OFFICIAL REPORT
AITHISG OIFIGEIL

Equalities and Human Rights Committee

Thursday 18 June 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 18 June 2020

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EQUALITIES AND HUMAN RIGHTS COMMITTEE

11th Meeting 2020, Session 5

CONVENER

*Ruth Maguire (Cunninghame South) (SNP)

DEPUTY CONVENER

*Alex Cole-Hamilton (Edinburgh Western) (LD)

COMMITTEE MEMBERS

*Angela Constance (Almond Valley) (SNP)
*Mary Fee (West Scotland) (Lab)
*Maurice Golden (West Scotland) (Con)
*Alison Harris (Central Scotland) (Con)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Claire Cairns (Coalition of Carers in Scotland)
Heather Fisken (Inclusion Scotland)
Kim Hartley Kean (Royal College of Speech and Language Therapists)
Kathryn Lindsay (Social Work Scotland)
Carolyn Lochhead (Scottish Association for Mental Health)

CLERK TO THE COMMITTEE

Claire Menzies

LOCATION

Virtual Meeting

Scottish Parliament

Equalities and Human Rights Committee

Thursday 18 June 2020

[The Convener opened the meeting at 09:00]

Covid-19: Impact on Equalities and Human Rights

The Convener (Ruth Maguire): Good morning and welcome to the 11th meeting in 2020 of the Equalities and Human Rights Committee. I thank all members and witnesses for their attendance in these very unusual circumstances. We are grateful to the broadcasting office for all its work in setting up this remote meeting of the committee.

We live in challenging times, and the committee pays tribute to all the organisations in the equalities and human rights sector for their continued dedicated service and hard work at this time. Parliamentary scrutiny continues, and we are grateful to the witnesses and others for finding the time to answer questions from the committee, and to them and other bodies for responding so quickly to our call for views. The responses are on our website.

Our main item of business this morning is our third evidence session on how Covid-19 has impacted on equalities and human rights. We have two panels. I welcome our first witnesses: Claire Cairns, who is the network co-ordinator for the Coalition of Carers in Scotland; Heather Fisken, who is the head of the policy and research team at Inclusion Scotland; and Kim Hartley Kean, who is the head of the Royal College of Speech and Language Therapists' Scotland office.

I refer members to paper 1, which is a private paper by the Scottish Parliament information centre. We will take questions in a pre-arranged order. After inviting a member to ask questions, I will invite the witnesses to respond, also in a pre-arranged order. If you have nothing to add, please do not feel the need to speak and simply say so. I will go back to that member for any follow-up questions. Once a member has completed their questions, we will move on to the next questioner. We will proceed in that way until the evidence session is concluded.

I expect our session with the first panel to last for no more than one hour. We will get the most out of the hour if we keep our questions and answers succinct. Please allow the broadcasting staff a few seconds to operate your microphone before beginning to ask a question or to provide an answer.

I will ask the first question, which is about communication. In respect of people who may have communication needs and require social care support, how do we make sure that our legislative provision on inclusive communication has a positive impact on the lives of people who need it now? I invite Claire Cairns to start.

Claire Cairns (Coalition of Carers in Scotland): We do not have a lot of data on carers with communication needs. Carers who have no online access have difficulties in finding out accurate information. That is particularly true of older people. At the moment, most information is available through social media and online.

As far as other communication needs are concerned, we do not have any information, so I will pass over to Heather Fisken, who will have more information.

The Convener: Thank you. We will go to Heather Fisken.

Heather Fisken (Inclusion Scotland): Thank you. This issue is extremely important for many disabled people who have communication needs.

The first thing to say is that communication is not just about giving people information; it is a two-way process. It is all very well having information and guidance in accessible formats, but we must make sure that the response to that is also accessible and that people can make contact. There is an SMS service for people who have received the shielding letter, so that they can make contact and ask for support. That is useful for some people but not for others. It must be recognised that there are many specific needs with regard to accessible information. The provision has to be based on what works for that person.

Another thing to flag up is the fact that some of the guidance communication that has come out has come out only in written English format. We have had to go to the Scottish Government to say that it must come out in easy-read format at the same time.

There is also a big issue around access to technology and information technology, which ties in with poverty and people not being able to afford it. Some poorer rural areas do not have the right kind of network service. All those things must be taken into account. Legislation is a good starting point, but there is a lot to learn and there is a lot of practice. Disabled people know best what happens and what works; one size does not fit all.

The Convener: Thank you. That was helpful.

Kim Hartley Kean (Royal College of Speech and Language Therapists): Good morning, and thank you for giving me this opportunity.

With regard to whom communication inclusion is important to, people who live with communication disadvantage or communication needs are widespread and are disproportionately impacted by the current crisis. As has been said, there is a strong association with socioeconomic disadvantage, which might be linked to literacy difficulties and challenges that people experience, regardless of whether they have an identified communication support need. However, we do not have official statistics on the total number of people who experience communication needs on a day-to-day basis. That is a big gap, and I will come back to that in a moment.

As other witnesses have reported, the issue affects everyone who has an autistic spectrum disorder or dementia, people who experience mental illness, people with learning difficulties, 30 per cent of people who have had a stroke and people who have visual impairments; deafscotland has also given good evidence about the 1 million deaf and hard-of-hearing people of all ages. We are talking about a lot of people. The situation has brought a lot of stress, and none of us, when we are frightened or in crisis, are able to take on board complicated information. It has to be clear, we have to be carefully listened to and all our communication behaviours have to be attended to.

In answer to Ruth Maguire’s question about what we should do about meeting those needs, it is not that nothing is being done; good things have happened. However, as previous witnesses have said, it is not all good. There has been a lack of consistency. We want inclusive communication to be seen as a public health priority. Fundamental to any public health effort is the fact that people need to understand the issues and what to do to protect themselves, their families and their communities. As Heather Fisken said, they have to be able to ask questions and to communicate back to services. It feels as though we are not making that big connection between how clear, accessible and inclusive the communication is and the outcomes for public health. The data tells us that there is an association between people who are more likely to contract Covid and groups with communication disadvantage, such as people who live in poverty, older people and people with disabilities.

First, it is fundamental that the Government should take inclusive communication more seriously as part of the public health effort. Having done that positively, in the short term, it would be helpful if the Government set out a requirement for all publicly funded agencies to implement current law and policy relating to inclusive communication. Excellent resources are already available on the inclusive communication hub, and we have a workforce of speech and language therapists, who are experts in inclusive communication. Third sector organisations, such as the Stroke Association and Ideas for Ears, provide lots of information on how things can be done better.

As deafscotland said in its submission—the committee also raised this with the Scottish Government in its correspondence of 4 June—going forward, Scotland needs to take a more co-produced, strategic approach to creating an inclusive communication nation. That is not necessarily a consensus view across the sector, but the Royal College of Speech and Language Therapists, Inclusion Scotland and Camphill Scotland certainly want to introduce inclusive communication law in Scotland, and others want a sustained strategic approach.

Those are the things that it would be good to do. I am sorry that that answer was not short.

The Convener: That was very helpful. Thank you.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, everybody, and thank you for joining us today, albeit virtually. I have a couple of questions about equality impact assessments and shielding, but something has occurred to me about testing that we did not discuss in the pre-meeting briefing, which I would also like to come in on.

We have passed a lot of law in the foothills of the emergency, and a lot of it is quite draconian, although I think that everybody recognises the need for it. However, when we do that, especially at such pace, it is sometimes easy to miss things such as equality impact assessments. A lot of the policies that we have enacted will particularly affect people with disabilities or other socially isolating protected characteristics. Have we done due diligence on equality impact assessments? Are there big omissions in that regard, particularly in relation to the two coronavirus acts that we have passed?

Claire Cairns: Carers have been particularly impacted. Obviously, many carers are looking after shielded people—[*Inaudible*.]—has been done around the impacts that that has had on carers. The national care organisations have been looking at various ways in which carers have been impacted on. Carers UK has done a couple of excellent surveys, including a survey of more than 1,000 carers in Scotland, and we are in contact with carers centres and carers directly through social media.

On the current impacts on carers, carers certainly have additional caring responsibilities in this period because so many services have been halted. In addition, quite a lot of care workers are self-isolating or shielding, which means that they are not able to get the support that they need. That has quite an impact on many areas of carers' lives. On the impact on carers' health and wellbeing in particular, the Carers UK survey found that more than half of carers felt that they were at breaking point.

We really need to look at the current impact and the long-term impact on carers' health. As everybody starts to move slightly out of the lockdown and restrictions are eased, it is very important to consider people who will not have the same freedoms that other people currently have and will have in the future, and ensure that, as soon as possible, carers' rights are brought back and services are brought back safely so that carers and disabled people can be supported.

The Convener: Heather Fisken can come in on Alex Cole-Hamilton's question about equality impact assessments.

Heather Fisken: That is a really interesting question. Equality impact assessments are very important things that we should do, especially at a time such as this. However, it has been recognised that things are coming at such a rate of knots that it is really hard to catch up and keep up with them.

Inclusion Scotland has been very grateful for the opportunity to comment on several pieces of guidance in relation to equality impact assessments, for example, but we are asked to do that at very short notice and, as members can imagine, we have a huge amount of work at the moment. We do that, but in an ideal world, we would go out and talk to our members and do quite a lot of work on that. That is simply not possible at this time. We recognise that that is because people are crying out for the guidance that they need, especially for shielding. That goes not just for people who have the shielding letter but for people who are shielding themselves based on their own expertise of their own lives and conditions, and their personal circumstances.

It is worth saying that equality impact assessments are part of the public sector equality duty. The review of that has been delayed, and we hope that that will be picked up as soon as possible. At this time, it is very hard to give the issue due diligence in the way that we would want to, but that process must continue. Disabled people's organisations have a wealth of knowledge and lived experience of disabled people that we can share. In a better world, and in better times, we would be going out and talking to people, but we cannot do that just now.

09:15

Kim Hartley Kean: We have not, and I am not aware of other organisations—[*Inaudible*.]—asked to comment on equality impact assessments, so I cannot answer the question about due diligence. It has been exposed that there is no strategic and consistent approach to communication inclusion; there is no regulated or co-produced quality standard. If we had that, equality impact assessments in relation to people who experience communication disadvantage would already be covered centrally, rather than through the repeating of messages.

I do not know how diligent the process has been, Alex—Mr Cole-Hamilton—but I think that there is a gap relating to people with communication needs.

Alex Cole-Hamilton: I am always happy to be referred to as Alex, so that is fine. I will ask my question about testing, and maybe the convener can bring me in again on shielding, if there is time.

I want to ask about testing because, of all the policy shifts, the testing landscape has been the most volatile. It is very easy for us as members to ask for and then receive commitments to, for example, testing throughout care homes or across all residential care units. However, we often forget that that might mean testing extremely vulnerable people, many of whom have cognitive impairments—that might include people with dementia in care homes or those with profound learning disabilities in adult residential homes—and we do not stop to think about what that means in terms of the physicality of the process. I have had two coronavirus tests, and they are brutal and traumatic.

Have you picked up any feedback from any of your members or any group that represents people with cognitive impairment, on whom the testing process will have a real impact? What can we do to lessen the trauma of the testing regimes for those groups?

Claire Cairns: That has become an issue for carers more recently, because as part of the easing of lockdown, day care and respite services are preparing to open again, and a lot of carers have been asking about testing in that context. We have heard anecdotal evidence that, when people have gone for drive-in tests, not enough guidance has been provided on how to apply the test to themselves—people found that quite difficult—so that could certainly be looked at.

Most of our evidence comes from carers, who are now able to get tested. Unfortunately, we do not have as much evidence on the testing of people with cognitive difficulties, because most of our work is with carers.

Heather Fisken: There are two elements to my answer. First, the question about the trauma of testing, which I recognise, is very difficult to answer, as it is not an issue that I have any evidence on. However, people must be supported and they also need to have the choice, as far as possible.

Secondly, a great many people are not able to access those tests. We have an example from someone we know who supports a young lady in Dumfries and Galloway. She does not have a shielding letter from the chief medical officer, but it is well recognised by everyone who knows her that, if she contracts Covid-19, she will not survive. However, she cannot get her personal assistants tested, as the Scottish Government’s guidance indicates that PAs can be tested only if they have symptoms.

Basically, she is playing Russian roulette with her life every time PAs come in, because she cannot get them tested until they are showing symptoms, and we know that not everybody shows symptoms. We also know that care workers are contracting Covid-19. Very sadly, they are one of the professions with the highest fatality rates in Scotland. I think that the figure was 13.6 per 100,000 of the population, which came from National Records of Scotland.

I have gone slightly off track, but it is important to raise the fact that people cannot get tested. That is as big an issue as the trauma of being tested.

The Convener: Thank you. Does Kim Hartley Kean want to comment on that issue?

Kim Hartley Kean: I have nothing to add.

Angela Constance (Almond Valley) (SNP): Good morning. I have some questions about social care. The committee has received evidence that some health and social care partnerships have raised the bar on eligibility and that some packages have therefore been reduced or stopped. Is that a widespread practice in your experience, or is it specific to some localities? How is the assessment process working? Is the voice of the service user being heard? What is the impact on carers? What would help? What further action do you need from the Scottish Government and from health and social care partnerships now?

Claire Cairns: The criteria for eligibility were increasing pre-Covid-19. In addition, quite a few health and social care partnerships started looking at and reducing the packages when the changes to legislation came out. Obviously, some of that related to services having to cease or to deploy staff elsewhere, but it has caused people a lot of anxiety—it still does, in that they wonder whether their packages will be reinstated after Covid. Some people are hearing anecdotal evidence from partnerships that their full package may not be reinstated, while other partnerships are reassuring people that their packages will be reinstated. I know that the Scottish Government is looking at that, and it needs to continue to do so.

A lot of people with packages are receiving no services during Covid-19, due to a combination of factors. As I said, most building-based provision was shut down, although a few local authorities have carried on throughout. They introduced measures early on, which was helpful.

Other people who were using direct payments to employ PAs and whose PAs had to shield and could not continue to work have lost those services. Some carers and disabled people have chosen not to use any services because they are afraid of the additional risk. That has meant that many carers are caring for people full time—24 hours a day, with no breaks and in intense circumstances—which is having an impact on their health and wellbeing. They feel that they are at breaking point.

With services potentially starting to open again, people will have to make difficult decisions about whether to use them. Providers are looking at things such as all-risk assessments, but it is crucial that carers feel that it is safe to use services again.

Other things can help during this period. In particular, guidance was introduced by the Government in mid-May on how people with direct payments should be able to use them more flexibly, which is really important.

We started some research into that issue recently and we have had approximately 100 responses from carers. The survey is still open, but we have found that 60 per cent of respondents did not know that they should be able to use self-directed support more flexibly at this time to purchase items or equipment, or to employ a relative. We asked people who knew about the flexibility where they had found that information, and only 9 per cent had been told by their local authority that they could use their direct payment in a different way. That needs to be looked at.

There are other ways that people can be supported that are not traditional services. For example, we know that some of the grants that are available to carers have been very well used during this time to enable people to purchase different forms of support.

That was quite a long answer. Overall, I think that more needs to be done now. We also need to look at what happens after lockdown.

The Convener: Thank you. That is helpful.

Heather Fisken: I will try to build on what Claire Cairns said rather than simply repeat it. The issue of social care provision being stopped or reduced is really important. How widespread is it? We do not know. That is one of the things on which people have to gather information.

What we do have is anecdotal evidence. We did a survey, to which more than 800 people responded. Of those who responded to the question about social care, almost half—45 per cent—said that their social care support had been stopped or reduced. That sometimes happened suddenly—overnight—with no notice whatsoever, no advice about what to do in the interim period and so on.

As you can imagine, the impact of that on disabled people and their households has been absolutely profound. We found that, quite often, elderly parents have had to start caring although they themselves have disabilities. People do not know what to do or where to turn. They are still being charged, or their contributions are being estimated, for their social care, and they are struggling to access food, medicine and so on.

The survey was carried out in April, since when some things have moved on and improved, but the isolation and the not knowing were issues at the time. We know that people were being left basically living in their beds, without any hope of getting out of bed and with a disabled future. As you can imagine, that is a horrible situation for people to be in.

That fear and isolation are leading to a mental health crisis. Many people who responded to our survey reported that they really were at the end of their tether. Fifteen of those who responded actually opened up and told us that they were suicidal at the time of completing the survey. The survey was anonymous; we put out information to tell people where to go, but, unfortunately, we could not contact them directly.

In response to that, social care has to be reinstated by any means possible. We need to collect information about how widespread the situation is in order to plan for that, but we also need to look to the future and consider what we are going to do next. I do not think that this will be the last time that we are hit with this level of emergency. We know that the climate emergency is climbing up the agenda, and we are potentially getting closer to the point at which we will have more things like the current crisis happening.

We would also ask that charges are dropped immediately so that people can use that money to pay for other services to help them make up the shortfall in their social care.

The Convener: Have those answers covered what you were asking about, Angela? Do you have any follow-up questions?

Angela Constance: I have no further questions—that has covered everything. There were some really good pointers in there about social care charging in particular; I am sure that we will come back to that issue.

The Convener: I will bring in Maurice Golden now. Forgive me—I have just realised that I have not given Kim Hartley Kean a chance to respond to Angela Constance’s questions. Apologies, Kim—we can come to you now.

Kim Hartley Kean: Thank you, convener. I have some key points to make about social care. Social care is a multidisciplinary effort: it is about health and social care. We definitely have statistics on what has happened with the provision of speech and language therapy. We work with not only people who have communication disabilities, but people who have difficulties with eating, drinking and swallowing—the capacity to take in food and get nutrition.

In a survey that was representative of speech therapists in Scotland, which was carried out in the final week of April, 92.8 per cent of therapists said that Covid had impacted on their services and 74.6 per cent—so, 75 per cent—said that some individuals in their case load were not receiving interventions.

I will outline some of the reasons for that situation, to back up some of the comments from the other witnesses. It was a result of several things: changes to services because of national guidance; the closure of therapists’ usual place of work; and the fact that patients and clients did not want us to continue to intervene at the time or did not have access to telehealth and facilities such as the national health service’s near me service.

There were also risks associated with aerosol-generating procedures. Given that therapists’ procedures are not on the list of those that require top-level personal protective equipment, therapists were doing risk assessments and deciding that it would not be appropriate for them to go in.

09:30

On whether the practice that Angela Constance mentioned is widespread, it certainly is certainly widespread in the section of the multidisciplinary team that I know about.

Angela Constance also asked what would help. We need to remember that health and care services are multidisciplinary services. As well as our doctor and nurse colleagues, allied health professionals and speech and language therapists have to be involved in the return to care and in opening up services. At the moment, there is not that engagement with the people who provide broader services. We also need to work much harder at ensuring that digital inclusion works and is much more widespread.

The primary call is that the discussion should not be limited. We need to think about the whole healthcare package that people need and ensure that services are accessible, because they are essential, not luxuries.

The Convener: On that note, can you give a bit more information about the impact on an individual of not having their speech and language therapy? You spoke about the importance of therapy in relation to food and drink for some patients. Will you expand on that?

Kim Hartley Kean: The incidence of eating, drinking and swallowing needs in care homes is enormous. Everybody who experiences dementia will have eating, drinking and swallowing needs, and such issues are common for the frail elderly.

Following an individual's assessment, care workers get guidance and support from speech and language therapists on how they can minimise choking and coughing when people are eating and drinking at meal times, and on what to do in order to maintain nutrition. If people do not have access to that support, you can imagine the obvious issues that arise in relation to individuals maintaining their health and the distress that occurs around meal times.

In a crisis situation, eating, drinking and swallowing are obviously vital. Expressions of distress are communications, and distress can be reduced by enabling people to understand what is going on and to express themselves in ways that are less challenging for services. Communication between the individual and those around them is crucial to providing safe, quality care.

The Convener: That is very helpful.

Maurice Golden (West Scotland) (Con): What are the witnesses' views on the different impacts on men and women, on those in different age groups, on the lesbian, gay, bisexual and transgender community and on people from ethnic minorities?

Claire Cairns: There are certainly impacts on particular groups in the caring population. We know that women are more likely to have caring roles than men—the split is about 60:40. In relation to the impacts on carers during this time, we know that carers are caring for additional hours and that, quite often, they are trying to combine caring responsibilities with employment. That is another impact on women in terms of the economic viability of doing that, which is quite difficult.

A lot of carers are older, and there are even more impacts on their health and wellbeing as a result of their not receiving the support that they used to receive. Quite a lot of older carers care for a spouse or for an adult with a learning disability. Previously, those people might have gone to day care or attended a disability resource centre, but those services are not available at the moment, so carers are caring for them around the clock.

At the carers cross-party working group last week, we heard evidence from one of the organisations that support older people on the particular impacts on carers who are in that age group. Exhaustion and isolation are the two things that they are particularly suffering from at the moment. Again, it is crucial that services such as day care open up as soon as possible.

Another area I want to touch on is carers from black and minority ethnic communities. We think that they are undersupported. That is the evidence that we are getting, particularly in relation to communication. At the moment, an avalanche of communication is coming out and the national care organisations are trying to make sure that, for example, local carer centres have the essential information that carers need.

We and the Minority Ethnic Carers of People Project run a BME carers forum for organisations that support BME carers. The picture across Scotland is inconsistent. There are few specialist workers in the area; it is not often funded, so we know that there are huge gaps. Although there is some national generic information for people from BME communities, we do not know whether there is anything specific for carers from BME communities. We feel that that is a gap.

There is another measure that we think should be taken. As far as we know, the newly established expert group that is looking at BME communities does not have a carers representative, so that is another gap that should be filled.

Those are the particular impacts on carers from different communities.

Heather Fisken: I agree with Claire Cairns. We need to spend more time on the area but we are in a bit of an emergency response stage at the moment.

Some of the information that I have with me today relates to young people and age as a characteristic. We know that 44 per cent of disabled people aged 16 to 24 are likely to live in poverty. That is an issue when it comes to Covid-19 because we know that people who live in poverty and in areas of multiple deprivation are more likely to contract and die of Covid-19. We also know that, as Claire said, there is evidence that Covid affects people from black, Asian and minority ethnic communities more than it affects people from other communities. Clearly, the area needs more work.

I flag up the fact that we have recently published a piece of research in a report called “Services for Who?” It took a small sample and looked at how disabled people with other characteristics access services. Many of the people who spoke to us commented on health services and how they felt that their characteristic, whether it was race or another characteristic, and their disability impacted on how they were treated by medical professionals and the access to the healthcare that they received.

The epidemic is hard-wiring health inequalities that already exist. If I can digress slightly, we know from Mencap in England, which is an organisation for people who have learning disabilities, that such people are disproportionately likely to die of Covid. However, we cannot find the statistic for Scotland because the figures have not been broken down. The evidence that comes from National Records of Scotland and Public Health Scotland shows how many people are dying, whether Covid-19 is responsible and whether they had an underlying health condition. However, it does not tell about access to healthcare for people who have learning disabilities or people who have a mental health issue. That might not necessarily mean that they are more likely to die of Covid-19, although they are. We need to get to grips with the data on that as soon as possible.

The Convener: Thank you. The committee would be interested to read “Services for Who?” if you are able to share it with us.

Kim Hartley Kean, can I bring you in to answer Maurice Golden’s question about the impacts on different equality groups?

Kim Hartley Kean: The link between communication needs and those groups is—

Let me start again. People who experience communication disadvantage are disproportionately represented among people who are living in poverty, older people and people with disabilities. It has already been stated that people with communication disadvantage who are living in poverty and experiencing digital exclusion are more likely to be impacted by Covid, and we have heard from other witnesses that communication inclusion, or access to information, guidance, advice and services, is not as we might want it to be. Those are the impacts.

The Convener: Thank you. Maurice, are you content or do you have a follow-up?

Maurice Golden: I am happy with that.

Alison Harris (Central Scotland) (Con): Good morning, panel. What else should the Scottish Government be doing to mitigate the impact of the lockdown and Covid-19 on disabled people and their carers?

Claire Cairns: The national carer organisations group has just put out the “Life Leaving Lockdown Discussion Paper” on that issue. We worked directly with carers on it, we had several meetings in which we consulted with people on it and we worked with carers centre managers on it. It sets out what needs to happen now and as restrictions ease further, and it puts forward solutions to some of the impacts that have already been felt by carers.

I will quickly run through some of the measures that we have set out in the paper, but, first, there are two principles that we think are important. One is that carers should be involved at every stage in making decisions that will impact them. We have had a bit less carer consultation and engagement during this process, and, at a time when big decisions are being made about social care services, it is even more important to involve carers. The second principle is that carers’ rights under the Carers (Scotland) Act 2016, some of which have been suspended, should be reinstated as soon as possible.

Solutions for now include ensuring that the SDS guidance, which I spoke about earlier, is applied. Carers should be able to use it more flexibly now, but that is not happening in every area. Day care respite services should be started up as soon as possible, but obviously that should be done safely and carers must feel that those services are safe to use. Carers should be supported with practical matters such as shopping; Northern Ireland has done some very good work in that area.

Support should be directed particularly to shielded people and their carers, and they should be offered wraparound support as much as possible. With regard to the provision of specific information, as things move on and not everybody gets the same level of freedom, information will need to be more nuanced. People will then understand what they can and cannot do and will be able to make risk-based decisions.

We think that people who are shielding need to have broadband and to have devices that some of them do not have access to at the moment. That is for their mental wellbeing through connection with the outside world, as well as for getting appropriate information.

Reinstatement of access to health services is crucial, as well.

As lockdown begins to ease and the furlough scheme ends, there need to be other forms of financial support for carers who cannot return to work. Priority should also be given to replacement care to enable people to return to work, because, until that is in place, they will not be able to do so. There will also need to be guidance for employers on supporting carers in the workplace.

There is more in the paper, but I will not go on. It looks at the many areas where carers are impacted and suggests measures for support as lockdown eases.

The Convener: Thank you. That is helpful.

Heather Fisken: That is a very wide question. One thing that the Scottish Government and everybody has to do is recognise right at the start where disabled people are, because that will drive how they address what they are going to do. Earlier I spoke about health inequalities and the lack of accessible information in lockdown, but those are actually not new experiences for disabled people—a lot of disabled people have been in lockdown for years. That is because of inaccessible housing or housing that they cannot get out of, lack of social care, social care that turns up at 6 o'clock in the evening to put you in your pyjamas, the employment gap and all that that means for income, being on benefits, and so on.

09:45

Moving on to what the Scottish Government can actually do in the immediate period, we have talked about reinstating social care and ceasing charges, and there has been investment in social care. We should recognise what the Scottish Government has done, but, of course, local authorities are not necessarily stopping the charging that is going on.

There should also be a recognition of risk—that has to shape the way in which the issue is addressed. Right from the beginning, it has all been about what you can do for the vulnerable people or disabled people, but disabled people are employers and carers as well. It is not about having a set of guidance for you—whoever that is—on vulnerable people. That just does not work. There has to be guidance for everybody that recognises the risks and where they put people in the great scheme of things. We need to recognise that some people might not necessarily be at any more risk of contracting Covid-19 than the next person, but they are at risk from the responses to it and from the lockdown if they cannot access food.

As we move forward, we know that 180,000 people have had the shielding letter, but we do not know how many people who have not had the letter are choosing to self-isolate or self-shield. It is important that the Scottish Government reaches out to them and addresses their needs, and that they are not, if you like, warehoused.

I remember once reading a letter in a newspaper that asked why we spend so much money on making public transport accessible for disabled people, because they never use public transport. Well, go figure—that is, of course, because transport is not accessible. If people are stuck at home and shielding, nobody is conscious of them, but they have a voice and it must be listened to. They really need support with self-isolating. Some of that will be about providing guidance that is specific to their conditions. I gave an example of a young lady. The guidance all relates to conditions that make people eligible for a shielding letter, but what about the people who are self-isolating?

Disabled people must be involved in setting the priorities, identifying what needs to be done and shaping the services. In the future, we must change the way we talk and not talk about things such as "the vulnerable". We have to start talking about everybody. We have to gather the data and start to see the issue through a human rights lens.

The Convener: Kim, do you have anything that you wish to add on Alison Harris's question?

Kim Hartley Kean: Yes, I have three points to make. The first is that inclusive communication needs to be seen as a public health priority, in terms of physical and mental health, and the Government needs to state that that is the case.

In the short term, we need to set out requirements for all publicly funded agencies to implement the current law and policies relating to inclusive communication. That means engaging executive leaders in the Scottish Government and at local authority level on communication inclusion and asking them to demonstrate that they acknowledge that every community or group includes people with different communication strengths and needs. It also means gathering information about how actual and potential users want to receive information and how they understand and express themselves. We already have a lot of that data.

The Scottish Government needs to co-produce a standard that is based on what we know people want to happen. Part of the requirement is expecting and requiring the Scottish Government and national and local agencies to better use existing resources such as the inclusive communication hub and the knowledge and skills of speech and language therapists. That is point 2—it is about the requirement to use what is already there in the law.

The third point is that the Government needs to commit to co-producing a much more strategic and sustained approach to inclusive communication in the longer term. As I said, consideration should be given to introducing an inclusive communication law in Scotland, which would be incredibly welcome for many.

The Convener: That is really helpful.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Good morning to the panel. I have a quick question about shielding. Roughly what proportion of people whom your organisations support is in the shielding category? What more could the Scottish Government do to provide—[*Inaudible*.]—so that informed choices can be made, and how can it best do that for your individual groups? We have talked a wee bit about the matter, but I would like to home in on it.

The Convener: Does Claire Cairns have anything to add on shielding? It might also be helpful for the committee to know whether the issue affects different groups—younger and older people, those in rural and urban communities—differently.

Claire Cairns: There is a smaller proportion of the caring population who are themselves shielding—some people are caring and shielding at the same time because they are more at risk. However, it is more common for carers to be looking after somebody who is shielding. A large majority of carers are either doing that or are more at risk, so shielding impacts a large number of carers.

In relation to information for shielded people, I have already said that, as restrictions ease but not necessarily as much for shielded people, we need more specific information. I take Heather Fisken's important point that one cannot put carers in neat boxes. Carers will look at information that is not just for the people whom they look after or for caring situations; they are also parents, and they are sometimes employed, so they look at information about those aspects as well. It is about forming the links between the two things.

If one gives the advice to people who are shielding, and to their carers, that they need to stay in the house for longer, how does that impact a situation in which a carer's employer wants them to go back to work or in which they are told that they have to home school their children? All those things have to be looked at together.

I have said before that there is a bit of an information tsunami at the moment and it is really difficult to get those nuanced messages. We are doing our best: guidance is really important, but people want it reduced to simple messaging, and we find that is what works best. People do not have enough time to read large Government documents, so we use a lot of social media infographics, polling and so on. We try to give people bites of information when they need it, but that system is by no means perfect, because it is difficult for people to keep up to date with everything.

With regard to higher impacts on specific groups, so far I have not mentioned the young carers group and the impacts that the situation is having on them. The education of young carers is particularly impacted, because, at the moment, it is difficult for them to study at home. As schools potentially go back in August, it might be difficult for young carers to combine their caring responsibilities at home with their school work. The matter of the education of young carers and how they are impacted needs a wee bit more thought. We need to look at issuing specific guidance for them, and we must work with schools to ensure that young carers are supported.

The convener mentioned rural areas, and we have a rural and remote carers working group that meets several times a year, with which we have been keeping in touch during this period. There are obviously particular challenges for our carers in rural communities—there have always been difficulties in getting support to those communities—but, to be honest, the playing field is more level now, because it is difficult for everybody to get support at the moment.

As we move out of lockdown and services start opening again, issues such as transport will be particularly difficult. Normally, people would attend a day centre and be picked up by a minibus, for example, but that might not necessarily still be the case when services open up again, and that might be a barrier to people accessing that service.

Those are just a few of the impacts for shielded people and carers in general. The "Discussion Paper on Life Leaving Lockdown" that the national carer organisations group put together provides a lot more detail on all those issues.

The Convener: It would be excellent if you could share that paper with the committee. I ask Heather Fisken to address Fulton MacGregor's question about shielding. What are your main concerns for disabled people? You have already mentioned that some people are themselves choosing to shield. You are interested in how different groups—younger and older people, and those in urban and rural parts of the country—are being affected differently.

Heather Fisken: That is right. I should start by saying that Inclusion Scotland does not actually support individual disabled people; we are an organisation of disabled people and disabled people's organisations across Scotland. I therefore do not have a figure that indicates the proportion of our members and partners who are shielding. However, to return to a point that I made earlier, shielding is not just about those people who have got a letter from the chief medical officer. A lot of other people are shielding, too, and they are doing so without the same level of support, although they do need it.

Let me recap on some of the things that I have already mentioned. Given the support that comes with the shielding letter—access to food and the ability to contact somebody and say, “I’ve been caught short,” and to ask for help or information from the local authority or another supplier—how do people return to work if they do not have a shielding letter, which could entitle them to statutory sick pay and so on? They know that they, or perhaps somebody in their household who is disabled, will be at risk of illness if they return to work. There is also the matter of guidance for disabled people who are themselves employers—we are not all employees—and there is the question of our having involvement in any specific guidance that comes around.

Most importantly, there are the issues of isolation—we have waited a long time on that—and of people’s mental health and wellbeing. How can people begin to go back out again safely? What is the basis for that? It is interesting that we are talking about changes. We have found it ironic that, since the epidemic started, some of the changes that disabled people have been asking for for years have now come about, such as remote working practices, online resources and accessible information. Those things are suddenly possible.

I would also mention the need for proper investment in social care and the discussion about a commission to look into a social care service. The people-led policy panel is already in place for that, so it is somewhat ironic that the changes have been coming about as a result of such a disaster. That has put disabled people on the back foot from the beginning.

To sum up, the issue is about all people who are shielding, not just those who have received a shielding letter.

The Convener: Thank you. Your point about the things that disabled people have been campaigning for for ages is well made. We need to ensure that we do not step back from that when it comes to flexible working and online services.

Kim, I invite you to respond to the question about shielding.

Kim Hartley Kean: I am afraid I do not have data on the proportion of people we are working with who are shielding. However, shielding is happening for a lot of people with whom speech and language therapists work, including frail and elderly people, those with dementia and people with respiratory issues, including those with motor neurone disease or multiple sclerosis. I do not feel that I can add anything more to the previous answers.

The Convener: That completes our questions for the first panel. We have managed to get a lot in during this hour. Thank you very much for your evidence.

The witnesses should wait for the broadcasting team to switch off their video microphones. You are free to leave the meeting, but you can continue to watch, if you wish to do so, on Scottish Parliament TV.

09:58

Meeting suspended.

10:01

On resuming—

The Convener: I welcome the witnesses on our second panel, who are Carolyn Lochhead, the head of communications and public affairs at the Scottish Association for Mental Health, and Kathryn Lindsay, the convener of Social Work Scotland. I thank you for joining us, and I am grateful to you for finding the time to answer the committee’s questions.

I will quickly recap how this works. The questions will be asked in a pre-arranged order; I will invite members to ask their questions and then the witnesses to respond; and I will go back to members for follow-up questions. I request that questions and answers be kept succinct. Please give broadcasting staff a couple of seconds to operate your microphones before beginning to ask your question or provide your answer.

Alex Cole-Hamilton: A range of legislation was passed at the start of the crisis. The Coronavirus (Scotland) Act 2020 has some pretty draconian measures in it, not least regarding changes to mental health legislation, although we all understand the necessity of the measures. In particular, I highlight the requirement for a second medical health practitioner to sign off a recommendation to have somebody moved to detention and the longer period for which people can be detained.

The measures have not yet been enacted, but they are very much live in the legislation. Are the provisions in schedule 9 of the act justified? Can you see a time when they might still be required or, now that we can see that the strain on the national health service is not quite what we feared, can we stand the measures down and repeal the provisions?

The Convener: There seems to be a problem with the sound for Carolyn Lochhead. We will suspend briefly to allow broadcasting to sort it out.

10:04

Meeting suspended.

10:07

On resuming—

The Convener: Welcome back. I ask Carolyn Lochhead to respond to Alex Cole-Hamilton's question about schedule 9 of the Coronavirus Act 2020.

Carolyn Lochhead (Scottish Association for Mental Health): The question was about the emergency legislation. We were prepared to support the legislation when it was introduced, because we understood that we were in an unprecedented situation. However, we had concerns, particularly about how any decision to use the powers would be taken, what the trigger point would be and how a decision would be taken to revoke them.

We called for a scrutiny group to be set up, and we were pleased that that happened. Indeed, we sit on the group, which is hosted by the Mental Welfare Commission for Scotland and has met a couple of times.

However, our central worry remains that there is no clear trigger point for when the powers can be used. When the Government previously consulted on what should happen with mental health legislation in the event of a pandemic, we told it that a clear trigger point was needed before the powers could be used, such as our reaching a predefined level of staff absence. We have seen nothing in that regard, and we consider that there is still a lack of clarity on what needs to happen in order for the powers to be invoked.

Similarly, what must happen in order for the powers to be revoked was very much left to the Government's judgment. We did not consider that to be clear enough, and we wanted a lot more clarity about that.

The time has come for the powers to be reviewed. It seems as though—thankfully—we will not need the emergency powers. However, they exist in legislation that lasts for two years, so that needs to be looked at again.

In previous policy work, we have called for a tiered system, so that not all the emergency powers come in at once; we can be a bit more sophisticated than that, by introducing groups of powers as they are needed. There is probably a lot to learn from our work.

It might also be worth my while to point out that mental health tribunals, which make decisions about whether and for how long people can be detained, are having to operate remotely. We understand the reason for that, but we are concerned about how well people can participate in the discussions, particularly given that they can happen when the person is distressed. It is very difficult to participate in such discussions by telephone. Participation is one of the principles that underpins mental health legislation, so it is important that people can participate. That also needs to be looked at.

Kathryn Lindsay (Social Work Scotland): SWS has been supportive of the powers in the Coronavirus Act 2020. We are also supportive of the fact that they have not been used, and we commend the Scottish Government's approach of holding the powers in abeyance until there is evidence for the necessity of using them.

We are aware that that has not happened by accident and that the Scottish Government has consistently had to hold the line in response to calls from some areas to commence the powers. We, along with the colleagues in the Scottish Government to whom we have spoken, have been clear that their use would represent an erosion of rights, and that the threshold to move to commencement must be high. Because the Scottish Government has held firm, the people who raised issues have found solutions.

The powers should be used only as the exception. However, we are conscious that although it might look as though the staffing crisis has passed, from an NHS perspective, we are not sure what the evidence is telling us about what will happen in autumn and winter. I am not confident that there will not be a resurgence in staffing challenges in the medical and social work professions that are part of the processes.

Although a number of critical pieces of infrastructure around such decision making—courts and other support agencies—are not available as they would normally be to support people, we consider that there is value in retaining the powers for the time being. However, I emphasise that the threshold for using them must be high.

Alex Cole-Hamilton: Before I ask my substantive question, can Social Work Scotland provide a little bit more detail on the quarters from which requests for the powers to be commenced were coming? What were the circumstances? What mitigation was found?

We know that some NHS departments, particularly intensive care units, have been overwhelmed because of Covid-19. However, Covid-19 has also led to a drop-off in demand across the health service. Therefore, although it might be busy in acute areas, demand is perhaps lower in areas that are related to mental health legislation. That is because people are not leaving their homes and are not reporting to, or wishing to engage with, primary care. Given that, even if there is the second wave to which you have alluded, are we not better equipped than we thought we were, and can we manage the strain and deal with issues in the normal way?

Kathryn Lindsay: I cannot provide detail about who called for use of the emergency powers. However, I am aware that some of our members know of colleagues in other services who have pushed for the powers to be made available. The answer to their requests has been, “No, not yet.” The bar—which is unspecified—has not been reached. We could ask our members for more detail on that, if that would be helpful.

We are seeing a change in the NHS demand profile as the virus subsides. As lockdown restrictions are eased and we move through the phases of recovery, that might trigger additional staff-capacity issues, as the virus becomes managed in a different way.

10:15

We know that there is a backlog of lower-priority cases relating to mental health legislation, including guardianship assessments and so on, that are being held back until courts are running on a more business-as-usual basis. That puts pressure on mental health officers, who are a social work resource that is held in local authorities and are responsible for parts of those processes, along with their NHS colleagues.

As we go into autumn and winter, it is likely that there will be a potential reduction in availability of staff as people have to self-isolate through the test-and-protect process, as well as a significant increase in the volume of demand on services at a point when all parts of our system are looking to get back to business as usual.

Cases that needed to be progressed several months ago have not disappeared—that work is still there. We know that the MHO resource is very small and that its capacity to do the work within a very tight timescale will be limited. It is for those reasons, rather than capacity within health services, that Social Work Scotland urges caution in respect of there being no legislative basis in place.

Carolyn Lochhead: As I have said before, it is important that we are clear about exactly when the powers can be used. I understand and accept that there is a lot of pressure on MHO resources—that is undoubtedly true. However, if we are to retain the powers, it is important that we are clear what they are for, what the threshold for using them is and how we will come out of using them, because they have very serious impacts on people’s rights.

The Convener: Thank you, that is helpful.

Maurice Golden: We have touched on the Coronavirus (Scotland) Act 2020 provisions that allow local authorities to disapply key principles of the Adults with Incapacity Scotland Act 2000 and on the fact that the measures will enforced only in exceptional circumstances. What are Social Work Scotland’s views on that?

Kathryn Lindsay: I would say—[*Inaudible.*]

The Convener: I am sorry to interrupt Kathryn, but your sound is dropping on and off. You do not need to touch the microphone—broadcasting colleagues will do that for you.

Kathryn Lindsay: Our position on the powers that are available in relation to adults with incapacity is the same as that on the powers for mental health. From our point of view, it is helpful that the powers exist in the event that capacity issues arise, because if, down the line, we discover that we need them, it would take too long to put them in place if they were not ready to be enacted and commenced.

We project that there a risk of peak demand on social work in autumn and winter, which is when we tend to get an upturn in referral requests in relation to adults with incapacity, and more generally for social work and social care. It is often the same staff who carry out those two roles. For our members, it is a comfort that, should the resources be such that it is not possible to meet all the obligations within the current legislation, there is a fallback position. However, we want to make it clear that we do not want that to be commenced unless there is critical necessity.

Carolyn Lochhead: The provisions in relation to adults with incapacity relate more to people who have dementia or learning disabilities. Therefore, SAMH has not involved itself much in that.

Our other concern is about the ability of local authorities to conduct social care assessments to a less-high standard than they normally would. We know from the Scottish Government’s reporting on the coronavirus act that at least five health and social care partnerships have used that power.

We understand that it is not business as usual, so flexibility is needed. However, our concern—which is similar to one that I outlined earlier—is that we are told that the regulations will remain in operation only while it is

“absolutely necessary to protect people”.

We would like more clarity on what that means and what it looks like. That definition is quite loose, so we would like it to be tightened up.

The Convener: Maurice, do you have a follow-up question?

Maurice Golden: No, I am content.

Alison Harris: What impact are the lockdown measures having on mental health across different groups, and what range of supports are in place in the short and long terms?

Carolyn Lochhead: We know some things about the impact of lockdown, particularly on people who have mental health problems. There has been a lot of discussion about its impact on everybody's mental health; I am sure that many people have struggled with the strange times that we are living in.

We did a bit of work with people who have used SAMH's social care services—it has around 60. We wanted to understand what they were experiencing. Our survey had about 458 responses, and about half of respondents said that they were feeling anxious or scared about the virus. They talked about the disruption that it has caused, cancellation of activities that they would normally do and missing their friends.

We also found that people had seen their support switch to telephone or video support, or they were simply not getting it at all. The level of access to support is obviously having an impact on people.

We can also draw information from our monitoring of how our services are working, and of how the people whom we support are doing. As most social care organisations do, we log incidents of concern relating to service users. We have seen an increase in people having times of distress; there has been an increase in the number of incidents involving self-harm, attempted self-harm and thoughts of suicide. We cannot say that that is definitely an impact of lockdown, but it is certainly very noticeable that the timing of that increase has coincided with the introduction of lockdown. People are telling us that they are struggling with it.

From our information service, we also know that there has been an increase in calls—in particular, calls about depression and anxiety, as well as calls in which people talk about having suicidal thoughts. Our average call time has also gone up because—although it is an information and signposting service, not an emotional support service—people have been looking for much more support, as they try to find information.

Those are some of the indicators that we have about the effects of lockdown on people.

Kathryn Lindsay: Social Work Scotland does not deliver direct services; it is a membership organisation for social workers across Scotland, including chief social work officers. Therefore, part of the challenge is that we do not conduct research ourselves.

However, we are well aware of research across a range of areas of business that we are involved in, which is highlighting a significant upturn in mental health and wellbeing concerns across the whole age range.

Our members recognise that this is a particularly distressing time. People would ordinarily receive support from a range of places—not necessarily from social work, but from the third sector, schools and respite care, which are examples that panel members have spoken about. Unavailability of those services compounds distress about other things.

Social workers across the country are certainly seeing that with the people whom they support directly. The range of activity that we would usually help to co-ordinate and support is not there in the way that it usually is. Obviously, the plans that we put in place to keep people safe and well are not, at the moment, as full as they would usually be, which will not be without impact on people's ability to cope.

Another point that I add for the committee's information is that there has been an upturn in the number of adult protection concerns in some areas, which I think is a clear indicator that some adults are struggling with lockdown and its emotional impact on them.

Alison Harris: What does the reduction in support services mean for mental health clients in the community? What pressure is it placing on the staff? Have you any more information on that, please?

Carolyn Lochhead: From talking to those who use the SAMH services in particular, we have seen that people are certainly not getting the services that they would normally get. There is not a lot of information about when those might resume, although the statement from the minister yesterday about some moves towards resuming services was very welcome. Around a third of the people whom we support said that their NHS or related support had moved to video calls or telephone calls. Around 15 per cent said that they had not had any contact at all with their usual contacts, which could be a community mental health team or a community psychiatric nurse. That is obviously quite worrying, because those people do not know what is happening or when anything is going to resume, and they are operating without the support that they would normally have.

An important point is access to technology. In some cases, we have seen support begin to switch to telephone or video support. Indeed, we have done that with our own support provision. However, we know from the survey of our service users that around a quarter said that they did not have access to or know how to use technology. We will certainly bear that in mind as we go forward. It is important as we move towards the resumption of services that we do not assume that everything can be delivered online, because we know that that leaves out a big group of people. That aspect is going to be important as we go forward.

More broadly, we certainly expect an increase in demand for mental health services. We saw that in the financial crash in 2008, which led to an increase in the need for mental health support. There is also some evidence that previous pandemics impacted on people's mental health. We certainly expect that there will be increased demand that we will need to try to meet, as challenging as that might be. People are going to have quite serious mental health needs, particularly those who were struggling with a mental health problem at the start of the pandemic and have had to go through lockdown and perhaps a lot of isolation, uncertainty and anxiety.

The Convener: Kathryn, I know that your organisation does not work directly with those service users, but do you wish to add any comments?

Kathryn Lindsay: I am aware from our discussions as an organisation that the majority of social work services are using technology very heavily at the moment to sustain and maintain contact with those vulnerable people with whom they work. We are still receiving referrals and conducting assessments. There was reference earlier to the ability to conduct assessments at a lesser depth and the limited way in which that has been used across the country. That relates to people with mental health issues as well as to a range of social services-related referrals. People are working very hard to try to maintain contact, but the reality is that some of the supports that people with mental health needs most rely on are community-based support services, which have not been able to operate fully in the current climate.

10:30

Access to physical exercise and social gatherings has not been possible recently, for instance, and we are aware that the package of support and connectivity to others that we would usually promote and encourage has not been as available as we would have liked. That has meant that there has often been a different kind of reliance on one-to-one support by telephone or by digital means, as was mentioned earlier. That has its limitations. Although some people have responded very well to it, and it suits them to communicate like that, it is not for everybody. There is nothing that replaces face-to-face connection and the building of a relationship in supporting people through what are very difficult times.

Angela Constance: I have a couple of questions for Kathryn Lindsay from Social Work Scotland. I should, of course, declare an interest as a former social worker, practice teacher and mental health officer. I am particularly keen to understand more about what it is actually like for front-line statutory social work staff who have been working throughout the pandemic, especially in carrying out assessments.

I note that, in a Social Work Scotland briefing that was prepared for the Parliament when it was debating the emergency legislation, you expressed concerns about the removal of section 13ZA from the Social Work (Scotland) Act 1968. That measure took out the need to take into account the views of adults and other interested partners.

I do not know how anybody can do an assessment without taking on the views of the person being assessed, even in an emergency situation. Of course, on balance, professionals do not necessarily have to agree with the views of their clients, as long as they can justify that. However, I just do not know how anybody can do an assessment without listening. I would be interested in hearing your views on that.

Are there enough returners to services? If the number of adult protection cases is increasing, is there also an increase in the number of child protection cases? Is there anything else that we need to do to prepare for winter?

Kathryn Lindsay: That is a fair list of questions from a fellow social worker—thank you.

First, you asked what it is like for staff on the front line. Although we do not represent a broad base of front-line social workers—it is important to mention that the majority of our members are in managerial posts—we get feedback from our staff and we discuss the challenges before us on a regular basis.

It is difficult to operate a social work service when the majority of staff are working from home. There are issues with confidentiality. Our staff, like other professionals, are trying to juggle other important caring responsibilities and home schooling with the delivery of a front-end social work service. That is a fairly unique context for the delivery of social work, and I commend our staff for the energy that they have put into that.

We are aware of some challenges across the country regarding people's digital ability and their being connected enough to do their work from home, which we need to facilitate and support. Some local authorities have good digital infrastructure, and some geographic areas obviously struggle with digital connectivity more than others. That is partly to do with hardware, and the general quality of the IT infrastructure has made things challenging in some areas.

From the outset, our staff have continued to see people face to face. Although much work is happening from a base that is someone’s home, people are still going out into communities and into people’s homes. They are doing that to ensure that people remain safe.

There is no desire on the part of social work not to be absolutely front and centre in communities and to support people through this difficult time.

On your specific question about the removal of section 13ZA from the 1968 act, I should declare that I am not a mental health specialist whatsoever, but we have had a lot of discussion about that issue. We were very concerned about it at the outset of the crisis, and those concerns were very strongly worded in our briefing at that point. However, as things have progressed, it has not emerged as a significant concern. That may be partly because hospitals have not been as overwhelmed in terms of space as was perhaps anticipated, so the urgency of moving people out of hospital without undertaking a full, rounded assessment of people who may not have the capacity to share their views, and whose views cannot be ascertained, has not presented as a significant-volume issue across the country. That is reassuring. Individual chief social work officers have been keeping a close eye on the situation in that regard, because we are very much of the view that people’s views need to be heard and taken into account in making decisions about care.

You also asked about returners to services. Are you referring to the opportunity for people to come on to the temporary register?

Angela Constance: Yes.

Kathryn Lindsay: As far as I understand it—although I do not know the national figures—there has not been a massive uptake. A number of people have come forward and said that they are prepared to do certain tasks in particular areas and that they have joined the Scottish Social Services Council register. In addition, a number of qualifying social workers, who will become newly qualified social workers imminently, have joined the temporary register.

Local authorities, where most social work services are located, still have to go through their own recruitment process in order to deploy any of those staff, because we are not a national service and there is no central infrastructure for that. Local authority areas are very much still looking at what staffing capacity they need and what they have the budget to pay for, and they are then recruiting.

Nonetheless, it is certainly helpful for local authorities to be able to see at a glance from the SSSC register who is available in their area and is keen to be taking on work. That means that we can promote the fact that we have advertised the job to those individuals, and we hope that they will not miss the opportunity to come and work with us.

I think that there was another facet to Angela Constance’s question, but it has gone out of my mind.

Angela Constance: You mentioned that there was an increase in the number of adult protection cases, and I wondered whether there was also an increase in the number of child protection cases.

Kathryn Lindsay: Absolutely. The Scottish Government collects weekly data, which is then provided as a composite report. It shows that, in the initial weeks, there was a significant drop in the number of child protection referrals across the country. However, over the past few weeks, we have seen a fairly steady increase, and a number of areas are starting to report that the underlying referral rates for social work—not just protection concerns—are starting to climb.

What we are concerned about—I remember the final part of your question now—is what the situation will look like into the autumn and winter months. In Social Work Scotland circles, with our children’s services hat on, we are mindful of the plans for children to move back into schools in the early autumn period. We know that, at that point, children’s exposure to a wider range of people with whom they can share their worries and concerns is likely to result in some concerns being referred to social work. We are anticipating an upsurge in referrals in August, when more children start to have more access to a wide range of adults in whom they might confide.

We spoke earlier what we do not know about the pandemic and how it will behave. We are all hoping that there will not be a perfect storm of capacity in the autumn and winter months, in which the ordinary flu season, and the opening of other organisations leading to an upsurge in social work activity being required and reinstated after the past few months, combines with a coronavirus upsurge. We are very concerned about the end of the year.

Fulton MacGregor: Good morning, panel. Following on from Angela Constance’s declaration, I, too, declare an interest, as I am a registered social worker and my partner is a practising mental health officer.

I want to ask a wee bit about changes to social care support. What steps should be taken to ensure that people get the social care support that they need at this time of crisis in particular?

The Convener: We will come to Carolyn Lochhead.

We seem to have lost Carolyn's sound again. We will go to Kathryn Lindsay, and broadcasting can try to sort Carolyn's sound out while we hear from Kathryn.

Kathryn Lindsay: Part of the challenge with social care support is the need for financial support for social work and social care across the piece. There have been additional moneys, which have absolutely been welcome but, at the same time, we know that there is likely to be a significant upturn in demand.

Most local authority areas and health and social care partnerships were already saying to start with that there was not enough money in the pot. We are very concerned, as the other panel member is, about the likelihood of an upsurge in mental health and wellbeing issues, which may well result in an upsurge in referrals to social work and social care for different kinds of support.

With regard to capacity, it will certainly be a challenge to meet both the existing need and the growing need. Money is only one part of the issue. The other aspect that we, as an organisation, are concerned about is the lack of capacity in the system—

Temporary loss of sound.

The Convener: Now we seem to have lost Kathryn Lindsay, too. I will suspend the meeting briefly while we try to fix the issue.

10:42

Meeting suspended.

10:44

On resuming—

The Convener: Welcome back. Kathryn, we were listening to your response to Fulton MacGregor's question.

10:45

Kathryn Lindsay: Yes. I am sorry—I do not know what happened there.

The other point that we would make is about the availability of a workforce. There has been a high-profile campaign around recruiting to social care, but the social work workforce is also a fairly limited pool nationally and we would welcome any support from the Scottish Government to grow it. That could involve funding and support for social work students to encourage people to decide to move into a career as a social worker. At present, that is a challenging decision for people to make, certainly as a second career, which used to be a route of choice.

The Convener: Thank you. Carolyn, do you need Fulton MacGregor to recap or did you manage to catch his question before we lost you?

Carolyn Lochhead: I heard the question. I missed one or two of Kathryn Lindsay's points, though, so I apologise if I repeat anything that has already been said.

I heard Kathryn talk about the importance of funding and of the workforce being there to provide a service, and we certainly agree with that. We know that the effects of the coronavirus are not going to be felt equally across the population. People who have existing mental health problems are likely to be more affected, as are people who work in the health and social care sector and people from black, Asian and minority ethnic groups.

One thing that will be really important in ensuring that there is care for people is to understand who needs care and what the baseline is. I heard the Minister for Mental Health talk yesterday about asking health and social care partnerships to establish a baseline for what has been happening with services, what is available now and what needs to be rolled out. That process is welcome and will be important.

We know that we will need good data in order to manage that. There are probably a few areas where we need to examine the data, but I will mention one in particular. We are worried about the pandemic's impact on mental health and any potential for an increase in the number of suicides. We note that there is no scheduled date for the publication of the annual statistics on suicide, which normally come out in the summer, and we are worried about that. We would like to see not just information on the resumption of services, but information on the publication of data and when we will have it.

A lot of social care is delivered through the third sector, so we definitely need it to be involved in the discussions that will take place about trying to get services back. I did not want to say "up and running", because they have never stopped—our services have certainly not stopped throughout the period. However, we want services to get back on a normal footing, so it will be important that we have genuine cross-sector conversations about what is being provided and what still needs to be provided. Mental health needs are going to be substantial and we need to work together to ensure that we can meet them.

Fulton MacGregor: Sticking with the issue of social care support, I note that there has been a lot of talk about us perhaps being over the peak of the pandemic and about care plans beginning to return to some normality—although slowly, of course. However, there has also been a lot of talk about a second wave later in the year. What can we do as a society to ensure that we are more prepared for that in relation to social care plans? Can we do things differently so that people will be more supported if—fingers crossed that there is not one—there is a second wave later in the year?

Carolyn Lochhead: We can undoubtedly take learning from the current situation. The pandemic is something that none of us has ever gone through before, so, of course, we will be able to learn from it.

We hope that there will not be a second peak, but, if there is one, we hope that we will be better prepared for communicating with people about the services that they receive and what will happen to them. I mentioned that 15 per cent or so of our service users said that they had heard nothing about what was happening to their services. I hope that we could do better than that and communicate with people really clearly about what will happen, what will be possible and what will not, and particularly what will happen once things start to get back to normal again.

We have been concerned about people who needed support but were unable to access it during the crisis and whether the onus will be entirely on them to go back to the beginning of the process and start seeking support again. If we absolutely cannot support people during a period of crisis, can we at least ensure that it is not entirely up to them to restart the process of seeking support?

It is about communicating with people about what is possible, what is happening and what the timescales will be. It is also about seeking to ensure that support is provided through digital means as much as possible, while recognising that that just does not work for quite a lot of people with mental health problems.

Kathryn Lindsay: I agree. There are definitely things that we can learn. The pandemic is not something that any of us has had to plan for previously, and I do not think that we could have anticipated the responses that would be required or the volume. Going forward, it would be helpful to have from the Scottish Government an indication of how it plans to respond to any second wave of infection, including whether we would see a return of lockdown and how that might look.

We are now in a better position in that employers have an understanding of how they might respond and what facilities they might have available to help them to sustain the support that they deliver for people. I guess that we would spend less time trying to get our heads around all of that and putting the infrastructure in place, providing that we can maintain that infrastructure with funding in future. We are also in a better position in relation to how PPE interrelates with the activities that we undertake. PPE is now available for a wider range of services than would have needed it in the past.

The effort and energy that went into the initial weeks of the pandemic could be used very differently if there was a second peak. I hope that we would be able to provide a greater degree of clarity and certainty for people who use our services about what the impact of a future lockdown would be, or certainly about what a staff shortage that was caused by a second peak might mean for their packages of care. We need to have conversations with people now about how we would approach that up to a point where the virus has completely gone or we have some sort of inoculation against it.

The Convener: Thank you. That is really helpful. That concludes our evidence session. I thank both witnesses for their evidence and their time. There is certainly a lot for the committee to think about and act on.

At our next meeting, we will take evidence from the Minister for Older People and Equalities. In the meantime, any follow-up scrutiny issues will be dealt with by correspondence, which will be published on our website.

That concludes the public part of the meeting. As previously agreed, we will now move into private session.

10:53

Meeting continued in private until 11:18.

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