staff members where they were exposed to Covid deaths in care homes. They are used to the concept of palliative care , it is a necessary part of life in a care home, however, during the pandemic they could be faced with people dying in quick succession with no time to grieve or process in between due to the intensity of the job and covering for other staff members who might be isolating.

163. We did have staff shortages during the pandemic, at times these became critical and we became very close to being short staffed. We did have to call on the staff support bank from time to time. At some point when you dropped below a certain level of staff you hit a red trigger. At that point you could access support from a wider staff bank organised by local health boards.

164. What we found was that the staff banks did not have lots of people in them anyway. We did have an experience where we approached the staff bank however, all available staff were fully booked anyway and we had to think again.

165. Community services were not as badly affected with staffing shortages as the residential settings as they didn't have the same levels of infection as the care homes however the guidance around isolating if you had been in touch with a Covid positive person did impact everywhere. Our community support settings and the housing support services had more opportunity to flex resources given that the level of support needs is not so high. Our co-ordinators could flex staff within services to support any gaps. Calls to service users could also be re-arranged if necessary in a way that urgent personal care cannot. We did not have that flexibility in our residential care homes due to the nature of the care required there, to be fed, dispense medication etc.

Prisons

166. CrossReach run two Prison Visitor Centres which support prisoner's families to maintain contact with prisoners through visits and by other means. During the pandemic prisons locked down and no visitors were going through. The co-ordinators were phoning families and checking in with people who regularly used the centre. Prison visits did not open for some time. The staff there had to be cognisant of the guidance around prisons and help families to understand that at the time. They also supported families to access virtual visits.

Current Position

167. We have been resilient as an organisation as we do have a good infrastructure behind us and although we had to manage a lot of different service areas during the pandemic, which was a challenge in itself we also have well established governance, systems and processes and were able to engage with staff through the employee representative body when emergency terms and conditions needed to be negotiated. We are a well-established part of the Church of Scotland and have had their financial support, and that has helped us to recover without immediate jeopardy to services.

168. There has been a general return to business as usual although, as noted above, the majority of our services were not stood down during the pandemic so perhaps that has been easier for us than for some other organisations.

169. Staff have been amazing and although exhausted I think getting in fast with wellbeing supports has helped us with the resilience of staff overall. It has allowed us to bring services back onstream where they were disrupted and allowed the staff who have stayed with us to feel supported enough to be able to continue to support our service users well.

170. We have seen a bigger turnover of staff since the pandemic than before. Normally we have a relatively low turnover of staff. At one point our turnover was 30% of staff. Some people were simply exhausted and chose to do something which was less emotionally taxing and better paid. The staff turnover has thankfully stabilised again, but we have a recruitment problem in social care and that has been exacerbated now. There is still something of a complexity of tasks and the clinical overlay that is there that was not there before. It is also a complicated job. Social care felt like it became the kicking boy of the pandemic which in turn can make it tricky to recruit people.

What could have been done better?

171. The fundamental thing that could have been done better was taking the time to understand social care and how it differs from NHS provision right from the outset. There are many different partners involved (voluntary private and statutory) and it is delivered in a range of settings including people's own homes. Not all settings in which social care support is offered are regulated services, and not all staff registered. Had there been meaningful engagement with the sector we might have come through this in a different way instead of experiencing the early confusion and then repeat mistakes throughout the time during which guidance was being issued. The Scottish Government should not have thought that they could treat social care like they could treat the health services in terms of the way in which guidance was issued given that we are organised very differently and do a fundamentally different task.

172. On a similar vein, earlier engagement might well have led to a better understanding of the social care workforce who operate under different terms and conditions and experience different challenges. Providers like CrossReach

were having to balance guidance which covered one set of workers but not others and attempt to make some sense of it so that there was consistency across the workforce. This could have been made easier had the scope and nature of the workforce been acknowledged earlier on.

173. This all meant that Providers were being left to carry a lot of risk, despite delivering services on behalf of statutory partners, without the resource or indemnity being offered to the NHS. There is a lesson to be learned here about the make-up of social care and the everyday risks which providers and managers of registered services carry. Resilience is weakened under lack of investment.

174. I also think if there had been some genuine acknowledgement of the frailty of people in care homes along with an upholding of the principle that their lives mattered as much as anyone else this might have influenced decisions initially around safety and a need to ensure care homes were not overwhelmed then later on about 'returning to normal' so that people could have been reunited with their loved ones more quickly than they were. There was a real strength of feeling from families of residents in care homes about how valuable their loved ones are- they are not just commodities to be locked away. I think there is learning at both the beginning and the end of the pandemic in that respect.

175. There is some positive learning. Because we were so misunderstood, and the guidance did not cover all services, we did get the opportunity to solve problems in collaboration with those we support rather than being tied to some of the constraints that commissioning contracts usually demand. This was because the statutory sector on occasions had to drop out from providing services but needed supported people to continue to be supported. That was a good thing. If our sector could retain some of that ability to operate more independently without onerous contracting and levels of scrutiny, then that would be helpful for the future. People were trusted to get on with their job at points during the pandemic. Rebuilding that environment of trust and recognising that our sector can innovate even in the most difficult of circumstances is important.

176. 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 **Personal Data**

Date ***27-11-2023***