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1. My full name is Heather Reid Edwards. I am a highly experienced occupational therapist with extensive experience gained from a thirty-five-year career incorporating clinical, managerial, and national positions held both in the UK and USA across health and social care with a focus on older people.

2. I graduated with a Diploma in Occupational Therapy from the St Andrew's School of Occupational Therapy in Northampton in 1988, and later completed a MSc in Occupational Therapy from Western Michigan University, Kalamazoo in the USA in 2008. While at the Care Inspectorate I completed the Scottish Improvement Leadership Programme in March 2018.

3. I am currently employed by the Care Inspectorate as its Allied Health Professions (AHP) Consultant. I have been in that post since 2017, although during that time, I have spent two years in the post of Head of Improvement Support, on a temporary basis. That was from January 2019 to February 2021, at which point I returned to my substantive post.

4. I joined the Care Inspectorate in January 2013 as the Dementia Consultant. I was initially seconded into that post from NHS Tayside, for a period of 12 months. I completed that secondment and was then offered a 1-year fixed-term contract – again as Dementia Consultant. That role was thereafter advertised as a permanent post, and I applied for it and was successful. That would have been around September 2015.

5. I remained in that post until 2017, when the previous Health Team went through a reorganisation. Generic improvement roles were developed, and I became the AHP Consultant with an emphasis on dementia, frailty and palliative and end of life care.

6. In my initial role as Dementia Consultant and later as AHP Consultant I had no line management responsibilities. I had line management responsibilities during the period when I was Head of Improvement Support. Currently I manage the Health and Social Care Improvement Team (HSCIT) and have eight Senior Improvement Advisers reporting to me. That HSCIT was established in April 2021.

7. For the role, function and duties of the Care Inspectorate please refer to Kevin Mitchell's statement.

8. In January 2020 when the Covid-19 pandemic struck I was in the role of Interim Head of Improvement Support and was a member of the Care Inspectorate's Executive Group. When the Care Inspectorate decided to implement a Gold and Silver command structure on 4 March 2020, I was allocated the role of keeping the policy decision making file up to date, and tasked with following up on outstanding actions from the meetings as required. I attended the twice-daily Gold meetings and contributed to the decision making process. I also attended some of the Silver meetings and acted as a liaison between both the Silver and Gold groups. Please refer to Kevin Mitchell's statement on the role and function of the Gold and Silver groups.

9. My role also included attending and representing the Care Inspectorate at Scottish Government groups where specific Covid guidance was being developed for the social care sector. The groups included the Clinical and Professional Advisory Group (CPAG) and subgroups from this overarching group on Covid testing, Infection, Prevention and Control (IPC) and early discussions around visiting in care homes.

10. The Scottish Government took on the role of issuing the Covid-19 guidance which was to be followed across all of health and social care and covered all social and personal mitigations to prevent the spread of the virus. This included the use of Personal Protective Equipment (PPE), physical distancing, IPC measures, including cleaning schedules and methods. The testing of social care staff, and vaccinations and the movement of residents and staff were also included in specially developed guidance for residential settings for people experiencing care, and social care provision in community settings such as care at home. The guidance was developed by subject matter experts from Health Protection Scotland (HPS), later to become Public Health Scotland (PHS), Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland, which is part of NHS National Services Scotland (NSS), the Chief Nursing Officer Directorate (CNOD) and the Chief Medical Officer (CMO).

11. The Care Inspectorate did not write specific guidance relating to the spread, management, or mitigations of Covid-19 - we relied on those with expertise in this field. We did promulgate the guidance and there were occasions when we interpreted

the guidance to give context for the social care settings. We ensured all updates from the Scottish Government and HPS were communicated out to the sector via our provider updates and added to our Covid-19 external website. The Care Inspectorate did not issue provider updates before the pandemic. The provider updates were a direct response to the pandemic. The provider updates are an e-newsletter that is emailed to the addresses attached to service providers' Care Inspectorate registration accounts. They also reach others who have chosen to receive them as part of their subscription to our Care News/e-newsletters service. At the height of the pandemic the provider updates were being issued daily.

12. We ran practice dilemma sessions for the social care sector to highlight what IPC guidance might look like in practice; for example we reinforced the message of "clean but not clinical", the use of mops and buckets after HPS published the Care Home IPC Manual, and cleaning schedules.

13. The briefings that we did write for the Scottish Government were reports on individual services, or providers, as a result of scrutiny activity. Details of these reports can be provided by Kevin Mitchell, Executive Director of Scrutiny and Assurance and Marie Paterson, Chief Inspector for Adult Services.

14. In March 2020, Marie Paterson, Chief Inspector for Adult Services, and I were tasked with setting up an internal Covid Team which we called the COVID-19 Flexible Response Team (CFRT). Staff were brought into this team from across the organisation, including: improvement support, scrutiny and assurance (covering adults and older people), early learning and childcare, children and young people, and strategic inspections. The key functions of the team were, firstly, to support the organisation's responses to Covid enquiries from Care Inspectorate staff, staff working in social care services, people using services, and members of the public, and, secondly – and importantly - to maintain knowledge of policy and guidance in relation to Covid-19, which was regularly updated in our "Covid Compendium." The Covid Compendium was a live document which catalogued all the most up-to-date Covid guidance for all service types registered with the Care Inspectorate. The CFRT also ran a number of webinars for the sector including two workshops for Nurse Agencies, highlighting key guidance to reduce the spread of transmission. These sessions also highlighted the current IPC best practice.

15. One of our current Senior Improvement Advisers took on the specific role of PPE lead, supporting the roll out of access to PPE for social care. Some of the more general and straightforward PPE enquiries were dealt with through the wider CFRT, but more specialist enquiries were passed to the PPE lead who liaised closely with NSS and HPS, both to provide responses and to flag areas of concern that needed a national response.

16. There were two influential groups where matters of concern could be raised that required a national response. These were CPAG and the Pandemic Response and (Recovery) in Adult Social Care Group (PRASCG). PRASCG's terms of reference describe the relationship between the two groups as follows: "PRASCG is a strategic group with an operational focus, while CPAG is concerned with clinical oversight and decision making." PRASCG was born out of the former Scottish Government Care Home Rapid Action Group in September 2020. Peter MacLeod, then Chief Executive at the Care Inspectorate, was the representative for us on these groups. Occasionally if Peter was unable to attend, a senior alternate would take his place.

17. I did not attend PRASCG, therefore I am unable to comment on the discussions which took place.

18. During this time, I represented the Care Inspectorate on CPAG with other Care Inspectorate colleagues. This was a Scottish Government led group which started in May 2020 and met weekly, finally ending in March 2022. This group gave us an opportunity to influence and comment on national guidance and discuss emerging hot topics as they came to light. The group was chaired initially by Diane Murray from CNOD, and later by Dr Graham Ellis, Associate Chief Medical Officer. There was another Chair of this group after Dr Ellis, but I cannot recall their name, other than they were a Geriatrician by profession.

19. The membership of the group was wide with over 100 people sometimes being on the call. There was representation from Chief Officers of the Health and Social Care Partnerships, Directors of Public Health and Health Boards, the Office of the Scottish Government Chief Social Worker, national organisations such as Scottish Care and the Coalition of Care and Support Providers in Scotland, and independent care service providers. The third sector was also represented as were trade unions and professional bodies. The meetings lasted for about 90 minutes and agendas were sent out ahead to give time for consideration of upcoming items.

20. My primary role in attending this group was to influence, wherever possible, new guidance and changes to existing guidance to ensure that it was 'fit for purpose' for implementation within the social care environment. We had concerns that guidance that had been developed for an acute health setting was to be applied in a care home setting without the appreciation that these were people's homes. There was an ongoing tension with promoting and maintaining an environment that would reduce the spread of Covid, while supporting a homely setting. There was significant discussion about the over "clinicalisation" of care homes, and I often felt that care homes were being viewed as being the same as community hospitals. I again tried to reinforce the idea of "clean but not clinical".

21. One of the areas that we joined others in influencing was around the issuing of guidance on a Friday. We had heard directly from care home managers that this was causing undue stress, as they were desperately trying to make the required changes before the weekend. This was taken on board by Scottish Government colleagues and every attempt was made to issue guidance earlier in the week. Staff also needed lead in time to implement the guidance and we tried to influence reasonable expectations around this. One of the difficulties associated with this was the amount of sign-off that was needed before guidance was published from CNOD, CMO and Scottish Ministers. We also supported the move to make it easier for care services to see where changes to the guidance had occurred instead of having to trawl through all the previous guidance looking for updates. Later on, all changes were referenced at the beginning of each updated guidance document, although I cannot recall when that first occurred.

22. There were subgroups which stemmed from CPAG and one of those was the testing subgroup. I attended these meetings giving a perspective where required on the impact of testing arrangements on the workforce and services. I did not have an opinion on the scientific rationale on testing, more on the logistics to support the policy position. The fact that much of the initial testing guidance was issued around Christmas 2020 was not ideal and the various methods of reporting the test results via different electronic portals increased confusion. The implementation of the testing guidance and subsequently how testing was practically done did vary depending on health board area and provider. Some social care staff found themselves being required to come into the care home on their day off to test, and there was significant discussion around whether it would be mandatory for staff working across the social

care sector to test, and what would be the consequences should they refuse to do so. The CPAG testing subgroup was a useful place for representatives from services to give their lived experience of the realities of guidance and policy. For example, the Director of Care at the Erskine Care Home was extremely vocal about the initial difficulties for both receiving test kits and having them collected. He was also able to give accounts of the amount of time that testing was taking up and the impact on staff capacity to meet the needs of those they were supporting. The Scottish Government's professional advisers did take this feedback well and try to mitigate the impact on services wherever they could.

23. The Open with Care Group was attended by Marie Paterson. I did however attend an earlier iteration of this meeting chaired by Jan Beattie from the Scottish Government which was attended by advocacy groups such as Alzheimer Scotland and PAMIS, and had a strong representation of families of people experiencing care. There were at times strong opinions from family members that the Care Inspectorate was not doing enough to mandate the opening up of services to visits. On one occasion a family member gave details of the difficulties she was experiencing, which were not supported by the then care home visiting guidance. This situation was passed to a Care Inspectorate team manager and the situation was resolved (if more information is required Amanda Welch was the Team Manager). There were many occasions when Care Inspectorate inspectors, team managers and service managers intervened and entered discussions with services who were not allowing visits permitted by the guidance, especially around end-of-life visits.

24. There was an opinion in the Care Inspectorate shared by me that the guidance and policy position from the Scottish Government - heavily influenced by the Directors of Public Health on visiting in care homes - was too severe, and that the unintended consequences of being isolated from family and friends was not given enough weighting in the decisions made around risk. I raised this viewpoint on several occasions at CPAG and, while it was listened to and acknowledged, the input from Directors of Public Health and the voice of HPS was stronger, and they had the final say.

25. We supported the vaccinations programme for social care staff, and we issued a joint statement of support with the Scottish Social Services Council (SSSC) encouraging staff to take the vaccination. There were questions at this time raised in CPAG as to whether staff could work in care homes if they refused to be vaccinated. It became

apparent that we could not mandate vaccinations, and this was communicated to the group. Encouragement and education was considered the best approach as there was no legal basis to enforce vaccinations, and there was considerable social media comment from those opposed to vaccinations targeted at social care staff. The health sector was experiencing a similar situation, and social care was by no means unique in this situation. We continued to promote all other mitigations, especially the consistent and appropriate use of PPE to limit the spread the virus.

26. When the NHS Education Scotland (NES) safety huddle tool was developed, I shared concerns at CPAG that this was yet another ask of an already stretched workforce and that we should not need to duplicate information that services were required to submit to the Care Inspectorate via our notification systems. My feedback along with others was heard at CPAG but resulted in no change of position. There was a strong commitment from the Cabinet Secretary that this should go ahead. The safety huddle tool was launched on 14th August 2020 with the aim of all care homes inputting information on their Covid outbreaks, staffing levels, and occupancy rates into the tool. Angella Fulton, Team Manager at the time for the CFRT took the lead on this from the Care Inspectorate's perspective.

27. Another key discussion at CPAG was the role of the Care Home Assurance/Oversight Teams. These teams were established on the instruction of the Cabinet Secretary via a letter to all Health Boards and Health and Social Care Partnerships on 17 May 2020. Scottish Care raised concerns that the creation of these teams had introduced an additional layer of scrutiny and services were receiving conflicting guidance from these teams and their Care Inspectorate inspection team. There were often discussions and follow up required by local Care Inspectorate inspection teams where there was a difference of opinion. However, with the Care Inspectorate inspection team managers attending the oversight team meetings, there were established channels for relationships to be strengthened and communication to be clarified.

28. Care homes have always had guidance relating to IPC in the form of what was commonly referred to as the "manual." The National Infection Prevention and Control manual (NIPCM) has been deemed good practice since 2015. It was not widely adopted by care homes as it was written for NHS clinical areas. The Healthcare Improvement Scotland (HIS) IPC standards dated 2015 were of the same ilk and, although deemed good practice, these were not seen as social care documents but

were useful reference points. At times, there was a sense that colleagues not working in social care thought that IPC was a new concept to the sector. As I have mentioned earlier, there was a tension between ensuring that care homes kept a homely feel (clean but not clinical) and did not become an extension of a community hospital.

29. Guidance that worked well and was appropriate for acute health settings could not be lifted and applied without adaptation into care homes. The role of CPAG was vital in giving a platform to a wide range of stakeholders from across the whole of health and social care, to have these important conversations and to flag potential unintended consequences. This was the forum where I could raise concerns coming from colleagues in the Care Inspectorate, especially members of the Care Inspectorate CFRT who were seeing the impact of the IPC guidance in practice, where it was working well and where there was perhaps confusion or difficulty implementing it.

30. As an organisation we did have the ability to influence the IPC guidance and we had representation on the group that developed the Covid-19 IPC Addendum and Manual for Care Homes. We agreed that the NIPCM care home Addendum would be mandatory, therefore all care homes needed to implement the guidance. Colleagues with enhanced skills in IPC at the Care Inspectorate continually fed back some of the challenges faced by care home providers when implementing the guidance due to the variation of size of service, environmental layout, and the ethos, aims and objectives of service provision. We continually fed back the challenges faced with implementation to look for an approach that was reasonable. For example, the need to change mop heads after every room, or every 15 mins. We also asked for the Care Home Infection Prevention and Control Manual (CHIPCM) and cleaning specifications to be reviewed and updated over time to ensure it remains fit for purpose.

31. From early on in the pandemic, Marie Paterson (the Chief Inspector) and I met weekly with ARHAI and HPS colleagues. During these meetings we could raise any concerns and they could do likewise. It was useful when we had a named person at ARHAI who could triage our questions and queries. We continually fed back some of the challenges faced by care home providers when implementing the guidance due to, for example, their size, the various environments in which care is delivered, and the ethos, aims and objectives of service provision. Social care is very complex and diverse. We continually fed back the challenges faced with implementation, to look

for an approach that was reasonable. We also asked for the CHIPCM and cleaning specifications to be reviewed and updated over time to ensure it remains fit for purpose.

32. Using the national guidance, the Care Inspectorate augmented our inspection quality frameworks by developing key question 7 to help assess how services were responding to Covid-19 and adhering to/implementing IPC best practice. Please refer to the statement from Kevin Mitchell for the rationale and development of key question 7. I was not involved in this work and Marie Paterson would be better placed to give detail on the impact of introducing key question 7 and the intelligence it enabled us to ingather. However, it was from our scrutiny activity that we were able to see common themes emerging where the care homes were having difficulties with IPC and not implementing the guidance effectively. To support services, we developed inspection tools on wellbeing, IPC, and staffing that were agreed with external stakeholders. We also developed a self-evaluation tool and support for services on key question 7 which reflected IPC good practice for the sector. The CRFT also ran webinars promoting best practice in IPC in the winter of 2020 as referred to in paragraph 14 above.

33. The Care Inspectorate did support services and Nurse Agencies to follow the appropriate guidance in relation the movement of staff between different services. Again, we did not write the guidance, this was written by the Scottish Government team with input from the relevant IPC and Public Health professionals, but we supported services to implement it in practice. Guidance for the movement of patients from hospital back into care services was also developed nationally and we again supported this with a publication co-produced with Scottish Care and the Coalition of Care Providers Scotland (CCPS) for services to follow best practice.

34. The biggest challenge in supporting social care through the Covid-19 pandemic was that social care was not fully understood by those in key decision-making roles across the whole of the system. Procedures and interventions that were effective in an NHS health setting could not always be lifted and fitted into social care, without unintended consequences.

35. CPAG was an extremely useful group as I have described previously and there was a genuine attempt by all parties to work collaboratively. There was however a

hierarchy of power when decisions needed to be made and the Directors of Public Health, PHS and ARHAI (formerly HPS) held considerable ground.

36. There was a great deal of learning from the pandemic and an increase in data and intelligence. For example, we revised our "Building Better Care Homes" guidance to take account of learning from intelligence on outbreaks in care homes and the learning about environments. We have always worked collaboratively but the pandemic opened up new stakeholders and for the Building Better Care Homes revision, we consulted with a wide range of professionals and experts.

37. The speed and pace of developing and implementing new guidance was a considerable challenge. Timescales were at times unrealistic and resulted in guidance that had unintended consequences and added considerable stress and pressure into an already pressurised system. We did however as an organisation work hard to maintain and strengthen relationships with all key stakeholders so that we could support the social care sector and champion their perspective.

38. As the regulator for social care, the well-being of people experiencing care was paramount. Over time we found ourselves moving from an initial position of reducing the risk of transmission at all costs, to balancing that against our growing understanding of the risks of social isolation for people living in care homes unable to see their families and friends for extended periods of time. This can be seen in the move from where we initially suspended all inspection activity in March 2020, to where this was resumed with all the appropriate mitigations, to finally supporting the move to Scottish Government "Open with Care" guidance. Please refer to Kevin Mitchell's statement for a timeline of the Care Inspectorate's activities.

39. The rights of people living in care homes were often little appreciated or taken into consideration, and this is the one area which continues to need further exploration and safeguards.
40. I declare that the contents of this statement are, to the best of my knowledge, true and accurate.

Personal Data

12 December 2023