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Scottish Covid-19 Inquiry

Day 33

April 16, 2024

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1 Tuesday, 16 April 2024
2 (9.45 am)
3 (Proceedings delayed)
4 (9.51 am)
5 MR CASKIE: We can't hear you at the moment, my Lord.
6 We can hear you now.
7 THE CHAIR: Very good. I said I'm sorry you can't hear me.
8 Good morning, Mr Caskie, good morning, Mr Cumming.
9 When you're ready, Mr Caskie.
10 MR ALEXANDER CUMMING (called)
11 Questions by MR CASKIE
12 MR CASKIE: Good morning, Mr Cumming. Could you tell the
13 Inquiry your full name please?
14 A. Sure. It's Alexander Douglas Cumming.
15 Q. And in what capacity are you here today?
16 A. I'm here representing, SAMH, the Scottish Action for
17 Mental Health.
18 Q. And what position do you hold in that organisation?
19 A. Executive director of operations.
20 Q. And how long have you been with SAMH?
21 A. Four and a half years.
22 Q. During the pandemic, what was your role?
23 A. For the start of the pandemic, my role was assistant
24 director, so I covered services across Scotland but
25 mainly in the east of Scotland.

1 Q. Can you tell us something of the history of your
2 organisation? When did it start?
3 A. Sure. So SAMH was founded in 1923, so we just
4 celebrated our centenary last year. And we were an
5 organisation since that time that has been representing
6 and supporting individuals with mental health problems
7 and mental illness and representing and advocating for
8 them during that time.
9 Q. At paragraph 9 of your witness statement you talk about
10 a large growth in the organisation in the 1980s and
11 1990s. Can you just tell us why that came about?
12 A. Yes, sure. So at that time it was obviously the
13 inception of the Care in the Community Act so a lot of
14 the kind of psychiatric wards and the hospitals where
15 individuals were admitted that were -- that had
16 diagnosis and mental illness were being -- yeah, were
17 patients, they were supported in the community. So
18 right across Scotland there were organisations that were
19 supporting the delivery and recovery of mental illness
20 and mental health problems in the community -- in their
21 own homes, but also within care homes as well.
22 Q. At paragraph 10, we can see in the witness statement
23 that you operate over 70 services and, at paragraph 11,
24 you have 26 registered services regulated by the
25 Care Inspectorate. Just to get an idea of the scale of

1 your organisation, can you tell us what your overall
2 budget is?
3 A. Sure. So our overall budget is £22 million a year and
4 we have our workforce of 590 individuals.
5 Q. 590. And tell me about your geographic spread.
6 A. Sure. So we are a national organisation, we're
7 Scotland's mental health charity, so we have national
8 provision and intervention and programmes that cover all
9 of Scotland, so information service, we have national
10 psychological well-being services as well that are
11 available in all 32 local authority areas. But
12 predominantly our kind of services, our 70-plus
13 services, are based and commissioned by local areas,
14 local authorities, health and social care partnerships
15 and NHS boards as well. So primarily Murray, right down
16 the east coast to the Scottish Borders, right across the
17 central belt to Inverclyde and also some services in
18 Ayrshire as well.
19 Q. Right. At paragraph 11 you provide an indication of the
20 range of services that you provide, including seven care
21 homes. Tell me about those.
22 A. The care homes specifically?
23 Q. Hmm.
24 A. Yeah, sure. So we have seven mental health care homes.
25 Five of those are based within Glasgow and two of those

1 are based in Forth Valley. Those are care homes --
2 they're not, I suppose, maybe the traditional care homes
3 that maybe you would expect for older people, where
4 there are quite often sometimes hundreds or -- dozens or
5 hundreds of individuals. These are much smaller, you
6 know, communal living and range from a number of
7 service users from five to 11.
8 Q. And the service users are people who suffer from mental
9 health problems?
10 A. Yes, a lot of them will have had stays within
11 psychiatric wards and hospitals and we are supporting
12 the exit and recovery back within the community, with
13 the ambition and hopefully the intention of moving them
14 on to their own tenancies where possible.
15 Q. Is that the general pattern that you hope will be
16 followed by individuals who move into your care homes?
17 A. It is. Probably 10/15 years ago, I suppose the set-up
18 and I suppose priority was slightly different. Those
19 individuals that maybe moved into care homes, it maybe
20 was seen as a kind of home for life, whereas now it's
21 very much around kind of through care and trying to
22 support individuals back into their own tenancies and
23 more independent living.
24 Q. You move on at paragraph 12 to talk about your -- you
25 describe it as your "Children and Young People

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

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

1 A. I suppose a consortium -- so a membership body,
2 a consortium of care providers in Scotland, not just
3 covering mental health -- I suppose care services, but
4 right across the board.
5 So I guess we're engaged in a whole range of kind of
6 consultations. We're quite often engaging in a lot of
7 our own kind of research as well to ensure that the
8 voice of lived experience aims at the core and is
9 central to what we do, but we also have been, on
10 a number of occasions, engaged in a lot of the kind of
11 Scottish Government programme boards, whether that be
12 children and young people in the past. We continue to
13 be and were very, very involved in the Suicide
14 Prevention National Leadership Group as well and we
15 supported and led the Lived Experience Panel for the
16 kind of Suicide Prevention Strategy (overspeaking -
17 inaudible) --
18 Q. At paragraph -- sorry. At paragraph 17, you make
19 reference to volunteers. You give us a figure there for
20 450 staff members and I think there it says "operational
21 area of the business". So the figure that you gave
22 earlier isn't inconsistent with that. You'll have
23 back-room staff --
24 A. Yeah.
25 Q. -- on top of the 450 presumably?

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

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

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

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

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

1 as a contrast between what SAMH were doing and what the
2 statutory services were doing. Can you just explain
3 what you identified as the contrast there during the
4 pandemic?
5 A. Yeah, and I know it was a phenomenally difficult period
6 for everybody and I know that some of our service staff
7 were pulled away to do other duties and no doubt other
8 statutory services were the same, but I guess generally
9 there was this feeling that all of a sudden everyone was
10 working from home and there was no engagement, but,
11 actually, certainly the SAMH services, and I know across
12 our kind of third sector partners that are delivering
13 health and social care services, they were still
14 engaging daily with individuals, with obviously the
15 appropriate restrictions and kind of I suppose
16 supporting the appropriate guidance as well. But there
17 were individuals that we were supporting on a daily
18 basis because, without -- we were the lifeline for them,
19 to be able to support their recovery and enable them to
20 live well.
21 On the -- I guess the stark contrast was we found it
22 particularly difficult to engage in statutory services,
23 and that was particularly difficult when we were trying
24 to support our service users, to engage with some of the
25 statutory officials and supports that there were maybe

1 available.
2 Q. Sorry, what statutory officials are you talking about?
3 A. So it would be around maybe care managers, social work,
4 mental health officers.
5 Q. CPNs?
6 A. CPNs, absolutely.
7 Q. Psychiatrists?
8 A. Yeah, possibly. There was definitely a -- yeah, there
9 was a real challenge to try and engage -- yeah, to kind
10 of engage them and particularly kind of care managers.
11 I think our engagement with commissioners was different
12 and actually they were --
13 Q. When you say "commissioners", are you talking about --
14 what are you talking --
15 A. So commissioners, I would say those that are not
16 necessarily involved in the direct support and the care
17 planning of individuals that we support but those that
18 are looking at the commissioning of the services,
19 I suppose, and how do they deliver holistic services
20 across a local authority area or a health and social
21 care partnership area. So those would be, I guess,
22 those individuals that have I suppose commissioned the
23 services, set up the services and they've identified
24 what the needs are within that particular area. So
25 certainly they were usually very, very good about

1 engaging and checking everyone is okay and ensuring --
2 and wanting to ensure that staff were kind of okay and
3 the service users and also working with us to change and
4 adapt some of the service models as well. But, as
5 I said, some of the staff members and statutory services
6 that were maybe more directly involved in individuals'
7 care and support, it was much more challenging to kind
8 of engage with them and that had quite a negative effect
9 on service users.
10 Q. So you're drawing a distinction, if I'm right, between
11 people who were essentially office-based within
12 statutory services and who presumably could continue
13 their work from home and front-line staff?
14 A. Yeah, that's correct. And a lot of the cases -- you
15 know, I think I lot of the staff, you know, all ended up
16 working at home and it was often quite difficult to, you
17 know, identify and find social work staff and care
18 managers that were assigned to some of the individuals
19 that we were supporting.
20 Q. So was that something that was a new problem or was that
21 something that had existed prior to the pandemic?
22 A. I think it sometimes depended on a particular service
23 user, on a particular area, but there's no doubt that
24 that was amplified because of the pandemic.
25 Q. Okay. You then talk about a challenge, at paragraph 34,

1 in managing staff expectations. Tell me about that.
2 A. Yeah, I think it was a very different space for
3 everybody and of course there were -- you know, lots of
4 us were watching the news every day and all the
5 bulletins, you know, multiple times a day, and very much
6 the message was around staying at home, "don't use
7 public transport", but at the same time obviously we had
8 a duty of care for our service users that we were
9 supporting. So understandably a number -- well, most of
10 our staff were anxious about that. They were the ones
11 that were on the public transport, they were the ones
12 that were engaging and going to individuals' homes and
13 occasionally there was the challenge where perhaps some
14 of our service users weren't following the guidance that
15 we would want and that we would expect.
16 Q. And did the organisation feel that your staff were
17 continuing to do what you might call face-to-face work
18 but statutory services weren't?
19 A. Certainly that was our impression, yeah, and certainly
20 a lot of our commissioned services and registered
21 services -- certainly our staff were continuing to work
22 kind of face to face. That might have been slightly
23 different with some of our other services because they
24 weren't perhaps as critical in relation to the kind of
25 care and support for individuals.

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

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

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

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

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

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

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

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

1 kind of pauses and delays to people maybe exiting
2 hospital, but then also people being able to exit
3 successfully on from care homes into other types of
4 accommodation as well.
5 Q. Okay. You talk about, at 39, complying with guidance
6 regarding visitors. We have a clear impression of what
7 that guidance was and that for periods visitors
8 effectively weren't permitted.
9 A. Yeah.
10 Q. Can you tell us about the impact of that, firstly, on
11 the client base?
12 A. Yeah. It was, yeah, phenomenally difficult for our care
13 home service users. There were -- I can't remember how
14 many months, you know, some of that guidance was in
15 place for, but, you know, not being able to have any
16 visitors whatsoever -- you know, we -- for a lot of our
17 service users, they maybe only have one or two
18 individuals that are, I suppose, a part of their wider
19 network, so it's the staff and one or two individuals
20 quite often are kind of core family members, and not
21 being able to, you know, visit the care home or -- at
22 certain points during the pandemic as well also not even
23 able to meet outside because they were already within
24 a bubble elsewhere, you know, was very, very challenging
25 for our service users, so it certainly increased the

1 isolation for our service users.
2 Obviously our staff did everything they could to
3 engage and it allowed us to, at the appropriate time,
4 you know, create bubbles in different ways within our
5 care homes. But it was definitely quite an isolating
6 time for our service users.
7 Q. The final paragraph on the screen at the moment is
8 paragraph 40, and that reflects something that -- some
9 evidence that you gave earlier. Again, can you say some
10 more about that, particularly in relation to care homes?
11 A. Yeah, so I think, as we mentioned earlier, you know,
12 whether it be care managers, whether it be CPNs, we
13 saw -- or our service staff and our service users saw
14 very little of the statutory support of their care
15 managers. The only exceptions to this might be when
16 there was really acute episodes of mental illness and
17 there was an emergency and maybe somebody had to be
18 readmitted to hospital, but there was very little
19 engagement with our statutory services.
20 Q. Would statutory services normally provide important
21 supports for people on the pathway into their own
22 tenancy?
23 A. Absolutely. I suppose there is also around that
24 ongoing -- there is ongoing case management reviews.
25 You know, there should be quarterly meetings or

1 certainly six-monthly meetings to check on progress, how
2 people are doing and what their pathway and what their
3 support plan looks like over the next period, what sort
4 of outcomes and goals are they working towards. You
5 know, I absolutely recognise that there will be -- there
6 was many other priorities during the pandemic, but, you
7 know, it could be quite an isolating time, not just for
8 service users but for our staff as well, around, as
9 I said, trying to get access to some of the core
10 statutory staff that they would usually engage with.
11 Q. Now, there's what I would refer to as a "bridge" between
12 42 and 44 in that in 42 you're talking about the support
13 provided, the peer support provided by care home
14 managers, then, at 44, you talk about the management
15 team, who aren't care home managers presumably but work
16 at a level above that, having to deal effectively all
17 day sometimes with questions coming in from care home
18 managers and others. How did that work in terms of them
19 carrying out their normal management role?
20 A. Yeah, it was -- yeah, there were sometimes days where
21 there was a real shift -- you know, there was a real
22 kind of shift away from their core day-to-day duties, as
23 I said, because the managers were either reviewing
24 information, collating information, interpreting it in
25 a particular way that's going to be relevant and then

1 thinking about what the most effective communication
2 channels would be to all our service staff and then
3 being able to support the managers within those services
4 to then distribute that across our staff teams as well
5 or across their own staff teams; thinking about
6 different ways to, you know, deliver team meetings and
7 do team meetings, so that people weren't missing out.
8 And then obviously during that period as well all areas
9 had obviously quite high staff absences because of COVID
10 and it was making sure that I guess staff, when they
11 were returning to work, again were kind of keeping up to
12 date and up to speed with all the new guidance and the
13 changes that had happened within services as well.
14 Q. One of the things that you spoke about was the
15 management team being involved in providing what might
16 be called "internal guidance" based upon guidance you
17 were receiving from Government and other health bodies.
18 Was there feedback in terms of the guidance that you
19 were providing from your users and staff and was that
20 incorporated?
21 A. Yeah, so I suppose because -- again, we had some, you
22 know, very experienced individuals within our kind of
23 practice team and, you know, we very quickly formed kind
24 of internal kind of core groups and core assurance
25 groups that would actually, I suppose, engage and be

1 able to kind of sense—check and support some of the
2 solutions as part of implementing the guidance. So
3 there will —— I'm sure there will have been times when,
4 you know, guidance landed on a desk and they go, "How
5 are we going to make that work?", and I suppose that was
6 probably reflected back to us. But more often than not,
7 the guidance and I suppose implementation and solutions
8 were developed in partnership with our service managers
9 and team leaders on the ground.
10 Q. So we're talking about within the organisation there
11 being communication vertically, if I can put it that
12 way.
13 A. Yeah.
14 Q. What about outside the organisation with the people who
15 were providing the guidance? Was there communication
16 both ways there?
17 A. Yeah, I mean, we've always had, I would say, a strong
18 relationship with organisations like the
19 Care Inspectorate, and that was probably —— in some
20 areas the engagement over the period —— you know, that
21 was definitely more intermittent during the pandemic, as
22 people were pulled into other areas. There were some of
23 our local areas where the guidance or the engagement was
24 probably quite impersonal. It was just you got the kind
25 of weekly or monthly kind of update around what was

1 going on. But there were some other areas where the
2 local inspectors were certainly very engaged and, you
3 know, making phone calls to the service staff or ——
4 sorry —— certainly to the service manager to engage in
5 about how things were going.
6 Q. From the level that you and your immediate colleagues
7 were working at, did that appear to be a function of the
8 individuals concerned?
9 A. Yes, it was. Yeah, there was definitely a bit of
10 a difference there depending on the styles and
11 approaches and because there was quite a turnover of
12 staff with the Care Inspectorate as an example. So in
13 some of our areas we might have had half a dozen
14 different care inspectors during an 18—month or two—year
15 period. That was sometimes quite difficult to keep
16 track of.
17 Q. You talk about difficulties in accessing PPE for the
18 organisation. Again can you tell us about that?
19 A. Yeah, I think we were all —— you know, particularly
20 within our registered services, you know, infection
21 prevention control was part of our kind of core
22 responsibility, even prior to the pandemic, but
23 obviously the pandemic brought in a whole other level of
24 guidance and there was, you know, probably a much more
25 kind of clinical setting kind of approach to what we

1 needed to do and what we were required to do. I suppose
2 we maybe didn't have some of the kind of national
3 procurement routes that we maybe do now to kind of think
4 about PPE ——
5 Q. How did that change?
6 A. So I suppose locally or pre—pandemic it was really down
7 to the service managers and a couple of national
8 contracts to kind of identify the best routes and most
9 effective ways to procure some of the different PPE that
10 was required for the different services and that,
11 obviously, continued during the early part of the
12 pandemic. Obviously we tried to kind of set up some
13 national things, but then there was probably a bit of
14 a challenge because we'd got services from Murray right
15 through to Ayrshire at the time —— you know, the
16 distribution of that was quite challenging. So
17 I certainly know there was a couple of days when I was
18 on the roads, you know, handing out PPE and making sure
19 that the staff —— you know, leaving things at the door
20 and walking away and making sure that service managers
21 and staff had the support that they required. So that
22 was definitely a bit of a rush and probably a wee bit
23 frantic for some of our services to be able to identify
24 where to go and, you know, again changing guidance
25 about, "Well, we've just bought this but actually we're

1 now being told this is the most appropriate solution to
2 be using", in relation to the some of the cleaning
3 products.
4 But certainly once the kind of PPE hubs were set up
5 in the local areas, that was a huge relief. It
6 definitely took a little bit of time for some of the
7 communication to be clear around which services could
8 access that. You know, maybe understandably there was
9 a focus on again care homes, but, as I said before, all
10 our other registered services were up and running and
11 continuing to do what they needed to do. So it probably
12 took a little bit of time for us to really break through
13 some of those —— some of the early communication to
14 understand that this was available to all of our
15 registered services and also our health and social care
16 services and mental health services.
17 Q. At paragraph 48 you indicate that there were no deaths
18 of service users as a result of COVID but you then,
19 I think very properly, recognise that, for example, in
20 relation to your care homes, it wasn't elderly or
21 physically unwell people who were in the care homes.
22 But you say people in your care homes often had chaotic
23 lifestyles. Tell us about that.
24 A. Yeah —— so, yeah, a number of our service users within
25 our care home have kind of multiple diagnoses and, you

1 know, also a number of other kind of challenges around
2 maybe addictions, substance use. I suppose the whole
3 kind of combination and the fact that the external
4 environment around the pandemic again was kind of quite
5 isolating and, again, you're trying to think about --
6 positive kind of coping strategies during that period
7 was quite challenging. So there were on occasion, you
8 know, some of our service users that weren't necessarily
9 following the guidance and we'd have had maybe
10 individuals in their home that they shouldn't have had
11 in their home.
12 So I guess it was about trying to educate and
13 support our service users to kind of understand and
14 comply and recognise that we had a duty of care to them
15 and also they were, I suppose, putting our staff at risk
16 as well by not kind of following the guidance. But it
17 was about trying to support them to understand the
18 reasons why and the rationale for the guidance being in
19 place.
20 Q. You did that by trying to get them to understand rather
21 than being prescriptive?
22 A. Yes, yeah, yeah, and where -- you know, and where
23 situations weren't appropriate, you know, our staff
24 always have the ability to kind of withdraw and take
25 a step back. So, again -- and that's maybe around also

1 thinking about our risk assessment approach as well, for
2 risk and vulnerabilities and maybe reassessing some of
3 the risks for our staff but also for our service users.
4 So where an individual, you know, maybe wasn't following
5 the guidance, we'd maybe also have to look and
6 communicate about having to change some of the different
7 styles of support that was available to them.
8 Q. I know you wanted to say something about care assurance
9 teams and you talk about that at paragraph 50.
10 A. Yeah, I suppose -- and I can't remember what month it
11 was during the pandemic, but at some point, you know,
12 kind of care assurance teams were kind of set up, and
13 these were I suppose led by I think the Health and
14 Social Care Partnership, so kind of
15 multi-function/multi-disciplinary teams and they were
16 there to kind of set up -- they were there to kind of
17 conduct kind of unannounced spot checks and kind of
18 visits to our care homes. We absolutely recognise that
19 there was, you know, so many challenges and pressures on
20 everyone at all levels during the pandemic, but there
21 was a particular challenge for our care homes staff and
22 as an organisation about how that was communicated and
23 what the purpose of those care assurance teams was.
24 I think, as the engagement continued, it got more
25 supportive, relationships got stronger, but certainly

1 initially, you know, some of our service managers
2 weren't necessarily clear about what the purpose was,
3 what the governance route was and the reporting routes
4 were, and these were individuals that were clearly very
5 experienced in their own setting. But I suppose our
6 general view from our care home managers was that they
7 didn't necessarily have any experience or maybe weren't
8 as prepared for the setting they were coming into, which
9 was a mental healthcare home, which kind of could be
10 a block of flats or it could be kind of communal areas,
11 and, as I've said before, it's not about a 100-bed
12 nursing home, which looks very, very different.
13 They took a very kind of clinical, medical model,
14 when they were thinking about some of the considerations
15 and things they were looking at, and certainly initially
16 it felt quite stand-offish, if we're honest, and it
17 definitely put an added pressure on us as an
18 organisation and on all the service managers as well.
19 And particularly for our service users as well, I guess
20 they were probably feeling that it was -- you know, as
21 we've talked about, the guidance was no one was able to
22 come into the care homes, but, yet, here we had
23 individuals that were coming into the care homes, not
24 really sure why, quite intrusive in some ways, and
25 I think that was certainly one of the more challenging

1 areas for us during the pandemic.
2 As I said, after a number of months, six/nine
3 months, et cetera, those kind of -- the kind of
4 I suppose tone changed, probably, I think. It was much
5 more supportive. I think everyone was clear about where
6 the boundaries were and what the purpose was. But
7 certainly at that time, when staffing levels were pretty
8 critical, you know, we'd had no outbreaks, no deaths
9 et cetera, that level of scrutiny was -- maybe it should
10 have been expected but it was certainly a challenge for
11 us.
12 Q. Okay. You then, in your statement, move on to the
13 testing regime and you say something about that, in
14 particular at paragraph 53, and the admin function which
15 went along with testing. Can you tell us about that?
16 A. Yeah, and obviously things got quicker and slicker as
17 everybody got better at it and better processes were put
18 in place. But I think, yeah, the different types of
19 test -- level of testing that we then needed to navigate
20 and understand for our registered services, our
21 non-registered services, community-based services, that
22 was kind of quite difficult and there was also some real
23 kind of practicalities around the way that we were
24 having to manage our services because of workforce
25 flexibility and some of the staffing challenges that we

1 all had during that period, you know, making sure that
2 we were -- you know, sometimes those set deadlines
3 around when testing had to happen and particularly our
4 kind of PCR testing, it was really, really difficult for
5 us to ensure that -- you know, ensure that staff were
6 able to engage in that and we were doing things in the
7 timelines, and then also reporting on the timelines --
8 reporting on it appropriately as well.
9 So we talked about, you know, some of the central
10 staff and management staff being pulled away on
11 different things. That was certainly a big focus for
12 all of our service managers and our service staff during
13 that period as well. And having to ask staff to kind of
14 come in, you know, a little bit early or a little bit
15 late or, you know, do testing at home, it was just a --
16 I suppose a different kind of -- a change of culture for
17 all of us.
18 Q. Was there a degree of resistance from staff to that, the
19 additional hours, if I can put it that way?
20 A. Yeah, I think -- I think all of our staff were -- just
21 the resilience during the period was absolutely
22 phenomenal and the changes that they had to make and,
23 you know, being dynamic and flexible and having to move
24 services when we asked them to move services, you know,
25 within a particular portfolio -- but, yes, there was

1 definitely the odd occasion where there was a query
2 around, you know, why we're having to come back -- you
3 know, usually it was explained away with some of the
4 guidance and some of the conversations that we were able
5 to have, but there would have been the odd occasion
6 where we were having to deal with additional queries and
7 challenges.
8 Q. At paragraph 58 you talk about your fundraising taking
9 a bit of a knock. You say something in paragraph 57
10 about not requiring to use furlough but in paragraph 58
11 you talk about your external fundraising.
12 A. Yeah, just quickly on furlough, there were a handful of
13 staff that we needed to support through furlough, but,
14 as I said, because we changed the modality of basically
15 our service delivery, we were able to kind of continue
16 to deliver a reasonably high level and in some cases
17 continue to deliver as we were.
18 So, yeah, I guess the mass participation events --
19 any form of kind of bringing people together wasn't
20 possible during the pandemic, so a lot of -- you know,
21 a lot of organisations like ourselves took a bit -- it
22 was really, really challenging to kind of engage in that
23 way. We obviously looked at other kind of creative ways
24 to think about fundraising, but particularly those mass
25 participation events and events that we would put on to

1 bring people together just couldn't happen during
2 particularly the first 18 months of the pandemic.
3 Q. So there weren't online jumble sales?
4 A. I can't remember if we had an online jumble sale, but,
5 yeah, there were certainly a few online events that we
6 managed to facilitate.
7 Q. Okay. You then go on, at 59, to talk about the impact
8 on several services. One of the things which I don't
9 think anybody -- well, very few other people have
10 mentioned is the horticultural service that you provide.
11 Tell me why the horticultural service is important.
12 A. Yeah, so we've got a number of therapeutic horticultural
13 services across Scotland and actually they're some of
14 our oldest services, to be honest. They've been in
15 existence, yeah, in some cases for over 30 years. We
16 know the benefit of physical activity, of working
17 alongside somebody and just having that meaningful
18 activity and, you know, being able to develop that kind
19 of therapeutic relationship with individuals and also
20 being able to provide that social connection is really,
21 really important.
22 Our therapeutic horticultural services have a range
23 of kind of outcomes around supporting people back to
24 work -- it may be they've had a period of absence -- and
25 also supporting employability skills and, you know,

1 providing different kind of interventions as part of
2 somebody's recovery from kind of mental health or mental
3 health problems. I suppose our -- because of some of
4 the restrictions and because -- again, because of types
5 of activities around sharing equipment and, you know --
6 and particular items of PPE as well and particularly the
7 restrictions on transport unless it was absolutely
8 essential, we had to obviously change the modality of
9 our delivery there. So that changed very much to kind
10 of online workshops, growing sessions, you know, growing
11 chillis on your balcony, and different well-being
12 approaches and techniques around kind of mindfulness,
13 yoga as well. That was one of the kind of biggest
14 challenges. I've already mentioned the kind of digital
15 inclusion or exclusion of a lot of our service users.
16 So actually probably the first kind of three to six
17 months of some of our service delivery there was
18 actually more around delivering IT sessions to some of
19 our service users. And we were fortunate enough within
20 one of our services to have an IT specialist, and that's
21 always been part of their core offer as part of our
22 Redhall service in Edinburgh. So he was supporting
23 service users not just in Edinburgh but in some of our
24 other therapeutic horticultural services as well.
25 Q. You talk about your national employment team. Tell me

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

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

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

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

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1 continued our kind of engagement with our service users
2 and more broadly during that -- you know, members of the
3 public during that period. So we recognised that we
4 wanted to have a kind of central place online and we
5 worked with our colleagues at MIND in England and Wales
6 as well to kind of pull together all the key resources
7 that we felt would be appropriate for individuals to
8 kind of keep themselves well. You know, we always have
9 a kind of core focus on population health and population
10 mental health and well-being at SAMH, so it's about
11 pulling together some of the resources and some of the
12 tools, techniques, and identifying other places for
13 support, not just within SAMH but across other
14 organisations as well, to make sure that I guess people
15 would have one place they could come and a place for
16 kind of trusted support, information and resources.
17 Q. I'm going to jump forward and back a little bit. You
18 talk again about the mental health hub at paragraph 82
19 and you talk there about numbers --
20 A. Yeah.
21 Q. -- just over 75,000. Is that a Scotland figure or
22 a UK --
23 A. That was -- yeah, that would be accessing -- that's
24 accessing the SAMH COVID hub, so that's just
25 specifically the kind of COVID pages and information

1 that was on our -- yeah, that was pulled together on our
2 COVID hub on our website.
3 Q. I'm going back now to paragraph 75. At the beginning of
4 that paragraph you talk about a survey that you carried
5 out. What were the main outcomes of that survey?
6 A. Yeah, I suppose the main outcomes of that survey or
7 probably two key things, they still preferred -- and
8 this was very, very early on in the pandemic -- most of
9 our service users said that they preferred and they were
10 missing face-to-face support from -- whether it be from
11 ourselves or from other services as well, and
12 particularly that -- yeah, that there is a massive
13 increase in isolation and loneliness during that period
14 because of feeling cut off from friends, family and
15 others.
16 Q. And at the end of that paragraph you say there was
17 little engagement by statutory services. Again, tell me
18 about that.
19 A. Yeah, I guess that goes back to probably kind of
20 previous points, and I know that services and staff were
21 pulled in multiple different directions, but
22 particularly the individuals that we were supporting
23 and -- the kind of core view was, "We kind of felt like
24 SAMH was the only one there for us", and I know that
25 other third sector providers have had the same feedback

1 as well. We were the ones that were still travelling on
2 the bus, still supporting them to, you know, ensure that
3 they were staying well and, you know, maintaining their
4 kind of life skills and everything else that they needed
5 to do to maintain their homes or to stay well around
6 medication as well, and it was only in the very, very
7 extreme situations or crisis situations where maybe
8 there would be engagement from other services.
9 Q. You talk at 77 about medication administration --
10 effectively medication administration visits and that
11 statutory teams were effectively passing that work onto
12 you.
13 A. Yeah, as part of -- one of our -- in some situations and
14 particularly in our care homes, you know, the
15 administration and support of medication would be
16 something that we would usually do. I'm aware that
17 certainly there was a couple of situations where
18 certainly we were asked to take on kind of elevated
19 responsibility around picking up, distribution and
20 administration of medication. You know, that was all
21 done within the appropriate kind of -- through the
22 appropriate channels and risk assessments, et cetera.
23 But, yes, it was definitely kind of another
24 responsibility because maybe statutory teams were
25 struggling for -- yeah, struggling for resources and

1 struggling staffing-wise.
2 THE CHAIR: Mr Caskie, I appreciated that you started
3 a little bit late, which wasn't your fault, so I'll add
4 a little bit of time on for that, but you're into your
5 last 10 or 12 minutes.
6 MR CASKIE: Yes, I am. I was moving on to paragraph 78,
7 where you talk about post lockdown, when things started
8 to open up, and that, once statutory services, as it
9 were, came back online, you saw an increase in your
10 work. Tell me why you think that happened.
11 A. I think probably for lots of reasons. There was -- you
12 know, there might have been occasions where -- well,
13 I suppose everyone was asked to kind of think about, you
14 know, "Do you really need to access this service?
15 Certain services are only for absolute critical
16 situations". So I think when things were opened up
17 around -- and there was further engagement and
18 particularly statutory services recognised the
19 challenges, the needs, that were then being presented to
20 them, we obviously saw an increase in the number of
21 referrals as well. You know, there will always be
22 conversations with our partners around what is an
23 appropriate referral or not and, you know, we can have
24 conversations around what a service specification tells
25 us, but certainly towards the end of the pandemic and

1 into that period coming out of the pandemic there was
2 absolutely an increase in some of the kind of more
3 challenging referrals that maybe we wouldn't have seen
4 pre-pandemic.
5 Q. At 79 you start to talk about your children and young
6 people team. Again, can you tell me generally about
7 that?
8 A. Yeah. I mean, during the pandemic, as well, you know,
9 there was a number of our teams that were working in
10 schools and working in the community, so obviously that
11 had to kind of transition until the guidance was
12 appropriate, that we could go back in and kind of change
13 face to face. We recognised during that period
14 particularly early on, when young people were at home,
15 the support for parents, teachers and school staff was
16 absolutely kind of critical. So we probably -- not that
17 we changed our focus from actually supporting children
18 and young people, but it was more focused on I guess the
19 parents and some of the school staff, and I know
20 certainly our teacher e-learning that we kind of
21 developed just prior to the pandemic, within April 2020
22 it was accessed over 4,000 times.
23 Q. You say that at paragraph 83. You also say at the end
24 of paragraph 83 that the website had a huge number of
25 hits. How many do you estimate that to be?

1 A. Yeah, we know precisely. So over the kind of 2021 and
2 2022, our website had over half a million hits. We were
3 accessed half a million times.
4 Q. Now, at paragraph 85, partway through the pandemic and
5 then subsequently, you commissioned a piece of research.
6 Please don't name the researcher but that research was
7 called "Forgotten", and then the follow-up was called,
8 I think, "Still Forgotten". Can you just tell me what
9 the findings of that were?
10 A. Yeah, I think I've probably submitted the full research
11 findings as part of the report, but I think it goes
12 probably back to some of the kind of key points -- you
13 know, the key points during this kind of witness
14 statement is that those with severe enduring mental
15 health problems with maybe kind of dual diagnosis,
16 multiple diagnosis, they were quite often the most
17 disadvantaged and most vulnerable prior to the pandemic
18 and that was kind of -- yeah, that kind of gap widened
19 during the pandemic as well. So we know that
20 particularly accessing a certain kind of support was
21 very, very challenging. Some areas got probably
22 slightly higher levels of satisfaction, so, you know, in
23 areas around engaging with kind of psychiatry,
24 et cetera, the kind of feedback was relatively positive.
25 But also there was again the feedback around the

1 essential nature of accessing face-to-face support.
2 Q. Okay. In terms of accessing face-to-face support,
3 obviously different organisations might do that at
4 different times. You say something about that at
5 paragraph 91.
6 A. Yes, so I guess one of our core services prior to the
7 pandemic and through the pandemic was our SAMH
8 information service, and it's not necessarily
9 a helpline, but -- you know, not listening service, but
10 it's an information service, so making sure people that
11 know where to go to access information and resources and
12 guided self-help tools. So during the pandemic or just
13 prior to the pandemic we were supporting over 5,000
14 individuals and at the end of the pandemic that was
15 7,000 individuals on an annual basis. So we saw quite
16 a sharp increase there, as other organisations such as
17 NHS 24 saw during the pandemic.
18 Q. And in terms of the information that you were receiving
19 out of this survey -- I'll try to summarise it -- you
20 had good levels of satisfaction amongst those surveyed
21 for GP services but poor levels of satisfaction in
22 relation to crisis services. Can you tell us about
23 that?
24 A. Yeah, I suppose that, as I said, the kind of probably
25 psychiatry and more -- yeah, probably the lower levels

1 of satisfaction was probably with -- was actually with
2 primary care and crisis services during -- yeah, during
3 that period, and it didn't necessarily change, you know,
4 between the two different surveys, the Forgotten and
5 Still Forgotten as well.
6 Q. You then move on to lessons learned and at paragraph 97
7 you talk about the improvement, as it were, in terms of
8 using information technology. Is there anything that
9 you haven't said that you want to say about that?
10 A. I think just generally, you know, our systems are better
11 and more reliable, more resilient, you know, whether it
12 be our kind of IT infrastructure but also the kind of --
13 the implementation of those different kind of platforms
14 as well, which has been absolutely kind of critical.
15 There's a huge amount of learning around I guess our
16 quality assurance but also our quality improvement
17 within the organisation as well, and I guess that has
18 been because of the kind of -- probably the constant
19 kind of focus and scrutiny that has been on infection
20 prevention and control and other -- and service user
21 outcomes as well over the last few years. So that's
22 definitely moved us on and definitely the kind of
23 flexibility and being much more dynamic in the way we
24 kind of deliver our services as well.
25 Q. SAMH have become nimble?

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

1 Third Sector. I would like to see transparency
2 surrounding this process. I would also like
3 Third Sector service providers to be able to access
4 resources and equipment like PPE right from the outset."
5 Q. Those are all the questions I have for you. Is there
6 anything that we've not covered today that you think is
7 important to cover?
8 A. No, I think -- yeah, I've had the opportunity to say
9 what we wanted to say and I think -- yeah, I appreciate
10 the opportunity to kind of speak today and I suppose
11 just want to thank all my colleagues within SAMH for
12 kind of their help, support and resilience during the
13 time.
14 MR CASKIE: Thank you very much, sir.
15 A. Thank you.
16 THE CHAIR: Very good. Thank you, Mr Cumming. I'm very
17 grateful for your evidence.
18 MR CASKIE: 3 minutes past 11, not bad.
19 THE CHAIR: Yes, very well done, Mr Caskie. We'll come back
20 about 11.20.
21 (11.04 am)
22 (A short break)
23 (11.20 am)
24 MR STEPHEN FINLAYSON (called)
25 THE CHAIR: Right. Good morning, Mr Caskie. Good morning,

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

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

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

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

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

1 who have got the experience, who have got that
2 expertise, that actually, you know, their experiences,
3 their knowledge, their background, is absolutely
4 critical to that. And we very much bring that into how
5 we operate, as many organisations do now.
6 Q. I'll ask you about that in a moment. But just at this
7 stage, can you tell us, what's your budget?
8 A. Our budget, so it's -- our turnover in 2023 was about
9 £16 million.
10 Q. 16 million?
11 A. 16 million, yes.
12 Q. And how many staff do you have?
13 A. Just about 600 -- you know, 600 kind of mark.
14 Q. At paragraph 14 -- and I'm not trying to limit what it
15 is that you do -- but at paragraph 14 you list three
16 main areas that I think you work in --
17 A. Yeah.
18 Q. -- which are home services, community services and
19 distress services; is that right?
20 A. Yes, that's how we tend to kind of conceptualise it as
21 a simple kind of way of summarising. So, as I say, home
22 services are the ones where you literally go into
23 people's homes and provide support from home; community
24 ones are the ones that are really about supporting
25 people to be part of their communities, you know, to

1 make connections, relationships with other organisations
2 or supports, to build natural supports; and then our
3 distress services are a range of services, such as the
4 Distress Brief Intervention. We also have a crisis
5 centre here in Edinburgh, a fairly new similar kind of
6 place in Dundee called "Hope Point", that have that
7 great focus on actually responding to people in
8 immediate crisis and distress --
9 Q. You've mentioned a couple of times the Distress Brief
10 Intervention --
11 A. Yes.
12 Q. -- programme. Seeing it written down and hearing people
13 talk about it, I think people don't necessarily put the
14 pause in the right place. It seems to me that the
15 correct way to say it is "Distress, Brief Intervention".
16 A. Yes, yes, I can see what you mean there.
17 Q. It's not about long-term support necessarily for people.
18 It can simply be go in, give advice or support and then
19 possibly walk away or signpost to another place?
20 A. Yes. Do you want me to talk a little bit more about the
21 structure of the Distress Brief Intervention?
22 Q. Yes.
23 A. So the Distress Brief Intervention programme began in
24 2016 and was a partnership between Scottish Government,
25 the University of Glasgow and several providers.

1 I guess a lot of it was about recognising that there was
2 a real gap particularly with kind of first responders,
3 with police, with ambulance services, et cetera, who
4 might come across people in distress but didn't actually
5 require really a police response in terms of any
6 criminal behaviour or didn't need to be in hospital but
7 there was a need for support, so it was recognised this
8 was a real kind of gap there. So the idea of Distress
9 Brief Intervention was to try and fill that gap.
10 So they talk about having two levels, level one
11 responders and level two. So level one is about
12 training people like the police, like ambulance
13 services, to provide that very immediate response, so
14 that when people, you know -- they come across people
15 who are in distress, they have the skills to provide an
16 immediate, compassionate and kind of skilled response.
17 But what it then allows is the level two response.
18 People can be signposted to this level two response
19 which organisations like Penumbra provide, where people
20 get a very focused two-week period of support and that
21 support is really about helping them to really think
22 about through what's causing the distress, "What are
23 your kind of strengths and things that we can really
24 support you to build on to manage this distress and how
25 do we help you to create a real kind of action plan that

1 are going to address issues that are causing this and to
2 take that forward?". Like I say, some of that will
3 include kind of signposting.
4 So it's not that people are just kind of left at the
5 end of the two weeks, it will be about having a plan
6 that you can take away, that's got the skills, that's
7 got the approaches, and if you need further support
8 you've got a clear plan of how you're going to access
9 that.
10 Q. So who else are first responders in this context?
11 A. So it would primarily be emergency services in terms of,
12 you know, a police/ambulance service, to some degree
13 fire service, et cetera. I guess one of the things that
14 changed in the pandemic was the establishment of what
15 they call the "national pathway", and that was very much
16 a response to the recognition of the distress that many
17 people were facing during the pathway [sic]. So one of
18 the things that that created as well was the ability for
19 NHS 24 in particular to then refer people to this DBI
20 national pathway and that national pathway then provided
21 that level one kind of response for that very immediate
22 response, so actually some of the providers then also
23 undertook that kind of level one response of doing that
24 very first stage kind of response to the distress that
25 people may be phoning NHS 24 about.

1 Q. We'll look at -- when we come to look at DBI, we'll look
2 at the types of causes of distress that you're involved
3 with.
4 A. Yes.
5 Q. But you also indicate at paragraph 15 of your report
6 another part of the work which you do, which is
7 accommodation services.
8 A. Yes.
9 Q. Is that essentially a care home?
10 A. So that becomes some of the interesting discussions,
11 I think, in terms of policy and things during the
12 pandemic. So they are shared homes where people live
13 together. So we have some in Aberdeen, some in Glasgow
14 and one in Edinburgh. So certainly in terms of
15 registration, in terms of the kind of policy and
16 registration kind of frameworks with the
17 Care Inspectorate, these are registered as care homes,
18 but there's an interesting kind of conceptual discussion
19 there I think about actually, "What do we mean when
20 we're talking about a care home?", which I think
21 probably is one of the real kind of issues (overspeaking
22 - inaudible).
23 Q. Well, one of the examples which you provide at
24 paragraphs 18 and 19, I think, demonstrates the extent
25 to which the use of the words "care home" in what you

1 might call the ordinary sense doesn't really fit what
2 you do. In those paragraphs you describe essentially
3 a block of flats --
4 A. Yes.
5 Q. -- in which people live --
6 A. Can I just say for clarity, though, these are slightly
7 different types of services again in terms of their
8 registration status, so these kind of services wouldn't
9 actually be classified as a care home, where people have
10 their own individual flats in a tenement block et
11 cetera, as that refers to there. As far as the
12 Care Inspectorate would classify them, they would be
13 more kind of supported accommodation services or housing
14 support or kind of caring support, so --
15 Q. So we've now excluded out from that care home part of
16 your work, the supported accommodation. What's left?
17 Tell me about the actual care homes that you operate.
18 A. Yes, so, as I say, we do have these buildings which are
19 completely shared buildings, where people would have
20 a bedroom as opposed to having their own kind of flat in
21 a tenement, sort of kind of things. So, say, for
22 instance, in Edinburgh, we have Milestone House out at
23 Oxgangs, which can support 12 people experiencing
24 alcohol-related brain damage, for people living within
25 the one property with their own bedroom and are

1 receiving support all within that one property. So that
2 does have I guess more of that kind of feel of a care
3 home.
4 As I say, the ones we're referring to at
5 paragraph 18 are supported accommodation where people do
6 have their own tenancy, they have their own flat, but
7 within that property there is a staff base that allows,
8 you know, support to be very easily accessed and
9 provided to the people living in those flats.
10 Q. Okay. And the care home element of it, the people who
11 are in the care home, they're not necessarily -- or
12 they're not elderly; would that be fair?
13 A. No, in principle they could be, but, yes, by and large
14 they are not.
15 Q. That would be coincidental?
16 A. Yes, it would and it's probably actually very rare.
17 I suspect when people who are more elderly and also have
18 significant mental health difficulties, that is often
19 not the kind of place they may go to.
20 As I say, we have probably two key types. One is
21 the alcohol-related brain damage services, which, by
22 definition, is supporting people with alcohol-related
23 brain damage, who are often people who are coming from
24 hospital, having gone through an initial kind of
25 treatment programme for alcohol, and then this is

1 a supported place where they can then try to rebuild
2 their lives.
3 There are other accommodations, such as our service,
4 Carntyne, in Glasgow. It's primarily supporting people
5 with relatively complex long-term mental health
6 conditions; you know, they may have diagnoses of things
7 like schizophrenia, for example. So it's people who
8 have ongoing fairly kind of chronic issues with their
9 mental health who require a lot of ongoing support and
10 who -- in terms of what we'd refer to as their "recovery
11 journey", they're finding their way back to a good life.
12 That is likely to be an intensive sustained support over
13 several years at least, you know, so (overspeaking -
14 inaudible) --
15 Q. And for those who are in the supported accommodation you
16 spoke about, the block of flats, with one of the flats
17 being for care providers --
18 A. Yes.
19 Q. -- tell me about the progress --
20 A. So that would be sort of more of a -- and I guess it
21 would be slightly different levels of needs. So I think
22 the people in supported accommodation, where they have
23 their own tenancy, will very often be people, again, who
24 have fairly significant long-term support requirements
25 around their mental health but are perhaps at a place

1 where they are more able to manage a tenancy and to
2 manage their day-to-day lives to a greater extent than
3 the people who may be in the care homes as such.
4 Q. Is it fair to say that the majority of your work,
5 though, isn't provided through the accommodation areas
6 that you provide, it's much more in the community?
7 A. Yes, that's correct. So the significant majority of our
8 work is with the support to people in their own homes or
9 through the distress services, such as Distress Brief
10 Intervention, et cetera.
11 Q. Prior to working for Penumbra, where were you working?
12 A. So I worked for an Edinburgh organisation called
13 "Thistle Foundation", who are primarily more of
14 a physical disability -- kind of physical and learning
15 disability kind of oriented organisation, so they
16 support a significant number of people primarily in the
17 Edinburgh area with learning and physical disabilities.
18 So I worked for them for 20 years through a variety of
19 kind of support roles and management and training and
20 equality roles.
21 Q. So there are similarities in that, although you're
22 involved in ongoing care, it's not care-home modelled?
23 A. Yes, absolutely. So the Thistle Foundation only support
24 people in their own homes. They have no care homes at
25 all. And there's a very, very significant similar ethos

1 in terms of the values and approaches and what we would
2 refer to as "person—centred approaches" about how do you
3 actually design support very much around that unique
4 individual, you know, about their needs, about actually
5 who they are, what they want to get from their life. So
6 a very, very similar ethos and ——
7 Q. And you talk about that ethos at paragraph 26. Can
8 I have you just read paragraph 26?
9 A. Sure thing. So this is referring to my role I think.
10 Q. Yes.
11 A. So:
12 "This was a new role in Penumbra, and there was
13 a bit of a change in how things were structured which
14 very much attracted me because it provided the
15 opportunity around areas like equality, impact and
16 evaluation, what we are doing and really all about
17 really telling the story of Penumbra's work. That is
18 one of the things I am quite passionate about, actually
19 being able to describe why and what we do, how we do it
20 and why it makes a difference for people we work with.
21 There is something different and distinct about the way
22 that organisations like Penumbra deliver support for
23 mental health and being able to tell the story and
24 describe that really well is very important."
25 Q. Well, I'll ask you to do that today. You spoke earlier

1 about or I asked you earlier about the number of staff
2 that you had and you say something about your staff at
3 paragraph 28, where you talk about the staff being
4 effectively peer support.
5 A. Yes.
6 Q. Tell me about that.
7 A. Yes, so as I said, peer support is a really important
8 element of our work and has been for at least the last
9 kind of 15 or 20 years. So Penumbra have an absolute
10 commitment to employing people who bring their own lived
11 experience of mental health and very often that will be
12 experience of quite significant challenges with mental
13 health. You know, it will often be people who have been
14 through some of the support systems, who have been
15 through perhaps the kind of psychiatric system, for
16 example. And there's a very strong ethos —— we also
17 host within us a semi—autonomous organisation called the
18 "Scottish Recovery Network", who are committed to also
19 kind of having that ethos about, "How do we really make
20 sure policy and practice is led by people who have got
21 that experience?".
22 Q. So still in paragraph 28 you give a statistic about ——
23 A. Yes.
24 Q. —— the number of staff who have a history of mental
25 health problems. Can you just give us that figure?

1 A. Yes, so 26% of our front—line staff is delivered by
2 people who are employed explicitly within peer roles and
3 we have an ambition to increase that to at least 30% ——
4 Q. And again you say something about the philosophy of the
5 organisation in terms of employing people who can act as
6 peer supports at paragraph 29. Could you tell us a bit
7 about that in your own words?
8 A. Yes, and it's maybe helpful to just talk about connected
9 to that. So we would refer to ourselves as being
10 a recovery—focused organisation, and what we mean by
11 that is that what a good life with a mental health
12 difficulty or a mental ill health difficulty looks like
13 will be different for every person and that our role is
14 to help support people to identify what a good life
15 would look like irrespective of whether actually they
16 still experience symptoms. You know, part of the ethos
17 is that people may still experience symptoms but can
18 still lead a good life as defined by them if the support
19 is really effective at helping them to do so. I think
20 that's where a lot of peer work comes into that because
21 it's being led by people who have been through their own
22 journey themselves of working out, "Okay, I've had these
23 real challenges in my life, I've had real difficulties
24 with my mental health, but I've been able to find a way
25 through it. I've been able to find a way to lead a life

1 that is full and satisfying, you know, despite these".
2 So I think it's really connected to that sense that
3 while we work very closely with clinical partners, we
4 don't work from a clinical perspective ourselves. We
5 are not there to diagnose people, we are not there to
6 treat people with diagnosed mental illnesses. We are
7 there to work alongside them as citizens, to think
8 about, "Given where you're at with your life and the
9 challenges you experience, what would a good life look
10 like to you and what support can we provide that would
11 help you to move towards that?". Peer work and people
12 who have been through that journey themselves is
13 a really, really critical part of that for us.
14 Q. In terms of Penumbra's public profile, you say something
15 about that at paragraph 35. Again, can you tell us
16 about that?
17 A. Yes. It's interesting —— so this was my colleague who
18 I think was referring to this, but I suppose I think,
19 compared to some organisations, we probably don't have
20 the highest kind of public profile. You know, I think,
21 in terms of actual kind of provision, we're a fairly
22 large provider but we don't have quite such a high
23 public profile and we're not particularly a campaigning
24 organisation. Certainly at the moment you don't see
25 a kind of high profile campaigns led by Penumbra. We

1 primarily see ourselves as influencing by doing. We
2 want to provide really good support and provide really
3 good services and do it in that way.
4 You'll see we talk actually there about a kind of
5 rights-based recovery and again I think that's a really
6 kind of critical part of that ethos, that we see
7 ourselves as working alongside people to make sure that
8 their rights are respected because, you know, with
9 things like stigma and lots of processes in place, very
10 often people who experience significant challenges with
11 their mental health I think can face risks to their
12 rights being respected. So there's a really strong kind
13 of human rights focus to I think our ethos and our
14 values and kind of things that I guess we -- yeah, we
15 try to kind of focus on in the doing. But I think what
16 we're saying there is we probably aren't one of the
17 organisations who are out there with shiny PR campaigns
18 and that kind of thing --
19 Q. I'm not going to get stopped on the street by someone
20 asking me to sign up to Penumbra?
21 A. No, you certainly wouldn't be.
22 Q. At paragraph 37 you talk about the Scottish Recovery
23 Network. Again, can you tell us about that?
24 A. Yes, so Scottish Recovery Network are actually --
25 they're a semi-autonomous organisation, so -- we refer

1 to it as "hosted by Penumbra" so their staff are all
2 Penumbra employees and, you know, for -- in the
3 practicalities of running an organisation, they exist
4 within us, but they have a largely independent remit.
5 They are funded by Scottish Government. And their remit
6 is to promote specifically that recovery model that
7 I referred to about -- you know, a kind of view of
8 actually, "How do you build a life that is based on you
9 and your needs and your aspirations for your life?", and
10 very particularly about bringing that sense of lived
11 experience; how is that model furthered by really
12 listening to and really involving the people who have
13 got lived experience of their own mental health. So
14 they do a lot of just fabulous work around kind of
15 advocating for and supporting that way of working.
16 Q. At paragraph 39 and onwards you talk about your services
17 prior to the pandemic. Just as a base, can you tell us
18 about that?
19 A. Yes, so I think -- you know, as I say, I was only with
20 Penumbra a year before the pandemic started, but
21 Penumbra is a very well established organisation. We
22 had a whole range of services, as I say, largely up and
23 down the country, particularly in the supported
24 accommodation services and the supported living
25 services, our crisis centres. The Distress Brief

1 Intervention programme launched in 2016 had probably
2 been one of the really significant developments over the
3 two or three years prior to that.
4 I think, when things had hit, it was
5 a well-respected and remains a well-respected
6 organisation in terms of things like the
7 Care Inspectorate, who regulates about 50% of our
8 services, that, you know -- the Care Inspectorate have
9 a 1 to 6 kind of scale of grades, with 6 being the top,
10 and our consistent kind of average has always been about
11 5, the second-top from the highest. So, yes, I think,
12 you know, a well-regarded kind of organisation at that
13 point.
14 Q. You talk about, at paragraph 40, a lucky break.
15 A. Indeed. Yes, indeed.
16 Q. Tell me about the lucky break.
17 A. Yes, so as many organisations are, of course we were
18 looking at our IT systems and we had been planning
19 a really kind of significant shift to an entirely new IT
20 system, in which we'd incorporate all of our back office
21 stuff, in terms of HR and finance, but also all the
22 records for the people we support, our support planning,
23 our staff rotas, et cetera, so that was all being
24 brought into one new system, and that system literally
25 went live two weeks before the first lockdown happened.

1 It has been true to say, I think we have thought
2 many times, we can't quite imagine how we would have
3 done some of what we did had we not had that. Like all
4 IT systems, it had its challenges and still does, but in
5 particular what it allowed us to do was really look at
6 all the people we support and really think about
7 prioritising, really thinking about individual support
8 needs, and we had that in a very accessible way that
9 allowed us to, in that dreadfully corny term, pivot very
10 rapidly. We could really look very quickly at all the
11 people we support and think, "Right, who do we have to
12 see? Who are people who we can perhaps have a phone
13 call with and just check in with? Who are the people we
14 absolutely have to still go out and see?". And also,
15 just in terms of the communications with staff and
16 scheduling and just being able to think about actually
17 how people go -- particularly I guess with things like
18 staff isolation, you know, starting to kind of impact,
19 you know, being able -- it gave us that flexibility to
20 just have that picture very readily to hand. And while
21 it may not be a perfect system it certainly I think made
22 a massive, massive difference.
23 Q. You refer at paragraphs 42 and 43 to the Distress Brief
24 Intervention programme.
25 A. Yes.

1 Q. I'm going to ask you about that in more detail, but
2 I need to set something up about that so we'll do that
3 first. At 44 and 45, you say -- sorry, you talk about
4 the immediate impact --
5 A. Yes.
6 Q. -- of COVID and the lockdowns. Again, tell us about
7 that, please.
8 A. So I guess, like all organisations, we had to move
9 pretty quickly, particularly, you know, once the full
10 lockdown was launched in the March of 2020. So we set
11 up a daily kind of group of our senior management team
12 that I was co-ordinating to really kind of plan that.
13 A huge amount of that was about thinking about, "How do
14 we really think about the services that we provide?",
15 and, as I mentioned there, particularly about thinking
16 about who are the people we support, which of them are
17 people we think absolutely need support, that we need to
18 keep seeing, you know, that actually things will get to
19 potentially really quite serious situations if we don't
20 keep seeing these people; are there people who we think
21 actually, if we keep in touch by phone, et cetera, they
22 will be fine. So a great deal of thinking about how do
23 we prioritise people.
24 Also, as I guess lots of organisations did, shifting
25 to where we could -- supporting people remotely. So

1 I think in the first couple of weeks that was -- a big
2 part of what I was doing was working on a kind of model
3 for telephone and video support, you know, kind of
4 a structure for how we might actually engage with people
5 and make sure we're having an effective interaction with
6 them as much as possible, about where they were at and
7 about how their needs were kind of things, and
8 inevitably a huge amount of kind of staff communications
9 as the kind of official guidance started to emerge and
10 trying to start to translate that into practical
11 guidance for our staff.
12 Q. In paragraph 47 you're talking about the set-up of those
13 new systems to deal with the pandemic and at
14 paragraph 48 you say then you just go into a zone. Tell
15 me about the zone.
16 A. Yes, I think that's actually -- I think that's my
17 colleague that was speaking there, but --
18 Q. Aha. It's your statement now.
19 A. No, no, I'm just trying to put my head into ...
20 Yeah, I mean, I think it was just that sense of --
21 you know, as everybody did -- of, "Okay, how do we
22 respond to this? How do we reassure our staff?",
23 because -- I think that was one of the big challenges we
24 faced, as many organisations, who were going to continue
25 to provide services, about the messaging to staff and

1 about balancing that -- taking staff concerns really
2 seriously with reassurance and trying to manage that
3 guidance.
4 But I think a lot of it was also -- you know, I was
5 looking back at some of this over the last few days,
6 about some of our messaging that was going out -- about
7 trying to get really clear about actually -- there was
8 a lot of talk about essential services -- that actually
9 we are an essential service and what we do is essential.
10 But I think a lot of that zone was creating that
11 messaging, that culture of an organisation of, "We still
12 have a job to do here" -- you know, "While the country
13 is in many ways shutting down, we still have a job to do
14 here and we're going to carry on as much as we possibly
15 can". I think, yes, trying to establish, I guess, that
16 kind of organisational culture of communication and
17 support and how do we continue to do the job to the best
18 we can and do that safely.
19 Q. At paragraph 49 you talk about using the IT system to
20 manage --
21 A. Yes.
22 Q. -- risk levels to identify where the greatest risks are
23 for your users.
24 A. Yes.
25 Q. Tell me about that.

1 A. Yes, so actually that allowed us to really think through
2 actually what are people's needs because I think it's
3 one of the ways that perhaps mental health doesn't
4 necessarily always have the obvious needs that people
5 may assume for many people, but actually a very
6 significant number of people we support do have
7 long-term support needs. So, you know, people -- just
8 things like medication, many people will take medication
9 for their mental health, without which things may become
10 really kind of difficult for them fairly quickly and who
11 will not -- and many people may not take that medication
12 without that support going in, so kind of some real
13 practicalities with that.
14 There are many people we support who do have
15 significant difficulties or have real challenges just
16 about very day-to day tasks, like getting food, like
17 cooking for themselves, et cetera, paying bills,
18 et cetera. So there's a significant number of people
19 who I suspect a member of the public -- it may not be
20 obvious that, actually, without support going in, their
21 lives may become really difficult really quickly.
22 I'm bound to say, at the other end of the spectrum,
23 we will support people who actually by and large get by
24 in their life okay but still need support and so
25 therefore we might be able to check in with them by

1 phone or have a video call, et cetera. So that's what
2 that system allowed us to go, was to be able to go
3 through people and really identify, "These are the
4 people that we absolutely have to go and see",
5 actually --
6 Q. Now, whilst you're managing that internal system, you're
7 also receiving guidance from Government.
8 A. Yes.
9 Q. You talk about that at paragraph 54. That will appear
10 on the screen in a second.
11 A. Yes.
12 Q. Tell us about that.
13 A. Yes, so obviously, when things -- the lockdown things
14 first started or before that really, when the kind of
15 restrictions on schools, et cetera, started to come in,
16 we started to receive guidance coming from various
17 places, from Scottish Government directly, from local
18 authorities, from Care Inspectorate, from the Scottish
19 Social Services Council, who are the regulator for the
20 workforce, and Social Care in Scotland, from Public
21 Health Scotland -- so we started to get quite a wide
22 array of guidance coming in, both directly relevant to
23 our sector and relevant to the wider health and social
24 care sector. So that started to become that question
25 of, "How do we translate this into something that is

1 meaningful for our staff", and what very quickly became
2 pretty vast swathes of guidance.
3 Q. In your statement at paragraph 53 you use the phrase
4 "translating guidance [as read]" and you've just used it
5 again. Was the guidance not something you could just
6 read off the page and apply?
7 A. Certainly not specifically as it applied to us. It was
8 often very detailed and very understandably so, given
9 the circumstances we were facing, but particularly
10 initially I think it had quite a broad brush about
11 health and social care and actually what that looked
12 like for an organisation like us often did not seem
13 clear at all or took a great deal of trying to unpick --
14 of go in and trying to extract, "Okay, these are the
15 bits that actually apply to us". And of course what we
16 had to do -- our staff who were out delivering the
17 support don't have the time to be reading through vast
18 amounts of policy and guidance, so we -- initially we
19 actually started a daily communication of, "This is what
20 the guidance is saying, this is how it applies to us and
21 this is what we need you to do", you know, trying to
22 break it down into very kind of small chunks of, "This
23 is what this means and this is exactly what we need of
24 you in order for us to kind of be working within this
25 guidance and applying it".

1 Q. At paragraph 59 you talk about impact on service
2 delivery. You talk about that happening in three ways.
3 I'll take you through each of those in turn.
4 A. Yes.
5 Q. Firstly you talk about supported accommodation.
6 A. Yeah.
7 Q. Tell me about the impact there.
8 A. So the supported accommodation services probably did
9 have to some extent the biggest impact for us both on
10 a kind of practical level and I think for our staff in
11 terms of anxiety and stress and kind of things in terms
12 of actually following the guidance, and very
13 understandably, given what we know happened in many of
14 the care homes, you know, having that -- I can very much
15 understand where a lot of that guidance came from.
16 But I guess one of the things that was different in
17 the care homes was that in a lot of our other services
18 we could move staff about more easily. You know, the
19 care homes had to have staff on site and obviously we
20 didn't want, as much as possible, to be bringing a vast
21 range of staff. So that created real pressure on the
22 staff teams, just in terms of maintaining the service,
23 particularly when things like isolation kind of started
24 to come in, you know, if people did have symptoms,
25 et cetera. So that created some kind of real

1 challenges.
2 But also the guidance around care homes -- and I'm
3 sure -- I don't know if you want to get into this now or
4 come back to it -- but we particularly found the
5 guidance around care homes very difficult to work with
6 and to interpret because it really did feel that it was
7 written with an assumption that a care home is a place
8 for elderly people, for people with significant physical
9 impairments, and it didn't seem to have any kind of
10 recognition that actually care homes in a mental health
11 setting -- many of those assumptions about who is in
12 those kind of -- in a care home like that and what kind
13 of restrictions you might be able to put in place don't
14 apply; you know, they're not appropriate, they don't
15 apply. So I think some --
16 Q. From your perspective, was that predictable? If someone
17 was writing guidance, was it predictable that one size
18 would not fit all?
19 A. I mean, in principle, yes. I have much sympathy for
20 people trying to create that guidance at the times that
21 were going on. I think what it does speak to, at those
22 kind of levels, is a lack of broad understanding of
23 actually the breadth of the sector and the breadth of
24 the types of support that are out there. It felt that
25 the guidance was being written from a very kind of

1 health—focused, conical—kind—of—focused perspective by
2 people who perhaps just didn't appreciate that actually
3 there's a whole range of supports out there that your
4 frame of reference, your understanding of the world,
5 doesn't apply to.
6 So in principle, yes, but I think probably the
7 challenge there is about actually having the structures,
8 you know, that allow that kind of clarity of actually
9 the variety of support that is out there.
10 Q. At paragraph 60 you move on to the second area of work
11 that you predominantly do ——
12 A. Yes.
13 Q. —— which is visiting support.
14 A. Yes.
15 Q. The impact there?
16 A. Yes, so, as I say, we did a lot of the prioritisation
17 about who are the people who we absolutely still need to
18 see, and while we did move a lot of our support to video
19 support or telephone support, a significant number of
20 our services continued going out and visiting people,
21 particularly, as I say, for those people where things
22 could start to get really difficult in their lives if
23 they weren't receiving that support.
24 On many levels that actually went okay. I think
25 staff were able to do that. I think, you know, we were

1 able to kind of make sure that we were able to do so
2 safely. The people we supported almost overwhelmingly
3 were incredibly supportive and understanding about
4 distancing, et cetera, and wearing masks and all this
5 kind of stuff. A lot of the challenges were actually
6 quite practical ones. Many of our staff use public
7 transport. Getting actual public transport to go
8 between people was often a challenge ——
9 Q. You don't exclusively work in the central belt.
10 A. No. No, not at all.
11 Q. You do work in the Borders.
12 A. Yes.
13 Q. I understand that in some parts of the Borders there
14 isn't good public transport systems.
15 A. Yes. I don't live in the Borders myself, but ... yes,
16 certainly that was what we were told. At best of times,
17 the public transport could not be good and I think that
18 became particularly challenging for staff when they were
19 trying to move about in those kind of more rural areas
20 such as the Borders.
21 And just some really actual pretty brutal kind of
22 practical things, like accessing toilets —— you know,
23 public toilets were closed, and staff might in previous
24 times have gone to a supermarket and supermarkets were
25 often —— you had to queue to get into kind of thing. So

1 just some of those real practicalities of actually ——
2 with society closing down, the way you would structure
3 your day to make it manageable became really, really
4 challenging for a lot of staff.
5 Q. Now, I'm moving on to paragraph 69 about the importance
6 of the home visits. Just from your experience, can you
7 tell us about that?
8 A. Yes, because it's a real interesting one, because from
9 a mental health perspective —— and again that's part of
10 the wider mental health discussion about the whole
11 pandemic —— that sense of connection, of having people
12 in your lives, of people that care about you, of that
13 interaction, is just a massively, massively important
14 part of all of our mental health. So we definitely saw
15 that with people that we support, a kind of real impact
16 of that sense of isolation.
17 It was complex, in honesty, because some of the
18 people we work with also I think found some of the
19 pressure eased slightly in terms of, you know, actually
20 kind of being out in society, which many people can find
21 a challenge. I think the fact that there was less
22 expectation of that, for some people actually it was
23 welcomed in some kind of ways. But I think there is no
24 doubt many, many people found that challenging. And
25 again, inevitably in our care homes —— I think the

1 challenges about having visitors within care homes, you
2 know, was a real kind of challenge for people for that.
3 Q. At paragraph 70 you talk about the digital poverty
4 amongst your client base.
5 A. Yes.
6 Q. Tell me about that.
7 A. And that was a big focus for us in the early stages
8 about recognising —— there was a kind of push to move in
9 many ways to kind of digital delivery of video calls,
10 et cetera, but there was an absolute reality that
11 a substantial number of the people that we would work
12 with did not have easy access to digital devices; you
13 know, many didn't have a smart phone, never mind kind of
14 tablets or laptops, et cetera. So that was a real kind
15 of challenge for us and one —— there was work with the
16 Scottish Government, kind of thing, in its early days to
17 try and access kind of resources to buy, you know,
18 devices for people, which we were able to do to some
19 extent. But I think that's one of the things the
20 pandemic did highlight, was that they still retain
21 a significant kind of discrepancy. I think people
22 with —— a significant number of people that we support
23 will be people from areas of significant deprivation and
24 in those communities of people not having the devices
25 that allowed that to happen easily.

1 Q. And we've spoken exclusively so far about problems, but
2 it wasn't all negative and you talk about some of that
3 at 71. Tell us about that.
4 A. Yes, so it is that interesting thing about that
5 actually, I guess for all of us to some extent -- you
6 know, in a crisis, it also gives the opportunity for
7 people to respond positively and, as I say, I think the
8 people we supported were extraordinary actually, you
9 know, partly in the way they interacted with our staff,
10 the levels of kindness and support to our staff and
11 concern for our staff was massive, but also I think
12 a lot of people did discover skills -- I think many
13 people did discover that actually they could actually
14 perhaps do things that perhaps previously they hadn't
15 been aware of.
16 I think I talked a little bit later about I think
17 some of the challenges with this perspective, but there
18 is a danger with support that actually it becomes
19 entrenched and that actually people become deskilled,
20 and I think there was an opportunity for some people to
21 kind of reassess actually, "What actually is it that
22 I need and is there a risk that actually some of the
23 support that I've come to rely on is actually getting in
24 the way now?" and "Oh, actually I can do some of these
25 things for myself". So we definitely saw that and we

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

1 there's a risk that, actually, if we just view it of,
2 "People coped so maybe they don't need support", it has
3 a real kind of risk to it as well.
4 I think I talked about there being a double-edged
5 sword. I don't know if that's actually quite the right
6 term, but I think it's really important that we
7 recognise that some of these do provide really useful
8 insights into actually people's ability to be resilient,
9 to create their own supports, but we need to be really
10 cautious as well about not saying, "Well, that just
11 means they don't need support", when actually support
12 should be about a much bigger picture of people's lives,
13 to have a long-term good life.
14 Q. At paragraph 75 you talk about experiences coming out of
15 COVID, and I think you're referring to services like
16 psychiatric nursing and occupational therapists becoming
17 less available during the pandemic.
18 A. Yes.
19 Q. Can you tell me firstly about that, about those services
20 becoming less available?
21 A. We did notice without doubt that a lot of the statutory
22 services that many of the people that we support will
23 also interact with were certainly scaled back and in
24 many cases really did seem to largely disappear. People
25 were not seeing people like psychiatric nurses,

1 social workers, you know, psychiatry and psychology
2 appointments, et cetera, were largely cancelled and they
3 did seem, to a large extent, to disappear.
4 I was thinking about this earlier and one of the
5 things that I think is useful I think about this going
6 forward, there's a lot of talk about essential workers.
7 What I think there probably wasn't enough talk about was
8 essential work. So I think all of those people were
9 clearly classified as essential workers but I think,
10 when we were thinking about this, we were thinking, "Who
11 are the people and what do they need? Do they need to
12 see people, you know, do we need to go and support
13 them?", and if we thought we did, we continued to do so.
14 It felt to me like for a lot of people who were
15 classed as essential workers, though, the actual work
16 that they were supposed to be doing wasn't necessarily
17 considered -- "Is that essential? Is it essential we go
18 and see that person?". It felt like a huge amount of
19 that, the statutory provision, really just closed down
20 with a kind of blanket, "No, we're not going to see
21 people".
22 Q. In terms of the end of lockdown and things returning to
23 normal, did those services become available quickly?
24 A. No, it really did feel that a significant way into the
25 pandemic things were still very much operating on a kind

1 of skeleton level and people not seeing people. I say
2 there my memory is that significantly into 2022, many of
3 the people we support were still not seeing people like
4 psychiatrists, social workers, et cetera -- you know,
5 that things still felt very, very hands-off and distant.
6 Q. I'm going to move on now to ask you about Distress Brief
7 Intervention Service. You have explained this was
8 something that was set up in 2016 --
9 A. Yes.
10 Q. -- and therefore technically is outside our remit, so
11 the only reason I'm asking you about it is, had it been
12 in place during the pandemic, what could it have done?
13 Now, you've already explained the system of first
14 responder and then organisations such as yourself being
15 a second responder. What have you seen as the
16 consequences of this programme?
17 A. Yes, so it was in place throughout the pandemic --
18 Q. Ah, right.
19 A. -- I do think, so it exists to this day, and in fact it
20 is intended to be a completely national programme over
21 the coming year or so across all of the health and
22 social care partnerships. So it began as a pilot in
23 2016 and it had a very good formal evaluation, so
24 Scottish Government have now agreed that it should
25 become nationally available. I actually think it was

1 probably one of the fortuitous things that that
2 fundamental structure was in place because I think it
3 did allow that very quick transition to the national
4 pathway to respond to the distress of COVID.
5 So it has supported over 50,000 people to date, the
6 Distress Brief Intervention programme, and the national
7 pathway in particular saw a huge amount of calls during
8 and continues, I think, to see calls connected to COVID,
9 particularly around things like financial difficulties
10 and particularly as the furlough scheme started to kick
11 in and people's jobs were starting to be at risk, you
12 know, financial distress, relationship distress, you
13 know, caused by many of the challenges of lockdowns and
14 kind of family difficulties and kind of things like
15 that, just kind of employment kind of challenges,
16 people --
17 Q. Can I take you to paragraph 90, where you say something
18 about that, what might be thought of as causes --
19 A. Yes.
20 Q. -- for requiring engagement with a service.
21 A. Yes, so I guess that is about, you know -- obviously
22 many people will have some very kind of practical,
23 tangible things underlying their distress, so it might
24 be relationship breakdowns or it can be relationship
25 difficulties , financial breakdowns, job, employment kind

1 of concerns and things, and those are very much the kind
2 of things that people will be bringing to the
3 Distress Brief Intervention programme. I guess that's
4 maybe where it's perhaps a slightly different side to
5 our work that is with people with long-term, you know,
6 diagnosed mental health conditions, such as
7 schizophrenia, this is very much about responding to
8 these social, economic pressures that create real mental
9 health challenges for people, and that very often can
10 lead to very significant levels of distress and many of
11 those were inevitably really exacerbated during the
12 pandemic.
13 So that was very much a part of that intention of
14 the expansion to the national pathway for Distress Brief
15 Intervention, to provide that kind of very rapid,
16 solution-focused, compassionate approach to, "How do we
17 get you a plan here, you know, to really think about
18 what's going on that's causing this and helping you to
19 move through it".
20 Q. You talk about that a bit more at paragraph 94. Can
21 I take you there?
22 A. Yes, so I guess this is about the work that people --
23 that our practitioners within the Distress Brief
24 Intervention programme will provide, which, as I say, is
25 very kind of practical. We would talk about

1 solution-focused thinking, so it's really trying to get
2 a very concrete sense of, "What is it that's causing
3 your distress here?", and trying to actually -- we use
4 a thing called the "distress scale" to try and measure
5 that, actually on a level kind of 1 to 10, "How
6 significant is this distress for you and what would it
7 look like if you were to bring that down? What are the
8 really practical things that we can do to address some
9 of these ..." --
10 Q. In terms of those practical things, you say something
11 about that at the end of paragraph 94, where you say
12 it's often about that sense of losing control of things.
13 A. Absolutely.
14 Q. Can you carry on from there?
15 A. Yes, so, again, in terms of actually causes of kind of
16 distress and causes of pure mental health that are
17 associated with distress, a lack of control over your
18 life -- a sense of a lack of control over your life as
19 well is a really critical factor of that. If it's
20 feeling that things are spiralling out of control,
21 whether that's finances, whether that's with your family
22 breaking down, your relationships breaking down, that
23 sense of life -- just losing that sense of control over
24 it -- so that's really what we try to focus on in the
25 Distress Brief Intervention programme; how do you get

1 really clear about what these challenges that are
2 creating this distress are and how do you get a really
3 kind of tangible plan for how you're going to address
4 those and, you know, some of those —— maybe in terms of
5 financial stuff about kind of getting financial plans,
6 signposting to other kind of financial support
7 agencies —— you know, so just trying to get a really
8 kind of concrete plan of this —— (overspeaking —
9 inaudible).
10 Q. So if I approach a first responder or a first responder
11 approaches me and identifies that I'm in distress, the
12 first responder will make a referral possibly to your
13 organisation?
14 A. Yes.
15 Q. And the next day someone from your organisation will
16 contact me directly?
17 A. That's correct, yes. So the programme is a 24—hour
18 contact point, yes, so somebody will contact you within
19 24 hours of that first responder passing on their
20 details.
21 Q. But there's an expectation that, if required, you will
22 maintain contact for two weeks?
23 A. Yes, yes.
24 Q. And by the end of that period you will pass me on to
25 someone else?

1 A. Yes, if appropriate.
2 Q. If appropriate?
3 A. But part of that will be about actually what further
4 support do you require; is there organisations that can
5 help you here. So, you know, there will be a core kind
6 of exit plan of, "You're not just being left now after
7 these two weeks, you've got the strategies and you've
8 also got access —— other areas of support that you can
9 access" —— (overspeaking — inaudible).
10 Q. You also provide, at paragraph 95, an indication that
11 no one leaves empty—handed.
12 A. Yes, absolutely. So, as I say —— yes, my colleague
13 there talks about it as a distress management plan. It
14 really is that. As I say, that concrete plan of, "This
15 is kind of concrete practical areas I'm going to
16 address, this is other areas of support that I can
17 access if required". So everybody is going away with
18 something kind of really tangible.
19 Q. On paragraph 96 —— and I have to say we've heard this
20 from almost everyone in your type of position, "Our
21 staff were awesome" ——
22 A. Absolutely.
23 Q. —— can I give you the chance to say something about
24 that?
25 A. Absolutely. It was extraordinary, you know. There was

1 a real kind of sense of actually just commitment.
2 People wanted to continue working. People wanted to
3 continue providing support. I think the biggest
4 challenges we probably faced were sometimes about saying
5 to people, you know, "You don't have to do all of this,
6 you know, and you need to look after yourself". I think
7 there was just this incredible commitment that the
8 people we work with need support and we should still be
9 continuing to do this. So people were incredible. You
10 know, we had almost no issues whatsoever of kind of
11 people, you know, having huge concerns about actually
12 what they were being asked to do or about kind of
13 protocols or anything. Just a huge, huge commitment to
14 the people we support and a phenomenal response.
15 Q. You talk at paragraph 98 about the importance of that
16 because of what was happening to other supports —— three
17 lines from the bottom of that paragraph.
18 A. Oh, of 98? Sorry.
19 Q. Yes.
20 "... particularly when other supports ..."
21 A. Yes, okay —— yes, I think that's connected to that sense
22 of many kind of people not seeing things like
23 psychiatric nurses or kind of social workers, et cetera.
24 So I think there really was just a huge amount of care,
25 you know, actually for the people that they knew and

1 have built relationships with and of wanting to make
2 sure that they continued to have that support and that
3 they were okay.
4 Q. At paragraph 100 you talk about the difficulties faced
5 by staff at home.
6 A. Yes, indeed. So, as I say, we had a very mixed approach
7 and there was a reasonable amount of our support that we
8 were able to make digital, so we were supporting people
9 by phone calls and video calls. I think one of the
10 things in terms of some of the social inequalities that
11 that affected us differently, that we weren't all in the
12 same boat, to use that metaphor, is that our staff,
13 social care staff more widely, are not particularly well
14 paid —— well, many colleagues in statutory services are
15 also not well paid, but there is an ongoing inequity for
16 people doing similar roles, particularly in the third
17 sector, that their salaries are often significantly
18 lower. So these are people who earn very often not much
19 more than minimum wage and to a large extent that will
20 often mean that they're living in relatively small
21 properties for many of our staff.
22 So some of those challenges of working from home, of
23 trying to provide support from home, and often small
24 flats where you may not have the luxury of a spare
25 bedroom or a garage that you can turn into an office,

1 et cetera, were really, really challenging for people
2 and created real challenges for us about our kind of
3 guidance in terms of things like confidentiality. You
4 know, obviously if you're having a support call with
5 somebody, there's real confidentiality boundaries there,
6 and of managing that in a very small flat or house.
7 That kind of thing was really challenging for many
8 people.
9 So I think it just probably highlighted to me some
10 of those social inequalities about some of our very
11 essential workers in society but who are not very well
12 rewarded and so, therefore, when something like this
13 hits, don't have the luxury of big houses and gardens
14 and ...
15 Q. At paragraph 105, you talk about a particular group of
16 your employees, first-level line managers --
17 A. Yes.
18 Q. -- and them facing particular difficulties. Tell us
19 about that, please.
20 A. Yes, I think -- so I talk through about that kind of
21 anxiety about getting it wrong, particularly as far as
22 the guidance is concerned, and very particularly I think
23 for the managers of what are registered as care homes.
24 You know, the guidance was clearly very complex and
25 I think there was a real fear of, "If we get this wrong,

1 we are going to be held responsible. We are going to be
2 held accountable if there is an outbreak". Now, we were
3 very fortunate that we actually had virtually zero --
4 not quite, but almost zero actual levels of COVID
5 outbreaks or anything within our services or staff, but
6 there was a huge amount of anxiety, particularly of the
7 managers of accommodation-based services, that they
8 would be held accountable.
9 I think -- I talk a little bit later about when the
10 Care Inspectorate started providing reports to
11 Parliament and naming providers. I think that really
12 ramped up that anxiety, the real fear of. "If we do get
13 a COVID outbreak in our service, that we're going to be
14 kind of named before the Scottish Parliament as
15 a service where something has happened". So I think
16 that put a huge pressure and anxiety on our staff.
17 Q. You then move on to talk about the guidance and at
18 paragraph 108 you talk about getting new guidance coming
19 in at 4 o'clock on a Friday --
20 A. Yes.
21 Q. -- and the expectation being you would implement it on
22 the Monday morning.
23 A. Yes.
24 Q. Tell me about that.
25 A. Absolutely. It felt like that for a significant length

1 of time, of guidance changing very rapidly, you know,
2 certainly week to week and sometimes much less than
3 that. There was definitely times I remember it coming
4 in on Friday afternoon, with, "This is operational from
5 Monday", and you're kind of thinking, "Okay", and
6 that's, like I say there slightly flippantly -- but
7 a sense of putting out communications to staff saying,
8 "What we told you last Monday no longer applies. It has
9 now changed to this".
10 So rapidly changing and also just the guidance
11 coming from multiple sources. You know, we'd have
12 guidance from Public Health Scotland, from
13 Scottish Government directly, from the Chief Nursing
14 Officer, I recall at times there would be letters coming
15 out from, from the Care Inspectorate, which were by no
16 means always aligned. So this mammoth exercise of
17 trying to unpick this and, as I said earlier, breaking
18 it down into, "This is what this means for us and this
19 is what we need you to do", and quite often having to do
20 quite a lot of backwards and forwards to officials to
21 say, "Can you clarify this, please, because this doesn't
22 make any sense to the third sector" or --
23 Q. You provide quite a lot of detail of that from 100 to
24 about 116 but can I try to summarise what's there by
25 having you read the final sentence in paragraph 112?

1 A. "It just didn't feel well designed for our sector."
2 Q. Is that how you still feel?
3 A. Yes. I think what I said earlier was, particularly as
4 regards care homes, there seemed to be this assumption
5 that a care home is a care of the elderly home and that
6 the people within that are people with physical
7 impairments. The reality is that most of the people
8 that we would support in the settings are probably young
9 to middle-aged people. They are physically perfectly
10 capable of going about. We would have no powers
11 whatsoever to direct them or to restrict them. You
12 know, we would have no legal powers that would allow us
13 to kind of mandate that they follow any particular
14 guidance.
15 Now, again, I would have to say that just about all
16 of those people were fabulous. They got what was going
17 on and they respected the rules. But in terms of
18 actually, "Can we actually implement this guidance?",
19 there was a real question for us, and I think for me --
20 and I'm probably speaking to some degree more personally
21 here -- it felt very apparent to me, reading that
22 guidance, that -- some of the concerns about human
23 rights felt really -- it felt like there was a sense of,
24 "Because people are old, because they physically can't
25 move, that's okay, just keep them in their room. Just

1 keep them out of shared living rooms, et cetera", and
2 I think perhaps because actually that was virtually
3 impossible for us to implement in any kind of enforced
4 way, that contrast of actually we are talking about
5 essentially people's rights here and we're kind of
6 saying that because people in some sectors may not
7 physically be able to stop that, we can do it.
8 Q. You move on to talk about what you viewed as
9 difficulties with the Care Inspectorate and you alluded
10 to that before. Can you tell us about that?
11 A. Yes, and I think we have to be balanced here as well.
12 I think we got a huge amount of support from the
13 Care Inspectorate with our relationship manager, and
14 particularly in the early months the care inspectors
15 were actually very good at keeping contact with our
16 services, they were phoning up and kind of offering
17 support.
18 But to a large extent, you know, care inspections
19 stopped for the first kind of part of the pandemic and
20 they were then prioritised. Our services really didn't
21 start to actually have visited inspections until well
22 into kind of 2022, 2023. I think primarily actually
23 2023 was when they really started again.
24 One of the challenges was about the guidance, that
25 we were getting guidance from the Care Inspectorate that

1 at times would not be consistent for instance with
2 Public Health Scotland. I know my colleague talks
3 about, for instance, with care homes, "Actually are you
4 a care home or not?". Public Health Scotland would say,
5 "Oh no, we don't think of you as a care home"; the
6 Care Inspectorate would say, "You're registered as
7 a care home so you need to follow that guidance", so
8 things like that.
9 I think as things started to open up again, there
10 was a real sense that, when inspections restarted,
11 nothing had changed. It was on exactly the same basis
12 as before. And so some of our managers felt very
13 aggrieved, it's probably fair to say --
14 Q. Can I try to --
15 A. Yes.
16 Q. -- unpack that a little? You had a system of regulation
17 prior to the pandemic?
18 A. Yes.
19 Q. During the pandemic, obviously, there were changes in
20 the guidance and then after it, and you had concerns
21 about that and you talk about what you've already
22 mentioned, about reports going to the Scottish
23 Parliament.
24 A. Yes.
25 Q. And I'll ask you to say something about that.

1 But then, after the lockdowns ended, you still had
2 problems with the Care Inspectorate; is that right?
3 A. With some of the systems. I mean, in particular what
4 I think could have been done differently was that the
5 criteria that services were being inspected on hadn't
6 changed. Now, inevitably some of the things that
7 services would have been on top of prior to, they hadn't
8 been as on top of because they'd been focused on, you
9 know, the hygiene, keeping people safe and that kind of
10 thing. Services were then critiqued for not having some
11 of these things in place, you know, and it felt like
12 there was kind of no leeway. I think individual
13 inspectors got this, but there was a bit of a sense
14 of --
15 Q. You talk about the difference between the organisation
16 as a whole in the Care Inspectorate and individual
17 inspectors at 119. Do you want to say something about
18 what's there?
19 A. Yes, I think it was that sense that many of the
20 individual inspectors, I think, very much got these kind
21 of things. They were saying, "We know why you've not
22 been able to kind of maintain perhaps some of these
23 areas, we get that, but we're operating to the same
24 guidance, we have no choice". So some services would,
25 for instance, be downgraded because of some things they

1 didn't have in place and they'd kind of say, "But we've
2 been keeping people safe for the last two years, you
3 know, we've been doing these things so of course we're
4 not quite as on top of some of these other areas that
5 would usually be inspected".
6 And it felt to me there should have been some
7 different criteria about: "How well have you kept people
8 safe during the pandemic, how well have you kind of
9 managed to maintain people's rights and connections,
10 kind of things, and how well are you now emerging and
11 getting back to normal?" Rather than just a: "Right,
12 all the things that you should have had in place before,
13 are they all still 100% in place now?" when I think no
14 service across the country could possibly have
15 maintained the focus on all those kind of things when
16 you've got so much to do just to maintain things.
17 Q. At 126 --
18 THE CHAIR: Mr Caskie, you're almost out of time.
19 MR CASKIE: I know that.
20 At 126 you say:
21 "Because there were different things, the
22 Care Inspectorate, Public Health Scotland,
23 communications from the Chief Nursing Officer, there was
24 definitely a sense that these were not always coherent."
25 A. Yes, absolutely. So that sense in terms of the

1 guidance, with the formal guidance and, you know, we
2 refer there to some of the informal guidance, about
3 things like, "Are you a care home or not?", there was
4 very much kind of not a shared voice in that. And that
5 would be some of my sense of this, that going forward,
6 if we were to repeat this, how do you have that single
7 point of truth? You know, how do you have a system that
8 enables that kind of just clarity of communication from
9 one place?
10 Q. You start then to talk about funding and you make
11 a positive comment that, if you had been given an amount
12 of money to do a particular thing but you were unable to
13 do that thing --
14 A. Yes.
15 Q. -- funders would simply say, "Spend it where you think
16 it's needed".
17 A. Yes.
18 Q. Is that fair?
19 A. Yes. In many, many cases, I think a lot of the people
20 who funded our services understood that an organisation
21 like ours would collapse if they just said, "Well, if
22 you're not providing that in the way that you used to,
23 we'll have the money back thank you". So I think they
24 largely allowed us to kind of retain that money, you
25 know, and to keep paying the staff. Because, as I say,

1 we furloughed no staff whatsoever so all of our staff
2 were still being paid, were still trying to deliver
3 things in different ways. And certainly the large
4 majority of funders I think were very understanding
5 about that and did not attempt to kind of claw money
6 back which I think in different times they probably --
7 many might have done.
8 Q. At 136 you talk about private sector assistance?
9 A. Yes, and honestly that's probably a relatively small
10 thing. I think that was particularly about things like
11 the sanitiser and the --
12 Q. And you refer to that at paragraph 140. Can you just
13 tell Lord Brailsford about that?
14 A. So that was about those challenges with PPE,
15 particularly in those kind of first six months or so.
16 There was real kind of challenges. We were able to do
17 so but it was really, really difficult. The private
18 sector stuff was about sanitiser really, about actually
19 these kind of gin factories and things that kind of
20 pivoted to providing, so we were able to get some from
21 them.
22 But we did -- we were able to get PPE but it was
23 very challenging and particularly that sense about
24 actually it being reserved for the NHS. You know, so
25 consistent with being told of, "We can't issue you

1 supplies because actually we've been told we have to
2 reserve this for the NHS", and I think that was one of
3 the things that caused some degree of kind of ill
4 feeling with some of our staff, about a sense of not
5 being valued as much, you know, that actually the work
6 that we do is lesser and not as important as perhaps the
7 NHS kind of services.
8 Q. In addition to the services, was there also a feeling
9 about the attitude towards your staff, that they were
10 less important?
11 A. I think there was on a kind of structural level.
12 I wouldn't want to say that any kind of individual, you
13 know, actually believed that they weren't as important.
14 But I think, again, it connects that sense of services
15 disappearing. I think there was a sense of shut-down in
16 a lot of the statutory services, you know, "We have to
17 protect these people, we have to protect the NHS". That
18 didn't feel, you know, as if it applied to other
19 sectors, you know, such as ours, that actually it's okay
20 for those staff to go out. I know my colleague refers
21 to an example of an OT asking one of her staff to go and
22 visit somebody and saying, "I can't do it because we
23 have to protect NHS workers", and a kind of, "But it's
24 okay for you to go".
25 So I think there was that kind of broader sense of

1 that, that I wouldn't want to in any way attribute to
2 any kind of malign or, you know, anybody actually in
3 their own values not valuing, but a kind of structural
4 issue about --
5 Q. To the end of your very helpful statement, you provide
6 two sections: lessons to be learned and hopes for the
7 Inquiry. I don't intend taking you through those. They
8 will be read and considered. The lessons to be learned
9 are derived from the matters that I've already gone over
10 and they are your conclusions on that evidence. We will
11 take into account that, all of that evidence and your
12 effectively opinion.
13 In terms of hopes for the Inquiry, you say at 176:
14 "It is really important to say that we look at this
15 through the lens of the sector we are working in which
16 is community based mental health [services]. We are not
17 talking about staff who turned up to do a shift at A&E
18 or the people that carried on in the private care homes,
19 we are thinking about community-based health services."
20 That's your function, isn't it?
21 A. Yes. And I think particularly what my colleague did in
22 trying to express was, in terms of some of the concerns
23 about perhaps statutory services not always being there,
24 I think it's not wanting to be, you know, kind of highly
25 critical of them either. You know, clearly there was

1 hundreds of thousands at least of people doing
2 incredible jobs every day. I think it's more a question
3 about that kind of structural systemic stuff, about why
4 did some roles kind of disappear from actually some of
5 that kind of actually seeing people, actually engaging
6 with people. And I think that's the real question for
7 me, about actually, you know, what -- I said there is
8 something for me about that sense of actually essential
9 work as well as essential workers. How do we actually
10 identify the tasks that people should be doing? Because
11 that's where some of it seemed to disappear. People
12 were at work but they weren't actually necessarily
13 prioritising some of the tasks that I think needed to
14 happen to keep people well and to keep people safe.
15 Q. Those are all the questions I have for you. Is there
16 anything in the ground covered in the witness statement
17 which I've not asked you about that it's important that
18 you say in your own words?
19 A. I think there was something that just struck me there,
20 just back a little bit there, about reporting. I think,
21 again, in terms of some of the challenges that our
22 managers in particular faced was a vast array of
23 reporting requirements, which were really -- you know,
24 when they were already incredibly pressured just trying
25 to think about, "How do we keep this service going? How

1 do we keep the staff team going?", there were
2 expectations to report to multiple levels, to
3 Care Inspectorate -- you know daily reports to the
4 Care Inspectorate about COVID levels, staff absences,
5 et cetera; authorities were looking for bespoke reports
6 from services; Scottish Government were also kind of
7 having different reporting requirements. There was
8 a really very substantial amount of requirements for
9 reporting and enormous amounts of time needed for that.
10 Q. Was that reporting overlapping?
11 A. Yes, absolutely.
12 Q. Were you needing to tell the same things to different
13 organisations?
14 A. Yes, absolutely. Clearly there would be some
15 differences, but very substantial amounts of overlap, as
16 I say, about kind of staff levels, staff absences, about
17 levels of COVID within services, et cetera. So a great
18 deal of overlap.
19 Again, I think if there was one thing that -- were
20 we to face this again, a bit like the guidance, how do
21 we have a single point of reporting -- how do you have
22 a single point of truth for guidance and how do you have
23 a single point of reporting. I don't underestimate the
24 challenge of doing that, but I think that would be
25 hugely helpful because a lot of people's time was taken

1 away from actually keeping the services going and
2 supporting staff teams and things to adhere to these
3 reporting requirements.
4 MR CASKIE: Mr Finlayson, thank you very much.
5 A. You're very welcome. Thank you.
6 MR CASKIE: Thank you, my Lord.
7 THE CHAIR: Thank you, Mr Finlayson.
8 A. Thank you.
9 THE CHAIR: We're back at 1.30.
10 MR CASKIE: Thank you, my Lord.
11 (12.39 pm)
12 (The short adjournment)
13 (1.30 pm)
14 THE CHAIR: Good afternoon, Mr Caskie. Can you hear me,
15 Mr Caskie?
16 MR CASKIE: Apparently not.
17 THE CHAIR: I can hear you --
18 MR CASKIE: And we can hear you.
19 THE CHAIR: Good. Fine. Thank you.
20 MR EWAN AITKEN (called)
21 THE CHAIR: Good afternoon, Mr Caskie, and good afternoon,
22 Mr Aitken.
23 A. Good afternoon, my Lord.
24 THE CHAIR: Good. When you're ready, Mr Caskie.
25 MR CASKIE: Thank you, my Lord.

1 Questions by MR CASKIE
2 MR CASKIE: Would you tell the Inquiry your full name,
3 please?
4 A. Ewan Ritchie Aitken.
5 Q. In what capacity are you here?
6 A. I'm the chief executive of Cyrenians.
7 Q. And you've provided us with a very helpful and detailed
8 witness statement. Firstly, can I check that, with one
9 exception, which I'll deal with just now, at
10 paragraph 87 -- go to paragraph 87 -- in the second line
11 of paragraph 87, you provide an example.
12 "For example, the 17% increase in those being made
13 homelessness for the first time ..."
14 A. Yes, I know that example. Unfortunately the paragraph
15 numbers here do not appear to be the same as you, but
16 I'm aware of the example -- the statistic that you
17 referenced and, whilst I know where I heard it, I cannot
18 find the evidence to --
19 Q. No, I understand. We'll come back to that. I need to
20 work out -- because we're obviously working from
21 differently numbered statements. I have the Inquiry's
22 witness statement which Lord Brailsford also has access
23 to. Are you able to find in the document you're looking
24 at the 17% figure?
25 A. It's referenced in --

1 Q. It's just the paragraph number I'm looking for.
2 A. There's a reference to it in paragraph 54.
3 Q. Of your version?
4 A. Of my version.
5 Q. Obviously we have completely different versions. My
6 paragraph 54 says:
7 "Homelessness prevention needs to start upstream and
8 strong social relationships are key."
9 A. Mine starts:
10 "In August 2020, first time homeless presentations
11 in Edinburgh, increased by 17% from the previous year."
12 Q. That's paragraph 56 in my version of it.
13 Sir, I'm going to ask for a pause just so we can get
14 the ——
15 THE CHAIR: Get the right —— get a copy of the Inquiry
16 statement for Mr Aitken.
17 MR CASKIE: Yes, so a copy has been asked for. If we could
18 just rise for maybe ten minutes.
19 THE CHAIR: Surely, yes, we'll do that.
20 MR CASKIE: Thank you.
21 (1.34 pm)
22 (A short break)
23 (1.52 pm)
24 THE CHAIR: Very good. On you go.
25 MR CASKIE: Thank you.

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

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

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

1 A. Yes.
2 Q. Can you just tell us about that?
3 A. So Cyrenians is a homeless prevention organisation; in
4 other words, we want to stop people becoming homeless in
5 the first place as well as supporting people who are.
6 So a lot of the work we do is what you would describe as
7 "upstream", so we engage with people who are grappling
8 with poverty, people who are socially isolated, people
9 with mental health challenges, people who have been
10 through the criminal justice system, young people
11 struggling at school, although some of what they have
12 experienced is as a result of some of those other
13 things, people who have experienced challenges with drug
14 and alcohol addictions, women who have experienced
15 domestic abuse, families who are struggling with
16 conflict. We know that family breakdown is the most
17 common reason given when somebody presents as homeless,
18 therefore getting into families and supporting them so
19 that conflict doesn't have a consequence of homelessness
20 is one example of that.
21 We also do have street teams and work with people in
22 crisis, people who are actually homeless and get them
23 into a home. The plan there is to get them into a home
24 that they won't lose again because that's part of the
25 problem. But at its heart we're a prevention

1 organisation rather than a crisis organisation.
2 Q. You talk about some of the ways that you do that at
3 paragraph 12.
4 A. Yes, so the mediation, for example, that I describe. We
5 worked with about 200 families last year and virtually
6 everyone in that context the family stayed together or,
7 if the young people left, because the focus is on young
8 people, they left in a planned way rather than
9 a conflict-related way.
10 Mostly we create a space for people to have the
11 conversation that they want to have but haven't been
12 able to do so. We also support folk with mental health
13 challenges through the Royal Edinburgh Hospital and the
14 Midlothian. With gardens -- we've been able to evidence
15 that patients who spend time in the gardens spend less
16 time in hospital but they also get an opportunity to
17 build relationships. One of the challenges about mental
18 health is you're less able to create the social
19 relationships that will give you the capacity to
20 continue your life when you're living -- when you're out
21 of hospital again, so we do that. We have five
22 residential communities --
23 Q. That's exactly where I'm going next. Can you tell us
24 about that? I'm going to take a break in your evidence
25 after you've told us where they are and what they do and

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

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

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

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

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

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

1 times in that period of time and the best possible
2 support is peers. So we provide that -- develop that
3 capacity to be in a relationship with people in a new
4 context and then create the context for those
5 relationships to happen, and in that context you are
6 then more likely to flourish and therefore less likely
7 to become homeless.
8 Q. Okay. I just want to now go through a number of other
9 services that you provide, but on a headline
10 bullet-point basis.
11 Paragraph 16, you talk about your involvement with
12 the Community Payback system.
13 A. Yes. If you're in the criminal justice system, you are
14 13 times less likely to get a job. We provide people
15 the opportunity to do Community Payback activities,
16 largely outdoors -- not all the time but largely
17 outdoors -- through our community gardens, but also
18 training so that they can then get into work. Again, if
19 you're in work, you're less likely to get into poverty.
20 Q. At paragraph 17 you talk about your team embedded in the
21 Royal Infirmary and at the Western General.
22 A. People who are in unstable accommodation are
23 significantly more likely to use health services, so it
24 is a point of intervention that we can make because
25 people are asking for help and, if you can add to that

1 support into better accommodation, then you're more
2 likely to get support.
3 Q. What you say there is that everyone who walks into an
4 A&E in Edinburgh and identifies themselves as no fixed
5 abode or --
6 A. Actually it's not -- they don't need to identify
7 themselves. We've got about 5,000 temporary
8 accommodation addresses in their system for no fixed
9 abode and it's flagged up for them -- so they don't have
10 to make the identification -- it's flagged up digitally,
11 and that information goes to our team, who then go to
12 the ward, engage as part of the care package and --
13 I can give you examples if you wish of how that point of
14 asking for help and you can provide that support has
15 a -- is significantly more likely to engage and they're
16 more likely to stay healthy. So one of the things this
17 project has been able to do is reduce the attendance at
18 A&E by people who are more likely to use A&E because of
19 their circumstances by 63%.
20 Q. Housing First you do in the Borders --
21 A. Yes.
22 Q. -- at paragraph 18. Tell us about that.
23 A. So Housing First started in America. It works on the
24 principle that, instead of saying to somebody, "You need
25 to get your drugs sorted and your finances sorted and

1 your socialisation sorted and your employment sorted,
2 and then we'll give you a house", because you'll never
3 get there, that's how people bounce around the system,
4 we say, "We'll give you the house and we'll provide the
5 support around you so you can maintain the tenancy and
6 get that stuff fixed".
7 Q. And you organise that in the Borders?
8 A. In the Borders, yes. So we are contracted by
9 Borders Council to deliver that.
10 Q. You provide food through the FareShare Initiative?
11 A. Yes, so we're part -- it's a British-wide -- a UK-wide
12 service and we're the franchise holder for the
13 south-east of Scotland. We're in partnership with
14 170 organisations and we deliver about 100 tonnes of
15 food a year to those organisations. They get it at
16 about a fifth of the cost -- this is food that would
17 otherwise go to landfill out of the supermarket
18 system -- and it ensures that that food is used well and
19 those organisations can make their money go further.
20 With that, they're more likely to be able to deliver the
21 support they require for the people who use their
22 services.
23 Q. I want to ask you to explain the positive impact on your
24 food distribution service that the furlough scheme had.
25 A. So food was an issue, as we know -- access to food in

1 lots of different ways. We needed to ramp up and we
2 shifted from at that point doing 40 tonnes a month to
3 doing 100 tonnes a month.
4 Q. Well, how were you doing the food? Do you have
5 kitchens? How does that work?
6 A. So -- you're talking about the meals rather than the
7 redistributed food?
8 Q. Yes.
9 A. So we also have kitchens because we try and teach people
10 to cook because, if you can cook and budget, you're more
11 likely to maintain a tenancy. So we had this resource.
12 So we needed to turn that domestic training kitchen into
13 a production kitchen, so we had chefs who were on
14 furlough and they came in in teams along with some of
15 our staff. So we had three chefs go in and we produced
16 somewhere between 80,000 and 100,000 meals over that
17 period of time, using that --
18 Q. What period of time?
19 A. The first lockdown. We then had a whole bunch of other
20 people who were on furlough and volunteered, who
21 distributed that across the city, and we partnered with
22 a number of other organisations for that distribution
23 method as well.
24 Q. You were also talking about, before I rudely interrupted
25 you --

1 A. Possibly --
2 Q. -- about distributing non-cooked food.
3 A. Yes. So we were distributing about 40 tonnes. We
4 ramped it up to 250 tonnes a month during lockdown, the
5 first lockdown, and into the second lockdown, and were
6 able to support about 250 organisations with food that
7 they wouldn't have otherwise been able to access, and
8 actually, because we were purchasing that food, some of
9 that food was able to go free to those organisations, or
10 they were paying the fee but, as I said, it was only
11 a fifth of the cost so their money could go further. So
12 we distributed in that year the equivalent of
13 4.2 million meals worth of food.
14 Q. Right. And at paragraph 20, moving away from food,
15 looking at your wider service, and you talk about your
16 volunteer supporters. Tell us about those.
17 A. So at the heart of what we do, it's built on
18 volunteering. So last year we had about 460 volunteers,
19 gave us about 66,000 hours. That's about 40 staff, but
20 actually that's a huge range. There are people who come
21 and live in our residential communities for about six to
22 nine months from all over the world. So at one end
23 you've got that. We've got people who have gone through
24 tough times in their life and actually the best way of
25 them flourishing, because they're never likely to get

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

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

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

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1 they trusted that that due diligence would work for this
2 new set of circumstances. And they would say, "Go and
3 have the conversation and, if you're happy, then give
4 the money out". They started with smaller sums and then
5 went to larger sums. I have to say that, if we could do
6 more of that now, we would be in a better position in
7 terms of the impact of how we spend money.
8 Q. How did that come to an end after lockdowns? How
9 did they put the brakes on that freedom you had?
10 A. The money that was given to those organisations to
11 distribute went back to the old set of rules of somebody
12 decided what was the right thing to be done and us
13 having to make applications under the old system.
14 I mean, there are grant funders, who have more freedom,
15 who have continued some of this stuff. I mean, the
16 money that I referenced earlier for the green skills
17 stuff was a lot more about a conversation with
18 a grant-giving trust than it was a grant application, so
19 some people have learnt. But in terms of public sector
20 money getting to the third sector, we've gone back to
21 where we were before, which is a shame.
22 Q. You talk about, at paragraph 30, Scottish Frontline
23 Network. Tell us about that briefly.
24 A. So this is funded actually by a London organisation,
25 St Martin's in the Field, and it's one of the ones right

1 across the country. But basically it's to try to
2 provide peer support amongst front-line workers but also
3 learn from front-line workers, who in many ways are the
4 bridge between people with lived experience and the
5 organisations and the systems. So this network will
6 take an issue and folk from all over the country -- this
7 is one thing we did digitally -- kind of tend to have
8 a conversation about that. But it's specifically for
9 people who work in the front line, who work directly
10 with the people we support, so people like me don't get
11 to go. That's a good thing because it gets me out the
12 way. And out of that then things are raised and then
13 fed into the system in terms of trying to change the way
14 the system works.
15 Q. You talk about that being online --
16 A. Yes.
17 Q. -- for understandable reasons.
18 A. Yes.
19 Q. You also talk about your veteran service also being
20 online. Why are those two in particular online?
21 A. I just gave them as two examples, but what they both
22 were examples of -- having started running them, the
23 Frontline Network was in Edinburgh and the veteran
24 support for families was in Edinburgh and the Lothians.
25 But we discovered quickly that we could start providing

1 a much wider reach of service by doing digital stuff,
2 which we had not done before, and, of course, people
3 were up for the digital thing in a way that they weren't
4 because they were forced into it. So quite quickly we
5 were providing counselling support for the veterans'
6 families. The principle of the veterans thing is they
7 go in with huge -- often huge PTSD and all that kind of
8 stuff and the family around them becomes impacted by
9 that negatively and that breaks down. But if you can
10 keep the family as an asset by them understanding what's
11 happening and, through that conflict resolution stuff
12 I was talking about earlier, actually help them through
13 it -- and we discovered we were able to do that online
14 in a way that we probably didn't realise when we first
15 set the service up. So we were literally supporting
16 people in the Islands and things like that that we would
17 never have done previously and we're still doing work in
18 that area as a result of that.
19 Q. All in for Change you refer to at paragraph 31.
20 A. Yes. So All in for Change was set up as part of the
21 Ending Homelessness Together programme, which was signed
22 in 2019, a collaboration of the Government, local
23 authorities and the third sector to end homelessness.
24 This is a group of people with lived experience,
25 front-line workers and academics, and they're a sounding

1 board and an assessment of new policies and of new
2 services and they're a way in which you can really bring
3 those voices into that space and it's funded by the
4 Government. Again, we were doing that in person, but
5 we've started to do it online and were able to involve
6 more people more often as a result.
7 Q. At paragraph 32 you talk about family support and five
8 secure units.
9 A. Yes.
10 Q. Tell me about that.
11 A. So there are some -- randomly five secure units for
12 young people. It's not prison. It's where young
13 people, for their own well-being, need to be in a secure
14 context. The challenges -- what happens to the family
15 relationships when they're in that context -- because
16 often they're in that context -- the family
17 relationships have been damaged on the journey to them
18 being in that context. So we work with the units and
19 with the families to try and keep those relationships
20 strong, so when the young person comes out, they're
21 coming out to a different set of relationships than
22 before, because we know that, if those relationships can
23 be strong, the chances of the young people getting to
24 a better place are far higher. It's that old thing:
25 when can you intervene in a way that's going to change

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

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

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

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

1 themselves. So one of the things we did was just
2 constantly say, "It's okay for you to take a half-hour
3 break". We introduced a second half-hour break in the
4 day. It was almost like you had to officially say to
5 people, "It's okay to go for a walk", you know. So
6 there was a mindset thing in there that we had to do
7 that.
8 We also introduced additional support packages
9 through, you know, online counselling and so on that
10 people could access. We have a tool called "reflective
11 practice", where we encourage people to talk about how
12 they're feeling. There's a permission thing in there as
13 well. Since COVID we've actually significantly
14 increased that as a way of just letting stuff out
15 because they were carrying a lot of trauma.
16 But I think one of the hardest things was,
17 particularly when your way of supporting people is
18 through relationships and its relationships where you're
19 saying to folk, "No, you decide. You've got agency.
20 You can believe in yourself", and then we were saying,
21 "But, by the way, you've got to obey these rules" -- and
22 there was a real conflict there, a tension that they had
23 to manage, that was really, really difficult. And
24 usually they'd be doing that in a staff team, but now we
25 were asking them to do that on their own and that was --

1 that added to the challenge that they were facing.
2 Q. Okay. Paragraph 46, you talk about the difficulties in
3 accessing PPE.
4 A. Yes, that was -- to begin with you just couldn't get
5 hold of it and you had this situation of -- you know,
6 the national message was "This virus can kill you", and
7 we were saying to staff, "But we actually need you to go
8 into a situation and you've got an apron and a mask",
9 and trying to reassure them, so that's a stress level.
10 There was also contradictory messages about who could
11 get it, so if you were Care-Inspectorate-regulated there
12 was a route to get it, although it was quite
13 complicated. But you would also have that
14 situation where a service could be part
15 Care-Inspectorate-regulated and part not, so could you
16 get enough PPE, but it was very difficult, particularly
17 early on, for us to get access, partly because they
18 needed to give it to other people, like the
19 Health Service, and we just felt we were at the back of
20 the queue.
21 Q. You also -- you will have had people at the back of the
22 queue, as you put it, who work in regulated services --
23 A. Yes.
24 Q. -- but you would also have people who weren't working in
25 regulated services but might well have desired PPE.

1 A. Yes, yes.
2 Q. How did you deal with that as a manager?
3 A. So it was really difficult because you were saying to
4 folk, "We think there is a risk because of the virus but
5 there is also a risk of not engaging with these folk and
6 we need to be able to support them". So sometimes it
7 was, "Well, you'll just have to work out how to have the
8 conversation in a safe way because you haven't got the
9 PPE", so you're having quite personal conversations from
10 one end of the garden to the other, you know, and
11 sometimes it was saying, "Well, yeah, you've got a mask
12 and an apron so you can go into the house but only so
13 far". And in some cases, where we eventually did get
14 quite significant PPE, we were also going in and that --
15 and the PPE also was a barrier because it was how can
16 you have a relationship because there's this thing that
17 appears to be a threat in front of you in that space as
18 well.
19 Every service is different, so we had to have
20 different conversations with each service to work out
21 what they felt was safe and what they were willing to
22 do, and sometimes we had to make judgment calls about
23 whether or not we could do something and, if we couldn't
24 do something, we had to say, "Well, we'll have to try
25 and do this digitally. It will be difficult but

1 actually that's actually less of a risk than doing it
2 the other way".
3 Q. You say that during lockdown you continued to innovate,
4 and I'm looking now at paragraph 51, where you talk
5 about your employability programme.
6 A. Yeah.
7 Q. Tell me about that.
8 A. Yes, so, as we know, one of the biggest challenges was
9 people either getting jobs or -- keeping jobs or losing
10 jobs and needing new jobs, so we had an employability
11 programme and we were able to move that online and get
12 it accredited by Skills Development Scotland, which
13 allowed us to access at that point a particular stream
14 of funding. And because we got that accreditation, as
15 I understand it, we were the first organisation to be
16 able to do that and we were actually able to get people
17 back to work and, during the first lockdown, somewhere
18 between 35 and 40 people we got jobs. It also meant
19 that staff in that context could do it from home.
20 Normally that would have been done in rooms with -- in
21 small groups. The big change was we were doing it
22 individually rather than in small groups, which, again,
23 was a challenge because we needed to redesign the
24 courses so they could be done on a one-on-one basis, but
25 oddly enough it allowed some other people who normally

1 couldn't have done the groups to access it because we
2 could deliver it at different times, like twilight and
3 so on, which we hadn't done previously. So there were
4 swings and roundabouts with it.
5 Q. At paragraph 58 you talk about young people and the
6 increase in anxiety and depression.
7 A. Yes. So I think this is probably the biggest problem
8 out of COVID that we are going to face and it's going to
9 be around for a long time. So you first of all had
10 schools having to shift completely what they did and how
11 they did it. You had young people having to engage in
12 education in a completely different way. You had the
13 limits, the digital limits, where they only had
14 a smartphone or they didn't have the wifi or there was
15 only one laptop between three or four siblings or there
16 wasn't a space to do that work, so all those logistical
17 things that were there. So we knew that young people
18 were not engaging. We saw that through our mediation
19 services, where we were getting more referrals, where
20 that lack of engagement was causing stress to the
21 family, so we were trying to help the families work
22 through from that side of things.
23 But what we've seen since is the impact it had on
24 young people and their ability to socialise and be in
25 relationships. So you had the transition, the group

1 that went from primary school to high school and then
2 that mid-teens group as well. We build up confidence to
3 be in relationships through -- about ourselves and our
4 ambition through the relationships we create. If you're
5 in a situation where you don't learn how to make
6 relationships -- that's what a lot of teenage years are
7 about and in particular points of transition -- the
8 impact on your own self-worth will be enormous. If you
9 then, as a consequence, because you're struggling with
10 that, disengage with the place where you might get those
11 relationships and that experience, which is school, it's
12 going to perpetuate that.
13 And we're now seeing, as I indicate here, young
14 people coming to get support from us who haven't been to
15 school for two or three years. One of my staff said to
16 me this week -- he said, "We're getting referrals from
17 schools about young people that the schools literally do
18 not know because they haven't seen them for two years".
19 So they don't know how -- they were 14 when they last
20 saw them and now they're 16. A lot of change happens in
21 a child's life at that space. So they don't know
22 actually if what we're providing is what they need and
23 that means that that is a challenge in itself.
24 I think the tail of COVID, by "tail", what's going
25 to continue, will be around for a long time. Around 40%

1 of those people we support haven't been to school for
2 two or three years. It used to be about 10%. There's
3 numerous studies that have shown that attendance at
4 school is dropping on average. It's now about 90%.
5 When I was, as you indicated earlier, convenor of
6 education, the average attendance was 95%. This was
7 a trend that was happening, but it's getting much, much
8 worse, as well as that lack of socialisation.
9 Q. Okay. At paragraph 62 you talk about the third sector
10 stepping in. Why did you need to step in?
11 A. So the public sector was in a huge number of challenges
12 and part of the problem with the public sector is it
13 needs, generally speaking, to take a one-size-fits-all
14 approach, so it had to say, "Right, everybody has to go
15 home". I mean, that's a broad generalisation, but,
16 generally speaking, that's where it is. So it felt like
17 a lot of the services were being withdrawn, some mental
18 health services, you know, the LEAP service that
19 I referenced earlier, that stopped happening because it
20 couldn't happen online or they didn't know how to make
21 it happen online. A lot of mental health services,
22 a lot of criminal justice services -- community justice
23 services were struggling or weren't available. A lot of
24 services for older people weren't available, as
25 I referenced earlier, the employability services. So we

1 had to say, "How can we continue to support the people
2 we're supporting without the additional support that we
3 used to get from public sector services?". You know,
4 homeless presentations, where you present as homeless,
5 went online and didn't come back to face to face for
6 months and months. So you already have a very difficult
7 set of circumstances which are made more difficult
8 because you need to access them digitally with tools
9 that people are not used to using.
10 So we found ourselves again having to step into
11 spaces where the public sector ... Again, I have a lot
12 of sympathy with where the public sector is at because
13 it's called to account in a radically different way to
14 everybody else and that accountability means that you
15 have to get everything right the first time and you
16 cannot make mistakes and, as a consequence, it becomes
17 frankly more risk-averse than it needs to be and, as
18 a consequence, it makes choices that is about managing
19 that risk rather than thinking about the risk to those
20 that they are there to deliver services for. My words
21 are not to be critical of them, I'm trying to be
22 cognisant of the context in which they're in, but the
23 context created a vacuum that we had to step into.
24 Q. I'm now looking at 81. Yes, you're talking there about
25 putting people into hotels.

1 A. Yes, so this -- one of the things -- COVID was awful, it
2 was absolutely awful, but there were things that came
3 out of COVID that were good and I think the only way
4 we're ever going to process this is by paying attention
5 to both. This is one example of where things were
6 actually -- a good outcome came. So we had to get
7 people who were either on the streets or in congregate
8 temporary accommodation where they couldn't be safe in
9 the way that you could be in your house, where they
10 weren't households or where they were sharing kitchens
11 and sharing bathrooms, all that kind of stuff, we had to
12 get them into safer places. Of course there was no
13 tourists so we had hotels. So a partnership was created
14 between the Scottish Government, the local council and
15 five organisations, including my own, and we got 700
16 people into hotels across the city.
17 Now, what was really interesting about that was
18 that, when we were providing support and asking to talk
19 about what they might do when that time was over, we got
20 a far greater level of engagement. That's because,
21 instead of being in temporary accommodation that wasn't
22 very nice, they were in a place where, at a point of
23 crisis, it was actually quite nice so it felt like they
24 were being looked after. It was en suite, they knew
25 when the food was coming and we, who provide the

1 services, were coming to them rather than them having to
2 go to others. So at the end of this we were able to say
3 to the council, "Actually you'd get a better result by
4 continuing this", so that continues to this day. We no
5 longer have a night shelter in Edinburgh, nor in
6 Glasgow. We now block-book rooms in a hotel and --
7 Q. Can I take you to paragraph 82?
8 A. Yes, so it still exists. The Bethany Christian Trust
9 are the ones who manage it as a collaboration. It's
10 still funded by the council, who still -- despite the
11 restricted financial circumstances that we're in, still
12 realise it's a better way of spending money.
13 Q. It's a better way of spending money because the outcomes
14 are better?
15 A. The outcomes are much better because you're able to pay
16 attention to what people actually need. People don't --
17 it used to be you came out the night shelter -- you
18 couldn't get in until 9 o'clock at night, you came out
19 in the morning, you didn't know where you were going to
20 get your dinner, you had three appointments on three
21 different days -- three different days in three
22 different places with three different groups of people,
23 so you were going to have to retell your story and you
24 weren't sure where you were going to sleep that night.
25 Now they were able to say, "Well, you can stay here for

1 as long as you need, your dinner's coming, and the folk
2 you need to talk to are going to come to you, and then
3 they'll talk to each other and we'll work out a plan for
4 you".
5 Now, there's a huge challenge with the housing
6 Emergency we've got in Edinburgh so people are less able
7 to get into temporary than they used to, but that's
8 a separate thing. The level of engagement is
9 significantly increased because we're paying attention
10 to the person's needs on their terms in a place of
11 dignity. If we do those basic human things, we get good
12 results. In some ways it seems blindingly obvious and
13 it's a pity it took a pandemic to get us there, but we
14 have got there, and this is a good example of something
15 we haven't lost. I'm kind of laying it on thick, but
16 I want us to make sure that we hear that loud and clear,
17 that there are good things that we need to keep here and
18 hang on to because the human outcomes are really
19 positive as a consequence.
20 Q. Does that form part of the Public Health approach to
21 homelessness?
22 A. Absolutely, because if you grab folk at that point and
23 they get into a better place, they are less likely to be
24 traumatised by the experience of homelessness. So one
25 of the other interesting numbers -- and it references

1 the number that I removed previously -- is that in last
2 year, 50% of the people who presented at the Welcome Hub
3 had never used homelessness services before. Now,
4 there's a whole number of drivers for that, economic
5 drivers for that, but if -- often people end up in
6 homelessness for Poverty or trauma, but actually my
7 staff are now saying that they're now dealing with
8 people who are traumatised by the experience of becoming
9 homeless.
10 Now, if we can grab that early, we can get that at
11 a point of intervention where we can lessen the impact
12 of that and people are more likely to recover well from
13 that difficult set of experiences. We need to
14 understand the journey from exclusion to inclusion is
15 always primarily an inner journey. If you get to that
16 point of crisis, you feel hellish about yourself and
17 your recovery starts in there, and us engaging with
18 people in a way that pays attention to that, which the
19 hub does, means it's going to be more effective.
20 Q. The next main section in your statement is about
21 guidance and policy. The guidance and policy evidence
22 that we've heard so far from organisations such as yours
23 might be summarised by saying, "It changed very
24 frequently and it wasn't designed specifically for us".
25 A. I think that would be a very accurate and diplomatic

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

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

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

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

1 largely -- falls into those areas where people are
2 experiencing poverty and other forms of discrimination
3 and exclusion. You just can see from the SIMD data that
4 that's the case. So it gives us the opportunity to
5 engage with whole families in provision of support at
6 a point at which they're looking for help, so it allows
7 us to be in that space and that's why we're part of that
8 network.
9 Q. Tell us about the Randolph Crescent Centre.
10 A. The Randolph Crescent Centre was a really interesting
11 thing in terms of the changes it offered. So the
12 Randolph Crescent Centre was normally used for the
13 LEAP -- part of the LEAP programme I referenced earlier.
14 Because the LEAP programme was shut down, it was empty,
15 and at the time we thought that we need a space for
16 people who have -- who are homeless, who have COVID and
17 need to isolate but don't have accommodation in which
18 they can isolate. So we said we would create something
19 like that and the Government funded that. And that was
20 good. One of those funds I referenced earlier, it
21 was -- we went with a short proposal, they said, "That
22 sounds really good. Crack on with it". So that was an
23 example of what I was talking about previously, and
24 we're talking significant sums of money to put this
25 together because it was a 24-hour programme that needed

1 to be put in place. And we were able to turn it round
2 really quickly and we got the building because it was
3 a council building -- the access quickly.
4 Now, actually there weren't many people who fell
5 into that category of presenting as homeless with
6 symptoms, partly because of the other thing we'd done,
7 which is get people into hotels, because the other
8 really amazing thing about that period of time, the
9 first lockdown, those 700 people who were in hotels,
10 there was not one case of COVID in all that period of
11 time.
12 However, there was a requirement for people who
13 needed to get emergency accommodation because at that
14 point we didn't have the Welcome Hub. So we shifted
15 what was required because we saw that demand -- that
16 need that actually we thought was there isn't there, but
17 there's another need that this could provide, and we
18 said to the funder, the Scottish Government, "We think
19 this -- we could shift", and they said "Yes" really
20 quickly; again an example of paying attention to what's
21 happening, rather than saying, "This is success and, if
22 you don't get that, it's a failure". So between July
23 and September we supported 77 people who otherwise would
24 have been, again, on the streets.
25 Q. I've almost finished, I've just more thing that I want

1 to ask you about, and that's something that you talk
2 about at 156, where you talk about shifting your
3 employability away from adults and into children and
4 then a particular example you provided.
5 A. Yeah. So we were asked by CAMHS, the Children and
6 Adolescent Mental Health Service, to see if we could
7 engage with a group of people who were on their list,
8 and the numbers had increased on their list, and that
9 was the key thing on the data. So that was young people
10 with eating disorders had gone up by 200%. Now, the
11 assumption is -- I'm not an expert in these matters, but
12 the assumption is this is that group of people we were
13 referring to earlier, a high level of anxiety, the one
14 thing they can control is the food they put into
15 themselves, so there appears to be a connection with
16 those things. So we'd been asked to -- we work with
17 that group as part of our Creative Natives programme,
18 which is a programme for people using the creative arts
19 to get them back on to a pathway that will help them get
20 into a space -- a better space and a better set of
21 decisions.
22 It's also an attempt to engage again earlier than
23 a clinical service, which is what CAMHS is, because, you
24 know, it's a four-year waiting list for CAMHS in
25 Edinburgh. There's a whole bunch of people that

1 actually, if we can get engaged with them and find out
2 what they really need, we might be able to sort it
3 before they get to the clinical bit, which in itself is
4 a challenging process. This has proven to be very
5 successful as a result of that and we were able to build
6 on something we were already doing to provide that
7 resource as a --
8 Q. Now, as is traditional, the final part of your report
9 talks about lessons learned and hopes for the Inquiry.
10 I think all of the lessons that you want learned you've
11 already referred to and that also deals with hopes for
12 the Inquiry. I would also say that those sections are
13 particularly closely looked at before any conclusions
14 are drawn.
15 Those are all the questions I have for you. Is
16 there anything important that I've not addressed?
17 A. So I think the one thing that I'd want to say is about
18 how the third sector is treated as a participant in how
19 we make decisions as a society. So we were able to step
20 up at this point and say, "Here's the things that we
21 need to do to get through this", and we've learnt a lot
22 of stuff from that. Then we were asked to -- well, we
23 asked -- they were talking about, "How do we get out of
24 this politically?", and there was the Advisory Group on
25 Economic Recovery and so on, and we were asked to give

1 information and to evidence that. We met with the
2 chair, we put in a submission. That document came out,
3 it was supposed to be the pathway out of COVID for
4 Scotland, and there was not one reference to the third
5 sector in that entire document. Not one reference.
6 Q. Do you need to say any more?
7 A. I don't think I do in many ways. Just there are
8 three -- there's the public sector, there's the business
9 sector and there's the third sector, and I would like
10 our voice to be heard as a result of this, as
11 a consequence.
12 Q. Thank you very much indeed. I don't have anything
13 further for you.
14 A. Thank you.
15 MR CASKIE: Thank you for your help.
16 A. Thanks a lot.
17 THE CHAIR: Yes, thank you, Mr Aitken. Very good. I think
18 we can start at 3.15 with the last witness. Thank you
19 very much.
20 MR CASKIE: Thank you, my Lord.
21 (2.59 pm)
22 (A short break)
23 (3.14 pm)
24 MR GALE: My Lord, the next and final witness today is
25 Jennifer Ewen.

1 MS JENNIFER EWEN (called)
2 THE CHAIR: Good afternoon, Ms Ewen.
3 A. Good afternoon.
4 Questions by MR GALE
5 MR GALE: Ms Ewen -- it's Jennifer Ewen, isn't it?
6 A. Yes.
7 Q. You've provided the Inquiry with a detailed statement.
8 The reference for that is SCI-WT0062-000001. I think
9 you're agreeable that that statement be published and
10 that the evidence you give today will form your evidence
11 to this Inquiry?
12 A. Yes.
13 Q. You're here as the director of adult and community
14 services for Voluntary Services Aberdeen?
15 A. That's right, yes.
16 Q. You tell us at paragraph 27 of your statement that
17 that's a role that you've held for nine years --
18 A. Yes.
19 Q. -- albeit that you've been employed by that organisation
20 for 28 years.
21 A. Yes.
22 Q. I think that organisation is a registered charity.
23 A. Yes.
24 Q. You do tell us a little bit about -- we'll call it "VSA"
25 for shortened purposes -- tell us a bit about its

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

1 A. Yes.
2 Q. Now, your support for children and young people will be
3 considered by my colleagues in the other -- one of the
4 other portfolio teams, but for my purposes and for today
5 I'm going to concentrate on the adult services that you
6 provide.
7 A. Yes.
8 Q. I think at paragraph 15 we can see that, as you've
9 already alluded to, that includes people who have
10 dementia, people who have poor mental health and
11 learning difficulties .
12 A. That's right, yes.
13 Q. I think you also provide support for those with
14 addiction problems.
15 A. Yes, people that are in recovery from addiction, yes.
16 Q. Do those addiction problems cover both alcohol and drug
17 use?
18 A. Yes.
19 Q. I think geographically you are centred in the city of
20 Aberdeen.
21 A. We're centred in the city. We recently were awarded the
22 contract for carer services in Aberdeenshire.
23 Q. What has that -- has that involved in a widening of your
24 services geographically or has it involved greater
25 pressure on the services that you already offer?

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

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

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

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

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

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

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

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

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1 every week and test visitors before each visit, we
2 did it in that centre, which took, as I said previously,
3 all the pressure off the managers and team leaders from
4 having to -- they were busy enough, you know, trying to
5 stick to all the guidance and support people as best
6 they can without testing staff every week and testing
7 visitors every time they came in. So we seconded two
8 staff full-time to do all the testing for the whole
9 agency and for visitors.
10 Q. I probably should have asked you this. How many staff
11 do you employ?
12 A. It's over 500.
13 Q. Right.
14 A. Yeah.
15 Q. And I think what you've indicated is that staff required
16 to be tested three times a week with a lateral flow
17 test.
18 A. There was -- yeah, twice a week with the lateral flow
19 and then once a week for the PCR, depending on which
20 place they worked in. It was different for each case.
21 Q. I wonder, when did you institute that? Can you remember
22 approximately?
23 A. It was quite early on because we just thought this was
24 a lot of added stress for managers and team leaders on
25 each site, so we thought, "We've got this hall that

1 we're not using, not able to use, so let's use it for
2 this purpose". So quite early on, yeah.
3 Q. As you indicated, you had a dedicated team --
4 A. Yeah.
5 Q. -- who were carrying out the testing?
6 A. So two carrying out the testing. We also had an admin
7 worker who would liaise with the visitors and book in
8 all the visits as well because they had to be timed so
9 you didn't have lots of visitors turning up to one
10 service at any one time.
11 Q. Can I just ask you a little bit about what the
12 arrangements were for visitors? Can you indicate what
13 category of visitors you were testing and why you were
14 testing them -- it may be obvious -- and how frequently
15 that was done?
16 A. Yeah, so it was predominantly for our older adult
17 services, so two care homes and two very sheltered
18 housing. They tend to get the most visitors anyway. So
19 the visitors would book a test with us at the testing
20 centre, get tested and then they would head to whichever
21 service they were visiting and the admin person would
22 book that visit into each service, let the service know
23 the person had tested negative -- hopefully -- and then
24 they would go and do their visit with their loved one.
25 Q. You've mentioned that there was at least one person

1 associated with or in charge of the admin work that
2 was --
3 A. Hmm-hmm.
4 Q. Was that quite a considerable amount of work that was
5 required? Perhaps you could just explain to us what
6 that person would be doing.
7 A. Yes. So they booked in all the testing, they organised
8 the visits, liaised with the services themselves as to
9 visits, but also we had to record all the results of the
10 testing as well, and for the PCR testing, all the
11 specimens had to be gathered and then taken to the
12 doctor's surgery at the end of each day as well for
13 processing, for the PCR tests.
14 Q. It's again probably an obvious question, but if a member
15 of staff failed one of these tests, what was the
16 consequence of that?
17 A. Well, they just had to go right home because they
18 couldn't obviously work in the service if they were
19 positive.
20 Q. And that would put a burden on your staffing level and
21 presumably on your need to access alternative staff?
22 A. Yes, so that's why our line(?) kind of block-booked the
23 agency staff, so we were always kind of over the safe
24 staffing level, so if anybody did test positive, we'd
25 have a bit of contingency there with our staffing.

1 Q. One might think, from what you've said first of all
2 about the amount of PPE that you had in stock and also
3 the block-booking of agency staff, that you were in
4 perhaps an advantageous position in the amount of
5 preparation you had in place for the pandemic.
6 A. Yes.
7 Q. Would that be correct?
8 A. Yes.
9 Q. Can I ask why you were in that beneficial situation?
10 A. I think VSA have got a really robust business continuity
11 plan which we've always had, even pre-pandemic, so that
12 deals with critical incidents to minor incidents.
13 Anything that will affect service delivery is in this
14 plan and it's constantly reviewed. So we're always
15 looking at the horizon to say, "Right, what could affect
16 the business?", and I think we're pretty well prepared
17 for any eventuality.
18 Q. Was one of those eventualities the possibility of
19 a pandemic?
20 A. Yes.
21 Q. Right. Now, just on the question of PPE, you've told us
22 that you had a three-month supply of PPE for the
23 12 services that you provided, and I think inherent in
24 that is that, because you provide a variety of services,
25 then you needed a variety of PPE.

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

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

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

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

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

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

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

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

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

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

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

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

1 from Government to care home managers, but our local
2 Public Health nursing team set up weekly Teams meetings
3 with providers across Aberdeen City and all care home
4 managers were invited to that. So we would get
5 information direct from Public Health and their
6 interpretation of the guidance.
7 Q. Is this what you refer to at -- I think it's at
8 paragraph 167 where you're talking about the Health and
9 Social Care Partnership.
10 A. No, that's --
11 Q. That's something different?
12 A. Yeah.
13 Q. Okay, we'll come to that in a little then. One of the
14 points you make subsequently in your statement in
15 relation to the lessons to be learned is that you
16 personally and your organisation were not, as it were,
17 consulted on the guidance.
18 A. No.
19 Q. Do you feel you should have been?
20 A. I think from the point of view that VSA does deliver
21 lots of different types of services, yeah, and obviously
22 each provider has got their own area of expertise,
23 whether that be addictions, learning disabilities,
24 Cyrenians for homeless and things, so, yeah, I think the
25 Government could have benefitted from partnership

1 working in relation to guidance, yeah.
2 Q. Do you know if any sort of partnership working was done
3 with Government at that time?
4 A. I think for CCPS, yes, so people speaking on behalf of
5 the third sector, yes.
6 Q. Just going back to the guidance, providing guidance to
7 your staff, how did you actually do that? How
8 frequently were you having to give guidance to your
9 staff, particularly if guidance was changing?
10 A. Sometimes it could be several times a week. You know,
11 it was changing so rapidly at times. So I would convey
12 it to my managers and they would take that to their
13 teams and then, obviously, we've got a marketing
14 department as well, so they were tasked with putting out
15 communications to families as well because they
16 obviously needed to be updated every time the guidance
17 changed as well.
18 Q. Also communicating with families --
19 A. Hmm-hmm.
20 Q. -- I think at paragraph 138 you talk about that and you
21 say it was appreciated --
22 A. Yeah.
23 Q. -- if you were providing your interpretation of the
24 guidance to families. Would that be even if it was
25 restrictive of their entitlement to visit their

1 relatives?
2 A. I think so. I think they appreciated that we were
3 keeping in touch with them, so whether that -- every
4 time guidance changed, we would write out to family
5 members and, as I refer to in this statement, we also
6 had Zoom calls with family members as well, and we
7 adapted that to be mornings, afternoons and late at
8 night, so people could attend that were still working
9 during that time. But I think, you know, like I said
10 earlier, they might have interpreted guidance
11 differently from us, so just that explanation of, "This
12 is what it means for us as a provider", kind of gave
13 them a bit of reassurance that it wasn't just VSA
14 saying, "No, you can't visit". It was, "This is why".
15 Q. I think at paragraph 161 you say that there could be
16 difficult conversations with family members.
17 A. Yeah, I think in particular people who were on
18 palliative care and end-of-life care -- having to say to
19 those people, "You can't come in and spend that last
20 time with your loved one", was really difficult, yeah.
21 Q. I think that's something you give a fairly forthright
22 opinion on at the end of your statement, and we'll come
23 to that --
24 A. Yeah.
25 Q. -- in a moment. Now, one of the things you did manage

1 to do throughout the pandemic is that you were able to
2 keep your services running.
3 A. Yes.
4 Q. Was that -- one of the things I've obviously noticed in
5 what you've said is that, because of the services and
6 the range of services you offer, you were effectively
7 always full.
8 A. Yes.
9 Q. And how much of a demand was it on you, both personally
10 and on your organisation, to keep services going
11 throughout the pandemic?
12 A. I think -- I mean, there's always been a high demand for
13 our services anyway. That didn't really change pre or
14 post pandemic and we always operate pretty much at full
15 capacity. The staff -- I think because we were so well
16 prepared with staffing and PPE, we managed to deliver
17 our services to the same high quality as we always have
18 done.
19 Q. Now, you tell us a little bit at paragraphs 153 and
20 following about what you've termed as "Disaster Planning
21 Strategies".
22 A. Yes.
23 Q. You've touched on this a little bit and you've said:
24 "... VSA have always had a robust
25 disaster management plan in place, for pandemics or

1 major fires ... "
2 Now, I've also noted in your statement that you go
3 back to your work in a psychiatric hospital --
4 A. Yeah.
5 Q. -- presumably in Aberdeen at the time of the Piper Alpha
6 disaster.
7 A. Yes.
8 Q. Can you just tell us, in relation to pandemic
9 preparations, what did you particularly have in mind?
10 A. I think -- I mean, we had pandemic as part of our
11 disaster planning, but I suppose in our minds we were
12 referring to a major outbreak of norovirus or -- the
13 things that hit care homes quite regularly. Nobody
14 could have predicted a pandemic, I suppose.
15 But it's just making sure that we've got plans in
16 place for any eventuality and, in the past, we have had
17 fires. We do support people with mental health issues
18 that smoke indoors when they're not supposed to or light
19 candles. We've had floods. We have really robust
20 sprinkler systems and things in place for our care homes
21 in case of fire, but we had an incident where somebody
22 threw a bunch of keys and it knocked the sprinkler and
23 flooded the whole building. But we're always kind of
24 prepared for, I would say, pretty much every eventuality
25 and we do hold regular table-top exercises of that

1 disaster plan and regularly train staff so that
2 everybody knows. And we've got flow charts in every
3 service, so if something happens, this is the process.
4 Q. Since the pandemic, have you updated your strategies to
5 take account of what has happened in the pandemic?
6 A. Yeah, it's a document that -- I suppose it's a live
7 document, so it's always under review, yes.
8 Q. And I think I've asked you if you would be good enough
9 to share that with the Inquiry and you've indicated that
10 you will.
11 A. Absolutely, yes.
12 Q. Just a couple of other matters and something that
13 I referred to I think erroneously earlier. You talk
14 about guidance and policy notification, paragraphs 167
15 and following, and you say that the Health and Social
16 Care Partnership set up a group called
17 "Provider Escalations".
18 A. Yes.
19 Q. Can you tell us a little bit about that and in
20 particular whether it was geographically confined to
21 Aberdeen?
22 A. So, yeah, this was an Aberdeen City group and they do
23 actually still meet. So they meet over Teams and it's
24 a group of senior staff or managers, and it's not
25 just -- there's a residential Provider Escalations group

1 and a non-residential for supported living groups, and
2 during the pandemic personally I thought it was a really
3 good peer support group for other people that were going
4 through the same thing and, you know, we would speak
5 about guidance, we would speak about any difficulties we
6 were having, and it was really a very supportive
7 environment for other care home managers.
8 Q. Do you know if such groups were rolled out beyond
9 Aberdeen?
10 A. I think there was some in the central belt as well,
11 yeah. I don't know if they're still going, but I know
12 there certainly are in Aberdeen. It's something that
13 has continued post pandemic.
14 Q. Again, something I've touched on already. You do
15 observe that you were never approached for your input.
16 A. No.
17 Q. And probably a difficult question to ask you and
18 I probably have to ask you it from two different
19 perspectives: if you'd been asked at the time of the
20 pandemic, what particular advice or input would you have
21 wanted to give? And then, secondly, now with the
22 benefit of hindsight, what would you have wanted to
23 give?
24 A. I think -- it's probably towards the end of my
25 statement -- I think -- you know, I was asked during my

1 interview on reflection what I would change, and I think
2 one that I alluded to earlier was businesses profiting
3 from PPE and hand gels and sanitisers and things like
4 that. For me, the visiting -- I mean, it was really
5 heartbreaking, people not getting to visit loved ones.
6 In particular, some people weren't there for their
7 family's end-of-life care and they'll never get that
8 time back, you know.
9 Q. No. Paragraph 176 of your statement, you observe that
10 there were significant gaps in the guidance -- again
11 you've probably mentioned this -- because it was
12 predominantly written for older people's homes.
13 A. Yeah.
14 Q. What particular areas of guidance would you have liked
15 to see in relation to residential accommodation for
16 younger people?
17 A. I think for younger adults -- you know, there wasn't
18 really any sets of guidance for children in particular
19 and for -- although we were operating as a care home for
20 that younger client group, it was all about infection
21 protection and control, you know, the visiting -- no
22 visitors allowed and things, and that doesn't fit for
23 every service. So, you know, I think there should have
24 been -- we've got care standards for every different
25 type of service, so really there should have been

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

1 approach.
2 A. Absolutely, yes.
3 Q. Ms Ewen, that's all I want to ask you specifically from
4 your statement. We have a tradition of asking anyone
5 who gives evidence if there's anything further that you
6 would like to say having regard to what we've discussed
7 so far and also having regard to your experience in your
8 particular role during the pandemic. If there's
9 anything you'd like to say further, can you indicate
10 that at this stage?
11 A. I don't think so. I just want to thank you for the
12 opportunity -- for giving VSA the opportunity to take
13 part in this Inquiry, so thank you.
14 MR GALE: Well, we're very grateful to you, Ms Ewen, and
15 thank you very much indeed.
16 THE CHAIR: Yes, thank you, Ms Ewen. I'm grateful.
17 A. Thank you.
18 THE CHAIR: That finishes today's proceedings.
19 9.45 tomorrow morning.
20 MR GALE: Thank you, my Lord.
21 (4.10 pm)
22 (The hearing adjourned until
23 Wednesday, 17 April 2024 at 9.45 am)
24
25

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