Witness Name: Albert Heaney

Statement No: 1 in Module 2B

Exhibits: 195

Dated: 27/11/2023

UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF ALBERT HEANEY

I, Albert Heaney, CBE Prif Swyddog Gofal Cymdeithasol Cymru/Chief Social Care Officer for Wales, Welsh Government, will say as follows; -

Preface

1. The impact of the pandemic has been devastating. Devastating to those we lost to Covid-19, and to those who lost loved ones. Devastating to those who were unable to visit loved ones during their last days. Devastating for those who were unable to mourn the sad loss of friends or family, and devastating to those who lost their livelihoods and the ability to provide for their families. I understand the pain and sadness you experienced. I extend my deepest sympathies to those who have lost loved ones during the pandemic.

2. I would like to recognise the extraordinary dedication and unwavering commitment of my team here in Welsh Government who worked tirelessly during the pandemic to ensure the social care system was supported and that vulnerable lives were protected as best they could be.

3. I also extend my deepest gratitude to care service providers, everyone working in the care system, and to the volunteers who supported, for serving on the front lines of the pandemic and for their tireless commitment to providing support and comfort to our vulnerable and their families. Their dedication, commitment, and courage during a hugely challenging and unprecedented situation did not go unnoticed and will never be forgotten.

Background and qualifications

4. I am a career social worker and my qualifications across the social services and management disciplines include BA (Hons) Sociology with Professional Studies, Certificate in Qualification of Social Work, Certificate in Management Studies, Diploma in Management, Masters in Business Administration, and Certificate in using a Systemic Approach. Prior to joining Welsh Government, I worked successively as a social worker within a local authority social services department, as a manager in local authority social services, and as a statutory Director of Social Services for a local authority in Wales.

5. I was appointed to the role of Chief Social Care Officer for Wales in June 2021. In this role I am responsible for:
   i. acting as a strong voice for everyone working in the social care sector and providing impartial and informed advice to Welsh Ministers on priorities for change.
   ii. promoting esteem for all those in social care roles.
   iii. driving integration between health and social care
   iv. enabling people in receipt of social care to achieve their personal outcomes.
   v. reducing the numbers of children needing to be taken into care.
   vi. supporting innovative and social value models of service delivery.
   vii. developing new social care funding models.
   viii. promoting improvement and reform in social care.
   ix. supporting the wellbeing and development of the social care workforce.
   x. supporting local authorities and providers and improving quality and sustainability in social care.
   xi. delivering the intentions of the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016.
   xii. driving safeguarding arrangements and procedures to ensure the highest standard of practice.

6. I have worked in the public service since the 1980's having started work as a social worker, as well as undertaking positions including President of the Association of Directors of Social Services Cymru (ADSS Cymru), Lead Director for Children and Lead Director for Safeguarding and Prevention, ADSS Cymru, Chair of a Children's Safeguarding Board, and Corporate Director Social Services leading on Children's

and Adults Services. I am also a member of the Family Justice Board and Chair of the Family Justice Network Wales.

7. Prior to the pandemic, I was appointed initially to the role of Director for Social Services, Children and Families within the Welsh Government, a senior civil service level 2 post providing policy leadership over these two major policy areas, managing teams spread across several divisions to deliver policy in these areas, and serving as overall principal policy adviser to ministers on these topics. Due to a change in ministerial portfolios, policy responsibility for children and families subsequently transferred out of the directorate. At the commencement of the pandemic my role was as Director of Social Services and Integration ('SSID'), undertaking responsibilities as described above in relation to social care, health, and social care integration, and overseeing policy teams brigaded in three divisions. Shortly after the onset of the pandemic, from March 2020 until June 2021, I combined this role with the role of Deputy Director General, additionally supporting Dr Andrew Goodall CBE as Director General for Health and Social Services in his role at that time and being ready to act as Deputy as needed. This included representing the group on the Director General's behalf in key fora such as the Welsh Government Executive Committee (ExCo) and the dedicated Coronavirus-related sub-forum, known as ExCovid.

8. From June 2021 onwards I undertook the role of Chief Social Care Officer for Wales, maintaining the responsibilities of the role of Director of Social Services and Integration with an additional formal aspect of contributing personal expert advice to ministers on social care matters, providing a professional voice for the sector in government, and engaging on behalf of the Welsh Government with social care staff and other stakeholders.

9. With my oversight, management of normal business continued through the established divisional structures. In addition, I nominated a Deputy Director (Andrea Street) to oversee the directorate's Covid-19 response and directed a Covid Coordination Hub to be established, drawing in the first instance from staff already in the directorate. This hub ran in parallel with directorate structures for the duration of the period to which this statement relates. Importantly, under the hub was established a series of workstreams, running for various lengths of time. These workstreams, which were principally staffed by SSID staff alongside their substantive roles, allowed the directorate to play a role in a wide range of topics including food supply to care homes and vulnerable people, PPE, testing, vaccination rollout, communications,

care home visiting, and easements to relevant social care legislation. This structure changed as the pandemic progressed, with some workstreams (such as that on food availability) being stood down as systems were put in place or issues eased and others stood up (for example on vaccination).

10. The Hub also served to coordinate the flow of information into and out of the directorate relating to Covid-19, supported the recording of activity, and supported a regular 'drumbeat' of reporting (up to daily at certain times in the pandemic) to ensure that latest information was available to be acted upon. In addition, 7 days-a-week cover arrangements were put in place by the senior leadership team, under my leadership, to ensure prompt responses to urgent issues including over non-working days and drawing in wider directorate staff, as necessary. During this time, I also oversaw a moderate expansion in directorate staffing to go some way towards accommodating this new work.

Social Care in Wales

11. Social services in Wales are delivered by the 22 local authorities in Wales, as detailed in exhibit AGM2BHSSG01/6-INQ000000 of Andrew Goodall's statement. Statutory responsibilities for social care are vested in local government under the Social Services and Well-being (Wales) Act 2014 and the regulations and codes of practice made under the 2014 Act.

12. Social services encompass a wide range of services. Section 34 of the 2014 Act ('How to meet needs') provides examples of the kinds of services that may be provided under the 2014 Act, including:
    i. accommodation in a care home, children's home, or premises of some other type.
    ii. care and support at home or in the community.
    iii. services, goods, and facilities.
    iv. information and advice.
    v. counselling and advocacy.
    vi. social work.
    vii. payments (including direct payments).
    viii. aids and adaptations.
    ix. occupational therapy.

13. The 2014 Act requires local authorities, when exercising social services functions, to act in accordance with any relevant requirements contained in a code issued by the Welsh Ministers and to have regard to any relevant guidelines contained in it.

Overview of relationship with Welsh Government and key Individuals

14. On becoming the Chief Social Care Officer for Wales (CSCO), the role provided me with an additional scope to my then duties as Director of Social Services and Integration to provide a stronger voice for the sector, to reflect and learn from genuine experience of users of the services they engage with. I also took on the additional responsibility for promoting the workforce within and outside of government, the intention of the role being to align with the role of Chief Medical Officer who has a similar remit. The role would provide me with a platform for amplifying key principles, values, and aspirations around social care, including on co-production, prevention and early intervention, and multi-agency cooperation. Whilst much of this was part of my previous duties, the role as CSCO provides an independent voice. I remained responsible for advising ministers on matters related to social services and care, co-operation with local authorities and the third sector, partnerships with national bodies engaged in prevention and early intervention and with arrangements for services in Wales and legislation that supports these services.

15. My role during the period 21 January 2020 and 20 May 2022 changed in so far as I took on the additional responsibility of coordinating a response to the pandemic given the emerging impact on our communities and services. The main change was to consider Welsh Government's legislative powers in such a way as to enhance the ability to make vital decisions quicker, to ensure emergency action was properly coordinated and appropriately authorised, and increasing our work with our delivery partners to continue providing social services to those who needed them. As the pandemic progressed, I was particularly aware of the impact on communities especially diverse communities including Black, Asian, and Minority Ethic people.

16. A number of key individuals who provided support were Andrea Street OBE, Deputy Director Improvement, Alistair Davey, Deputy Director Enabling People, Anthony Jordan, Interim Deputy Director Inclusion and Corporate Business (November 2020 to April 2021), and Matthew Jenkins, Deputy Director Futures, and Integration.

17. Andrea Street's role was to act as a key link within SSID to wider Covid-19 structures across Welsh Government from March 2020 until June 2022. Alongside Andrea, a number of Covid-19-focused workstreams were stood up or evolved over the course of the pandemic:

- Care home visiting and engagement with Public Health Wales on guidance.
- Workforce capacity and well-being.
- Medicine administration for people receiving care at home and vulnerable people accessing pharmacists.
- Procurement.
- Social Care Coordination Hub.
- Coronavirus Bill – social care components.
- Safeguarding for children and adults.
- Children and young people policy.
- Advice and support for social care users, older people who live alone and/or self-isolate.
- Regulatory easements.
- PPE.
- Vulnerable people accessing food supplies.
- Hospital discharge liaison.
- Older people and carers.
- Modelling and monitoring (*formerly Social Care Surge Capacity*).
- Financial stability of the sector.
- The Workforce Payment Scheme.
- Testing.
- Care at home.

18. A copy of the Social Services and Integration COVID-19 workstreams organogram is exhibited at **AH/01-INQ000338685** and includes further detail such as timing of staff leading each workstream.

19. Further to this I had frequent interaction with a number of key individuals within the wider organisation over the course of the pandemic, including:

- Dr Andrew Goodall CBE, Director General, Health, and Social Services Group
- Sir Francis Atherton, Chief Medical Officer for Wales
- Dame Shan Morgan, Welsh Government Permanent Secretary

Initial response to the pandemic January – March 2020

20. On 29 January 2020 I first became aware of Covid-19 in an official capacity via early discussion at Welsh Government's Executive Directors Team meetings, attached as exhibit **AH/02–INQ000300083**. I was made aware of significant concern about the new virus, and this included the reasonable worst-case scenario, exhibit **AH/03-INQ000227250** refers. This highlighted the need for Social Care to be fully considered and factored into planning and preparation due to the sector dealing with many of the most vulnerable people in Wales.

21. On 6 February 2020 Welsh Government received a request from UK Government Cabinet Office to consider what additional legislative powers may be needed in relation to reducing or delaying a peak in the emerging virus. On 7 February SSID policy officials began considering this work and provided comments to the Health Emergency Preparedness Unit (HEPU) / Emergency Coordination Centre (Wales) (ECCW) Health. The following actions were requested:
    a. Review the existing clauses and comment on whether those clauses are still appropriate for a Reasonable Worst Case (RWC) in this outbreak.
    b. Review the discounted asks and fill in the table, commenting whether the ask may now be needed, or not, and if the previous reasons for discounting remain accurate.
    c. Report back on any additional asks or powers your department might want.

22. On 7 February 2020 my team highlighted the need to consider regulatory easements to ensure local authorities and service providers could prioritise their functions to continue to deliver care during the pandemic. As such, the directorate contributed to the Coronavirus Bill clause 14 regulations and guidance for social care. Details are exhibited in **AH/04-INQ000336237**.

23. Further early awareness of Covid-19 also stemmed from a 'lines to take' email issued on behalf of the First Minister on 11th February 2020, exhibited in **AH/05-INQ000336241**.

24. Following this, my team began preparing a summary of the situation across the social care sector in readiness for a Covid-19 preparedness discussion at the Welsh Government Civil Contingencies Group, held on 4 March 2020. This summary paper is exhibited in **AH/06-INQ000336263**.

25. Further examples of my directorate's early planning work in February 2020 included the repurposing of contingency planning arrangements that had been developed as part of our preparation for EU Exit. These arrangements were familiar to sector leaders and were repurposed quickly, and included:

- Letter issued to directors of social services entitled "Guidance for health and social care providers about health and social care workers who have travelled to China and other specified areas/countries," exhibited in **AH/07-INQ000336245**.
- Telephone conversations with social care sector leaders commenced, exhibited at **AH/08-INQ000336265**.
- SSID mailbox activated with links to ECCW health desk.
- Following my request through the Association of Directors of Social Services Cymru, for a nominated lead local authority director of social services, Alison Bulman, Corporate Director for Children and Adults at Powys County Council was confirmed to coordinate with the other 21 social service points of contact regarding contingency discussions, sharing good practice and intelligence regarding directly provided and commissioned services.
- Directors of social services reviewing their own contingency plans and raising awareness with their commissioned social care providers.
- Engagement with Care Inspectorate Wales (CIW) regarding service regulation and with Social Care Wales regarding workforce regulation.
- Commenced the drafting of guidance. The first of which, Guidance for social or community care and residential settings on Coronavirus, was published on 9 March 2020 and exhibited as **AH/09-INQ000336270.**

26. I recognised the need to ensure rapid communication mechanisms were in place to support the social care sector, and the Welsh Government as it identified the need

for a central coordination point which would have a specific health and social services group desk presence. Originally it was expected that this would take the form of the stand up of the Emergency Coordination Centre (Wales) (ECCW), however the final structure for coordinating this leadership and communication mechanism was the Planning and Response Group. This group was established to cater for the unique demands that arose as a result of a large and fragmented social care sector. The arrangements that were taken forward were the overarching Planning and Response Group for the Health and Social Care Group (HSSG) with a social care subgroup sitting as part of this which was supported by our Social Care Coordination Hub. I confirmed the arrangements specifically for the social care sector leaders. This ensured that sector partners, particularly directors of social services, understood when to contact the directorate with intelligence about impact on vulnerable people, or for information, advice, or support.

27. On 20 February 2020 HSSG Covid-19 Planning and Response Group met for the first time where key scientific advice, based on Scientific Advisory Group for Emergencies (SAGE) from 18 February 2020, was set out. The minutes exhibited here at **AH/10-INQ000310085** record that the duration of infectivity based on Pan Flu is that most adults are infectious for 5 days from onset of symptoms, children for 7 days and that "*some people can be infected, develop immunity, and have minimal or no symptoms but still may pass on the virus*". It also includes a recognition that the most effective way to limit spread in prisons is to reduce transfers between prisons. It was presumed that most health boards etc. had 10-14 days of PPE. Samia Edmonds, HSS Planning Programme Director; Rob Orford, Chief Scientific Officer for Health; Gill Richardson, Senior Professional Advisor, and the HSS Health Protection Advisor attended among others. It is minuted at §4 that social care did not currently partake in NHS Wales Shared Services Partnership (NWSSP) warehouse services.

28. On 3 March 2020 I received an email from the social services lead director (Alison Bulman) detailing the mechanism put in place with the Directors of Social Services (DOSS) across the 22 Local Authorities, confirming that DOSS had set up their battle rhythm to link to WG SSID and out to their citizens and therefore vulnerable social care services users, exhibited at **AH/11-INQ000336259**.

29. On 4 March 2020 I received an email from Gary Haggaty (Deputy Director Community Safety Division), exhibited as **AH/12-INQ000281647** providing detail on the Civil Contingencies Group (CCG) meeting held that morning. The CCG was to become

the Covid-19 Preparedness Group and this email attached the terms of reference. The new group was to meet at the ECCW. The message from the CCG meeting was the pace of work on Covid-19 needed to pick up.

30. On 6 March 2020, the Planning and Response Group held its first meeting, exhibit **AH/8-INQ000336265** refers. The meeting included external stakeholders, including local authority leaders. This meeting noted that although we were in the containment phase, we were moving to delay as transmission was in the community. I identified the fragile workforce in the social care sector as a concern. There were weekly calls to address business continuity concerns. Concerns were raised about: staff levels in the sector and the impact of isolation and school closures on staffing levels; PPE supplies; prioritisation of vaccination of the workforce; infection control protocols when a member of staff became infected; whether care home visiting should be stopped and whether hospital discharge should be expedited. The role of volunteers was also discussed and how they could contribute to domiciliary care and enable hospital discharge. On 9 March 2020, I provided a briefing to the Minister for Health and Social Care which set out that a preparedness and response social care group would be stood up to address the concerns mentioned above, exhibit **AH/14-INQ000336266** refers.

31. Further to this I set up the Social Care Coordination Hub within the directorate as a central point of contact with the sector leaders and with the ECCW. This hub supported the Planning and Response Group. A note of the 13 March 2020 meeting is exhibited at **AH/15-INQ000338684**.

32. The Social Care Stakeholder Communications Group was set up alongside the Planning and Response Group to ensure rapid communication of key messages with external and internal stakeholders including the Welsh Local Government Association (WLGA), Careers Wales, and Care Inspectorate Wales. The group also was also to seek feedback from these stakeholders during the rapidly changing environment. A note of the 8 April 2020 meeting is exhibited by way of example at **AH/16-INQ000338703**.

33. The Welsh Government's Guidance for social or community care and residential settings on Coronavirus was published on 9 March 2020. It is exhibited at **AH/09-INQ000336270**. This noted that: "*There is currently no good evidence that people without symptoms are infectious to others*." At section 9 it stated that if a staff member

or resident became unwell but had not been to specified areas in the last 14 days, then normal practice should continue. It stated at p12 that where a resident or a staff member has tested positive, PHW will conduct test, trace and protect.

34. On 10 March 2020 SAGE agreed that social distancing measures for the elderly should apply to those over 70 years old. At point 30 of the minutes SAGE advised that special policy considerations be given to care homes and various types of retirement communities (where residents are more independent). Following the SAGE meeting, a Technical Advisory Cell (TAC) advice for the Chief Medical Officer for Wales ('CMO(W)') (update 9) was prepared which identified the behavioural intervention of "*safeguarding of vulnerable groups and over 70s*" and stated that policy teams were working on policies associated with those interventions. That update is exhibited at **AH/18-INQ000336670**. TAC advice was primarily brought to my attention via my attendance at ExCovid and Executive Director Team (EDT) meetings where TAC representatives presented information or circulated papers via email. Any additional advice was conveyed to me, when needed, via the SSID workstream lead when they received information from the HSS representative who had attended the respective TAC meeting.

35. On 11 March Welsh Government's Technical Advisory Cell (TAC) met and a briefing for the meeting, exhibit **AH/19-INQ000336669** refers and states at p3 "*household quarantine and social distancing of vulnerable groups and over 70s is predicted to lead to a 37% fall in infection related deaths".* At p7 of the briefing it states in relation to social distancing of over 70s that *"policy would need to include rigorous infection control in care / nursing homes*".

36. On 12 March 2020 Care Inspectorate Wales ('CIW') was notified of the first suspected case of Covid-19 in a care home.

37. On 12 March 2020 I met with the First Minister, the Minister for Health and Social Services, and the Chief Executive of the NHS to discuss an announcement to be made by the Minister for Health and Social Services on hospital discharge which was to be made the following day. The written statement from the Minister was to detail a framework of actions which allowed for health and social care providers to make decisions that would enable organisations to make timely preparations for the expected increase in the number of confirmed cases of Covid-19. It included a range of measures such as to expedite discharge of vulnerable patients, the relaxation of

targets and monitoring across the system, the minimisation of regulation requirements, and the suspension of the right to choice of home in order to fast track care home placement. I exhibit the framework at **AH/20-INQ000252511**.

38. On 12 March 2020 CIW was notified of the first suspected case of Covid-19 in a care home.

39. On 13 March 2020, the Minister for Health and Social Services announced that there would be fast-track discharge of vulnerable patients from acute and community hospitals and their choice of home was to be suspended. The principle of not waiting in a hospital bed for a care home of choice was included in this guidance but had allowed certain timescales for this process to be completed. The purpose of suspending the guidance was to help ensure timely discharges during the pandemic and eliminate any delays related to care home choice, thereby ensuring hospital beds would be available to support a potential surge in hospital demand. The announcement is exhibited at **AH/21-INQ000226942**.

40. Also, on 13 March 2020 the Chief Executive of the NHS sent a letter to all local health board CEOs setting out the framework of actions. The letter is exhibited at **AH/22-INQ000182429**.

41. On 16 March 2020 CIW received its first notification of a suspected death related to Covid-19 (death occurred on 15 March 2020). CIW paused routine inspections to reduce burdens on local authorities and to reduce the risk of spreading the virus.

42. On 16 March 2020 I had a daily call with the Executive Directors, exhibit **AH/23-INQ000300091** refers, during which I emphasised that the care system was a major issue and that we needed to get food to vulnerable people. I had escalated my concerns with the Welsh Local Government Association, and we were having daily phone calls. They were very concerned in relation to PPE supply.

43. On 16 March 2020, the Supporting Covid-19 Planning and Response Cell became operational. **Name Redacted** (WG), Mary McKerrow (NHS Delivery Unit) and William Oliver (NHS Delivery Unit) redeployed to support Samia Edmonds (HSS Planning Programme Director), and the HSS Health Protection Advisor. The cell was accountable to Samia Edmonds. The purpose of the cell was to ensure that key actions in relation to the Planning and Response Group and sub-groups were

delivered as quickly as possible. Coordination and consistency were key. Included within its functions were:

- Providing links with the Department for Health and Social Care (DHSC), NHS England and PHE to support UK co-ordination, Engaging with PHW and Shared Services on key activities.
- Consider upcoming national plans and actions arising from COBR.
- Provide a mechanism for implementing Ministerial actions.
- Provide Ministerial briefings informed by NHS and Social Services contacts and group structure.

44. On 16 March 2020 TAC provided an update for the CMO(W) (update 10), exhibit **AH/24-INQ000337041** refers, following the SAGE meeting on 15 March 2020 stating that SAGE had decided to ramp-up testing capacity from 4,000 to 10,000 per day and that PHW expected testing capacity to reach 5,000 tests per day by 6 April 2020. Importantly, at §§ 2.1 and 2.2 it stated: "*Inpatient testing remains a priority. Within this, priority is given to ITU patients, followed by those with respiratory conditions and then key workers where capacity exists. It is desirable for testing to be expanded to the community, but testing capacity is limited and this is unlikely to be achievable at this point.*" At section 4, the update identified that social distancing of over 70s and vulnerable groups was a current behavioural intervention. It identifies the practical purposes as being "really high risk (e.g., underlying conditions, frail elderly)."

45. On 17 March 2020 I wrote to the Planning and Response Group exhibited at **AH/25-INQ000336289**, outlining the work that was being undertaken in social care in response to Covid-19 – this included: establishing the position on supply of PPE to the sector and developing guidance on the use of PPE in conjunction with PHW; publication of guidance on social, community and residential care settings, as exhibited above at **AH/09-INQ000336270**; and the development of a tool to track capacity in adult care homes to assist with hospital discharge.

46. Although by 18 March 2020 CIW had made a decision to suspend inspections in care homes, we were not in a position to prevent the movement of carers between care homes because of the pressure on the sector – care homes would not have had enough capacity to provide care and support to people, if we had prohibited the movement of carers between homes and we would not have been able to implement the discharge guidance. All of these decisions were difficult, multi-factorial decisions

that involved an assessment of evidence, risk and priorities. I was also particularly aware of the importance of balancing the need to protect with the system's ability to deliver care. During the pandemic I was often touched by, and I think emotionally grounded by, the heartfelt views of family members, compassionately representing their loved ones.

47. On 18 March 2020 the CMO(W) issued a public health link (CEM-CMO-2020-8) which set out the rationale for the prioritisation of testing. It stated that although a negative test did not rule out infection with Covid-19, it provided a basis for the early return of self-isolating health care workers. It set out 5 priority groups and group 4 was "clusters of disease in residential or care settings, for example long term care facilities and prisons", exhibit **AH/26-INQ000080850** refers.

48. Also, on 18 March 2020 I attended a meeting with the First Minister to discuss support for vulnerable people, exhibit **AH/27-INQ000336290** and **AH/28-INQ000336291** refers.

49. The same day I attended a Covid Core Group meeting with the First Minister, exhibit **AH/29-INQ000336350** refers. The CMO(W) informed us that the virus was probably circulating in the community – there were 136 cases in Wales and 2 fatalities. The CSA(H) advised that modelling suggested the UK was four weeks into the 'curve' and it was expected to be another eleven weeks before the spread of the virus peaked, whereas the NHS was four to five weeks away from maximum capacity.

50. A ministerial advice dated 18 March 2020 was sent to the Deputy Minister for Health and Social Services by SSID on the subject of non-legislative easements for social care providers and Regional Partnership Boards which is exhibited at **AH/30-INQ000144799**. The advice noted that CIW had suspended routine inspections and it contained recommendations to:
    a. Support a pragmatic approach by CIW and Social Care Wales to enforcement of the requirements around the workforce, including in relation to domiciliary care workers and other registered social care workers.
    b. Support a flexible approach by CIW to enforcement of the submission deadline for provider annual reports (26 May 2020).
    c. Not seek to enforce the statutory requirement on Regional Partnership Boards to submit annual reports to Welsh Ministers by 30 June 2020; and
    d. Determine not to claw-back Integrated Care Funding (ICF) in cases where ICF events and activities are cancelled, thus generating small underspends.

51. On 19 March 2020 I sent a letter to all directors of social services on the issue of PPE, exhibit **AH/31-INQ000336302** refers. I advised that PPE was to be worn by social care staff providing direct personal care to someone with symptoms of Covid-19. No PPE was to be used where a care receiver was asymptomatic. Certain levels of healthcare required higher levels of PPE because they were undertaking aerosol generating procedures. PPE could be accessed from local health boards where urgent assistance was needed. That arrangement would be superseded once the Welsh Government had implemented arrangements for the delivery of PPE directly to social care providers.

52. On 19 March 2020 (published 21 March 2020), the Minister for Health and Social Services announced in a written statement, exhibit **AH/32-INQ000383574** refers, that the country was in the delay phase and that the Welsh Government was ensuring the supply of PPE for distribution in social care settings the free provision of PPE to all social care providers. If PPE stock could not be accessed while the Welsh Government was preparing to distribute PPE stock to local authorities, arrangements had been made that care providers could approach local health boards for urgent assistance. I followed this up with a letter to care providers, which I exhibit at **AH/41-INQ000336310**, stating that limited PPE was available to care providers from a central contingency supply for health and social care and that it was important to follow PPE guidelines in order to preserve supply for the more necessary uses. The annex states that any service users with possible Covid-19 infection should be isolated in their own room. The agreed guidance sought a balance between the limited supply of PPE and the infection risk in such a way that infection could be reduced via the use of PPE in the provision of care for symptomatic individuals where it would have been clear that the virus was present, whilst reducing the use of scarce PPE used for the care of those who did not have symptoms and may not have had the virus at that time. I continued to support the drive to increase PPE stocks which eventually made PPE available for both symptomatic and asymptomatic care.

53. During this time, I was being kept up to date by my directorate on the actions that were being taken to manage the supply of PPE in Wales, exhibit **AH/33-INQ000336294** refers.

54. On 20 March 2020 there was a meeting of the Social Care Planning and Response Group. This meeting noted that there was limited testing capability, which would

increase from 800 to 5000 per day as of 1 April. It noted that healthcare and social care workers were to be prioritised. There was an action that SSID were to discuss testing for patients discharged from hospital. The note of this meeting is exhibited at **AH/34-INQ000338491**.

55. On 22 March 2020 I received an email forwarded by my team regarding a case of a care home expressing concerns around accepting patients from what they termed a "Covid-19 hospital" who were not displaying any symptoms of Covid-19. The care home felt that in order to protect its current residents, new residents should either be isolated or tested. They also expressed concern that no testing was currently available to staff who were ill. I responded that day detailing that PPE should be used when patients who are positive for Covid-19 are discharged from hospital to a care home and that testing was not available due to the limited capacity at this stage. I noted that testing capacity would increase at the beginning of April exhibit **AH/35-INQ000336323** refers. I followed up this email on the next day, 23 March 2020, advising that residents would need to self-isolate, and that PPE should be worn when dealing with confirmed or suspected cases of Covid-19, exhibit **AH/36-INQ000336324** refers.

56. On 22 March 2020 I attended a meeting between the First Minister and the Minister for Health and Social Services, exhibit **AH/37-INQ000336319** refers. It was agreed, inter alia, that the advice on visits to social care settings needed to be clarified. I then wrote a letter to care homes on the restriction to essential visits only which I exhibit at **AH/38-INQ000336332**.

57. On 22 March 2020, a ministerial briefing was drafted by the HSSG Covid-19 Planning and Response Group and is exhibited at **AH/39-INQ000300089**. It set out the structure of the organisation and identified 24 temporary actions taken by the group, including ensuring clarity on testing of health and social care workers and ensuring supply of PPE to care home staff, which was to be done by 23 March 2020 – in the meantime there were mutual aid agreements in place between local authorities.

58. The first Wales-wide supply drop of PPE was made 23 March 2020. A logistics assessment of all local authority distribution points was undertaken over the Easter weekend by military staff as part of Military Aid for Civil Authorities (MACA) to ensure effectiveness and a data collection system put in pace for local authorities to report product use and need.

59. On 24 March a member of my team brought to my attention some feedback from the Northeast Wales Joint Equipment Store related to issues with the standard and quantity of PPE being delivered to care providers. My team responded to these concerns indicating that WG were continuing work to address the issues and that a process had been set up where PPE would be delivered to community equip stores for distribution out to care providers, exhibited at **AH/42-INQ000336330**.

60. The same day, I was notified that no progress on testing patients on discharge had been made and that my team were working with PHW to issue a letter setting out care homes open for business supported by HB and PPE, with the current best advice being that people should remain at their home or return to their home when living in care homes in Wales rather than attend or stay in hospital exhibited at **AH/43-INQ000336335** and **AH/44-INQ000338813.**

61. On 25 March 2020, the Minister for Health and Social Services made a statement, exhibit **AH/40-INQ000299063** refers, indicating that work was being done to ensure that PPE was available for the social care sector. Arrangements were put in place whereby care providers could obtain PPE from local health boards. He also stated that if neither the social worker or the service user were symptomatic, no PPE was required over and above normal good hygiene practices.

62. On 27 March 2020, a ministerial advice (MA/VG/1136/20), exhibited at **AH/45-INQ000136770**, was submitted to the Minister for Health and Social Services attaching the Welsh National Covid-19 Test Plan, exhibited at **AH/46-INQ000253543**. It stated at §2 that one of the six workstreams was scaling of testing for patients, vulnerable groups and front-line staff. The lead for that work-stream was PHW. The fourth work-stream was point of care testing to control future outbreaks in, amongst others, care homes. This document also referred to using the Secure Anonymised Information Linkage (SAIL) databank to inform policy.

63. On 28 March 2020 Darren Millar AM sent an email to Tracey Cooper, PHW regarding routine testing of new residents prior to admission to care homes, I exhibit the email thread as **AH/47-INQ000336344**. Tracey Cooper replied on 29 March 2020 stating:

> "*New residents should similarly be assessed for signs or symptoms of COVID-19 infection and those affected isolated as appropriate. If new residents (or existing residents) do not have any symptoms prior to*

admission, there is no value in testing for the presence of the coronavirus. The test is designed for patients with symptoms and therefore we don't routinely test new residents prior to admission."

64. Also on 28 March the Minister for Health and Social Services provided a further statement on PPE supplies in which he confirmed that further deliveries of PPE were made on Monday and Tuesday of that week to the local authority joint community equipment stores for directors of social services to distribute within the local care sector.

65. On 30 March 2020 during the daily call with Executive Directors, exhibited above at **AH/23-INQ000300091**, we discussed PPE as an important issue. I expressed concern at the lack of testing for social care colleagues.

66. On 31 March 2020, the Deputy CMO(W) advised by email that Welsh Government guidance on discharge from hospital to care homes did not need to include a requirement for testing before discharge. The policy lead for care home inspection and regulation sent an email in which she expressed frustration at the delay on the part of PHW in providing their input into the guidance and referenced the fact that I had met with PHW the previous day to discuss the issue. I exhibit the email thread at **AH/48-INQ000336353**.

67. On 31 March 2020 during the daily call with Executive Directors, exhibited above as **AH/23-INQ000300091**. I raised concerns about PPE in domiciliary care and I was pushing hard for testing in the sector.

68. A Working group was put in place at the end of March 2020 to consider financial viability of the sector and to plan for care provider sustainability during the early phase of the pandemic to ensure business continuity. I exhibit at **AH/49-INQ000336347** an example email from the group. This group was necessary because we had to work through difficult issues relating to private sector funding, with some care homes running on a 90% break even rate and are not financially resilient. I exhibit at **AH/50-INQ000136775** an MA submitted to the Minister for Health & Social Services outlining a proposal to meet the initial additional financial costs of the Covid-19 outbreak for adult social care providers.

69. On 1 April 2020 I released a video message[1] to social care workers, in anticipation of the challenge to the workforce, to thank existing social care workers, to seek workers on the social care register who could undertake more hours and encourage retired workers to return to assist in the pandemic response.

70. On or around 3 April 2020 a TAC briefing for the CMO(W), exhibit **AH/51-INQ000336398** refers, stated that social care modelling was being undertaken, which included staff sickness, demand, and increased turnover of people in care homes.

71. Also, on 3 April 2020 the Social Care Planning and Response Sub-group met to discuss the issue of PPE. I exhibit at **AH/52-INQ000336366** the agenda and briefing for the meeting.

72. On 3 April 2020, a ministerial advice was submitted to the Minister for Housing and Local Government asking for approval for a number of activities (principally funding) to accelerate hospital discharge and decelerate hospital admissions. The advice is exhibited at **AH/53-INQ000097622**.

73. On 3 April 2020 I received a written advice from the DCMO(W), exhibit **AH/54-INQ000336377**, in response to a request for advice made by the Minister for Health and Social Services following a meeting with local government, during which concern was expressed that there was community transmission and care workers were not being prioritised compared to the NHS. The advice was that the risk to care homes workers was likely to be less than in hospital because residents were self-isolating and visitors were banned and that steps had been taken to ensure that all care homes had access to PPE if they had a resident who had tested positive for Covid-19. Inappropriate and/or unnecessary use of PPE would mean that there was less for other purposes.

74. On 6 April 2020 TAC met, exhibit **AH/55-INQ000310045** refers, and considered the Welsh interim guidance on testing of key workers which updated and extended the existing policy on testing of NHS workers (CEM/CMO/2020/8). The interim guidance, exhibited at **AH/56-INQ000336392**, was expressly limited to testing of symptomatic key workers and expanded testing to include police and social care staff in a residential care setting. Its purposes were identified as: (i) to enable key workers who have tested negative to return to work within the 14 day isolation period for business

[1] https://twitter.com/WGHealthandCare/status/1245380543929364481

continuity purposes (noting also that if a key worker was isolating because a household member was symptomatic, they could return to work when the symptomatic household member tested negative); (ii) to identify employees and places of work where Covid-19 positive staff may have infected patients, shielding individuals and vulnerable people; (iii) describe the process of scaling. It noted that whilst testing capacity was being ramped up, it was dependent upon the availability of kits and other supplies in relation to which there was international competition for procurement. It also advised that a report should be made under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ('RIDDOR') where an unintended incident at work led to someone's possible or actual exposure to Covid-19 which should be reported as a dangerous occurrence, or where a worker has tested positive and there is reasonable evidence that it was caused by exposure at work. The responsibility was put on local resilience fora to ensure that persons who met the requirements of the policy were notified of its contents.

75. On 7 April 2020 the Welsh Government discharge guidance was published and is exhibited at **AH/57-INQ000227334**. The main points that emerge from the document are:

- Acute and community hospitals were to discharge patients as soon as it was clinically safe to do so.
- The existing Welsh 'Discharge to Recover then Assess' model was adapted for the pandemic.
- Local community co-ordination hubs were established, and a care and support capacity tool went live.
- Multiple contacts for patients were to be minimised, and there was to be implementation of reciprocal arrangements for delegated tasks between health and social care staff e.g., simple nursing tasks were to be undertaken by care staff.
- If applicable to the patient, Covid-19 test results were to be included in discharge information and forwarded on if not available at the time of discharge.
- Further guidance on the care of patients being discharged to care homes was also published.
- Organisations were to consider alternative transport options such as volunteers and taxis.

- The requirement to carry out Continuing Health Care ('CHC') assessments was suspended and generally Local Health Boards ('LHBs') were to retain responsibility for organising, funding, and providing care as part of the discharge arrangements. However, the local authorities ('LAs') and LHBs were to work co-productively and consider joint packages of care or pooled funds – provided it did not delay discharge.

76. My team within SSID were involved in discussions with the Deputy CMO(W) in relation to the discharge of patients from hospital into care settings, such as care homes, with the Deputy CMO(W) providing final sign off for policy decisions.

77. Also, on 7 April 2020 the Minister for Health and Social Services made a written statement on testing. I exhibit that statement at **AH/58-INQ000182397**.

78. Also, on 7 April 2020 there was an exchange of emails between the head of care homes inspection and regulation policy and Deputy Director Andrea Street in relation to PHW, raising the delay in the sending of the letter from the CMO(W) and I. I exhibit the email exchange at **AH/59-INQ000336384**.

79. On 8 April 2020 I attended the Covid-19 Core Group, exhibited at **AH/60-INQ000311826**. Cases were rising and the spread was east to west and south to north. Progress continued on increasing testing capacity for health and social care workers. The peak was expected in 2 – 3 weeks' time. All shielding letters had been issued. Childcare cover and school meal vouchers were now available in all local authorities. Discussions on the delivery of food parcels were ongoing with the Minister for Environment, Energy and Rural Affairs. There was concern about the number of cases in care homes which was causing anxiety amongst care staff - PHW were providing support and it was agreed that officials would consider how to strengthen messaging. Local authorities had received additional supplies of PPE.

80. Also, on 8 April 2020 I attended an Executive Directors Team meeting, exhibited as **AH/61-INQ000222841**. I noted that on PPE supply there was pressure from local government and private providers. A supply drop was being made that day and the next. The military had been consulted on logistics. PHW advice was proving challenging. CIW were probing us for clarity on our policy.

81. On 8 April 2020 I met with the Older People's Commissioner for Wales. My briefing for the meeting is exhibited at **AH/62-INQ000338306**.

82. On 8 April 2020 PHW published 'Admission and care of residents during Covid-19 incident in a residential care setting in Wales' (commissioned by Welsh Government) which clarified that those who would be tested were: those in critical care with pneumonia, Acute Respiratory Distress Syndrome (ARDS) or flu like illness; all other patients requiring admission to hospital for those illnesses; and where an outbreak has occurred in a care setting. This guidance stated that "*negative tests are not required prior to transfers /admissions into the residential setting*." It stated at §2: "*some of these patients may have Covid 19, whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home of this guidance is followed*." Margaret Rooney (Deputy Chief Inspector, CIW) and the Head of Care Home Inspection and Regulation Policy made draft comments on this guidance, exhibited as **AH/63-INQ000336379** and **AH/64-INQ000336385**. PHW were reluctant to issue this guidance because it touched upon issues of PPE supply, so I was to determine that matter, exhibited as **AH/65-INQ000336393**. In the event, it was signed off by the CMO(W), exhibited as **AH/66-INQ000336397**, notwithstanding the concerns raised by CIW.

83. On 9 April 2020 the CMO and I wrote to the sector to share the discharge guidance, exhibit **AH/67-INQ000338279** refers. We noted that since 1 April 2020, local government had an established process to manage the prioritisation and referral of social care workers for testing. It covered both local authority social care staff and staff employed by commissioned providers who were symptomatic. The letter also stated that any staff member showing symptoms was to self-isolate for 7 days.

84. Also, on 9 April 2020 ministerial advice (MA/VG/1284/20) and exhibited as **AH/68–INQ000252566** was submitted to the Minister for Health and Social Services on testing criteria for key workers- NHS and non-NHS. At §6 it identified the identification of workplaces where Covid-19 positive staff may have infected vulnerable individuals as one of the purposes of developing testing criteria within the rubric of the national testing plan. The policy was to prioritise resources for social care staff. The timeframe for operational delivery was 6 April – 20 April.

85. On 10 April 2020 the Minister and Deputy Minister for Health and Social Services asked for a note to be prepared for Care Forum Wales and Care Inspectorate Wales

providing clarity and reassurance around the testing of patients leaving hospital and moving into care homes and reiterating that tests were available for staff, exhibit **AH/69-INQ000336400** refers. PHW had reiterated that the policy was not to test asymptomatic patients. This led to a joint letter from the CMO(W) and myself being sent to Care Forum Wales, exhibited at **AH/70-INQ000336404**, which stated that symptomatic social care workers were being prioritised for testing. The Welsh Government was working to rapidly increase testing capacity.

86. On 10 April 2020 TAC met, exhibited at **AH/71-INQ000313229**, and noted that Brendan Collins SSID had been asked to model deaths in care homes. Office for National Statistics (ONS) and Care Inspectorate Wales (CIW) were collecting data as well as PHW. TAC considered the CMO's discussion paper for the Recovery Plan in Wales v.0a. At §8 it stated: "*It should be noted that any lifting of interventions put in place to increase social distancing in the UK are based on multiple assumptions. These include…transmission is possible from mild and even asymptomatic cases*". The point is repeated at §11a. I exhibit the paper at **AH/72-INQ000215241**.

87. On 11 April 2020 ministerial advice (MA/VG/01250/20) and exhibited as **AH/73-INQ000336389**, was submitted to the Minister for Housing and Local Government, the Deputy Minister for Health and Social Services, and copied to the First Minister, on additional funding for local authorities to meet adult social care costs (£40 million from the Covid-19 response reserve). Costs were increasing because of (i) the number of new residents who were thought to require more care than those whose needs were known and (ii) the high incidence of illness amongst staff (10-35%) which meant that further staff were required / back fill agency staff were being used. §3.1 of the advice referred to data analysis carried out by CIW which demonstrated that the incidence of Covid-19 amongst adult service users was rising, in parallel with other services as of 31 March 2020. It stated that Analytical Services Covid-19 Hub (established on 24 March 2020) had been supporting social care data analysis. This data was collected by the Hub on 3 April 2020 using notifications to CIW of confirmed or possible cases. §3.8 of the advice stated that social care had a clear role to play in enabling efficient hospital discharge. This issue had been discussed in Star Chamber on 3 and 8 April 2020. Both the Minister and deputy Minister for Health and Social Services provided their consent to this proposal by email on 13 April 2020.

88. On 14 April 2020, the Minister and deputy Minister for Health and Social Services issued a joint statement announcing a £40 million package for adult social care

providers. I exhibit the cleared press notice at **AH/74-INQ000336408,** and the Ministerial Advice as exhibited above at **AH/50-INQ000136775.**

89. Also, on 14 April 2020 I attended a meeting with the Chair of Care Forum Wales, exhibit **AH/75-INQ000336409** refers. There had been steady progress on testing and PPE which had increased confidence and resilience in the sector. More clarity was needed on statutory sick pay and shielding.

90. On 14 April 2020 TAC briefing for the CMO(W), exhibited at **AH/76-INQ000220420**, identified at p4 that the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) had produced a paper which noted that facemask use by vulnerable adults for short periods of exposure may be reasonable given that it would lead to a small incremental increase in protection. It also referred at p4 to another NERVTAG paper 'Duration of infectiousness following symptom onset in COVID' which recommended: "*Particular caution should be exercised in Covid-19 patients discharged from hospital to nursing homes, homeless shelters, or other institutions where there are vulnerable individuals.*" At p5 it noted the SAGE advice that there were three distinct parts to the epidemic: community, hospitals and social care, with a different pattern of transmission in each. It stated that there was insufficient data around cause of death in care homes to estimate R in that setting although the number of outbreaks in care homes was almost certain to be increasing. The table at p8 identified an excess death category as being related to additional pressures on the health and social care system but the mitigation identified related to health only – it said nothing about the social care system. On p13 it noted that 87% of Covid-19 related deaths took place in hospital, 6% Care Homes and 6% took place in private homes.

91. On 15 April 2020 I attended the Covid-19 Core Group meeting, exhibit **AH/77-INQ000336472** refers. We were told that 81 care homes had reported Covid-19 infections. PPE supplies had been delivered to councils the previous day. There would be further discussions on the delivery of food parcels to vulnerable people.

92. On 15 April 2020 I attended a ministerial meeting on social care, exhibit **AH/78-INQ000336415** refers. The meeting discussed the issues in relation to PPE and testing capacity. There had been a drop in the number of safeguarding referrals to children's services. It was noted that very few vulnerable children were attending school and the definition was being reviewed. Care Forum Wales and Care

Inspectorate Wales raised concerns about the discharge from hospital to care homes policy and testing. The fall in domiciliary care packages was also discussed and the need to review the guidance was identified to avoid disabled people losing their rights and entitlements. A consolidated list of actions was agreed to address the issues in social care, including: £40m in emergency funding; access to food supplies for vulnerable individuals; consideration by CMO(W) of testing on discharge from hospital; consideration of regulations on care home visitors.

93. On 15 April 2020 policy officials conveyed a message to PHW that the CMO and I wanted a revised approach to testing to include testing on hospital discharge and more general testing for care home residents and staff so PHW guidance would need updating. This message is exhibited at **AH/79-INQ000336416**.

94. On 17 April 2020 WG officials attended a meeting with PHW regarding testing / discharge to care homes. This noted that the English guidance issued on 15 April 2020 included a policy of testing all residents prior to admissions to care homes. The NHS was responsible for testing in advance of a timely discharge. Where a test result was pending, the resident would be transferred but isolated just as a Covid-19 patient would be (presumed positive). It was agreed that PHW and SSID would work with local partners to ensure that there was proactive follow up and summary reporting (to be defined) of information / epidemiology for care homes at local and national level. The CMO(W) and I instructed officials to ensure testing of all patients prior to discharge from hospital to a care home setting. I exhibit a note of this meeting at **AH/80-INQ000336421**.

95. Also, on 17 April 2020 ministerial advice was submitted to the Minister for Health and Social Services, exhibited at **AH/81-INQ000336423**, reflecting the advice of PHW that there should not be an over-reliance on testing results on discharge from hospital because a patient who tested negative could still develop the condition. The proposal was to caveat the negative test with a requirement to self-isolate.

96. On 20 April 2020, new Daily Situation Report (SITREP) arrangements were put in place. Alongside these new reporting arrangements an additional task and finish group was established to support closed environments such as social care (and included other closed environments such as prisons). The Social Care Sub-group chaired by myself reported that military liaison officers had been deployed to social care settings to assist with and review flow of PPE. The testing arrangements for staff

were to be scaled up to reach 200 tests a day. An agreed approach to implement the new PPE guidance was to be established to include input from ECCW, PPE Cell and NHS Shared Services Sub-group. Prior to the introduction of military liaison officers to assist in the flow of the PPE, we were working on a system to supply PPE out of the distribution centres and then out to the care sector, the process of which needed some refinement. Thus, bringing in the military liaison officers, we were able to utilise their expertise and skills when it came to logistical planning. The idea was to have the military go in and review what we were doing and how we could better this process, using their expertise we were able to ensure that the supply chain of PPE continued.

97. On 21 April 2020 the TAC briefing, exhibited at **AH/82-INQ000336442**, for the CMO(W) stated at p10 that the percentage of deaths in care homes had risen sharply to 14%. It stated at p15 that there was a lack of data on the pattern of infections in care homes and so it was very difficult to understand the dynamics of Covid-19 in social care. It further noted that there was evidence of continued growth in care homes and an estimate of 90% of care homes experiencing outbreaks could not be ruled out. It also noted at p17 that any testing strategy should be targeted at those of highest risk.

98. On 22 April 2020 I attended a Covid-19 Core Group meeting, exhibited as **AH/83-INQ000311833**. The rate of transmission had stabilised which demonstrated measures were working. However, there were high transmission rates in closed settings, such as care homes. There were still concerns about the supply of PPE, testing and the control of the disease in care homes. Social care staff were the second priority for testing. Supply of PPE to local authorities had improved – but they were supplying private care homes. There had been engagement with PHW over infection control in care homes.

99. On 22 April 2020 I sent a joint letter with the CMO, exhibit **AH/84-INQ000336444** refers, confirming that testing would be undertaken before hospital discharge and guidance would be updated to reflect the discharge pathways for all patients due to be admitted into care homes.

100. I was aware that during March 2020 there was a real risk of the NHS in Wales becoming overwhelmed so initially the priority was to manage the capacity of the NHS at a time when there was insufficient testing capacity to test all patients being

discharged – the testing capacity that was available had to be focussed on the NHS and symptomatic patients. At this time some robust dialogue was needed to ultimately make the case that social care needed to be of equal priority in terms of access to testing.

101. However, it became apparent that due to the high level of risk of transmission in care homes, and the high degree of vulnerability of care home residents, it was imperative that we stepped up testing of staff and carers. The risk of the NHS in Wales becoming overwhelmed receded during April 2020 and the priority afforded to the social care sector increased.

102. On 23 / 24 April 2020 PHE shared the results of a survey of care homes (Easter 6), which indicated asymptomatic transmission, with NERVTAG. It noted growing international evidence of asymptomatic transmission of COVID-19 in care homes and recommended that all symptomatic staff be tested and isolated; all routine visits be stopped; and all new admissions or transfers back to care homes from hospital or the community be tested. This was shared with the Covid 19 Planning and Response Group on 24 April 2020.

103. On 24 April 2020 the CMO and I wrote to Health Boards, Chief Executives, Medical Directors and Directors of Public Health, exhibited at **AH/85-INQ000336460**, about mitigating the risk of the introduction and spread of COVID-19 in care homes. Our letter stated:

> *"All individuals being discharged from hospital to live in care homes regardless of whether or not they were admitted to hospital with Covid-19 must be tested for the virus. People who are being transferred between care homes and any new admissions from the community must also be tested for Covid-19. Discharge, transfer or admission will not take place until the result of a Covid-19 test is available and has shown to be negative.*
>
> *We are issuing updated Welsh Government guidance to reflect these changes - COVID-19 Hospital Discharge Service Requirements (Wales) and Guidance for stepdown of infection control precautions and discharging COVID-19 patients. Public Health Wales will also be updating its guidance on the Admission and Care of Residents during COVID-19 in a Residential Care Setting in Wales...*

Health Boards and Trusts need to ensure that systems are in place to sample / test individuals 48 hours before planned discharge from hospital and to ensure that resources are in place to enable sampling of care home residents or those in the community with planned admissions / transfers to care homes."

104. Also, on 24 April 2020 the head of care home inspection and regulation policy SSID sent an email to PHW, exhibited at **AH/86-INQ000336445**, chasing guidance for residential settings as I felt it was required urgently and to include global testing of residents and to ensure that staff testing was addressed.

105. On 28 April 2020, the TAC briefing, exhibited at **AH/87-INQ000336466**, for the CMO(W) stated that modelling had been carried out for discharge from hospitals to social care settings.

106. Also, on 28 April 2020 CIW advocated for testing of all residents and staff in care homes whether symptomatic or asymptomatic. Prior to this, on 22 April 2020, CIW met with Welsh Government and PHW to discuss testing of the social care workforce. Following this on 24 April 2020, CIW emailed WG policy colleagues to advocate regular testing for all care home residents and staff whether they are symptomatic or not and on 29 April 2020, CIW were sent an invite from the WG testing team to join an officials' group on testing policy including critical workers. The next day CIW contacted the WG testing team to share feedback from providers about difficulties with testing processes and CIW offered to support testing for care home staff on 1 May 2020, exhibit **AH/88-INQ000338307** refers.

107. On 28 April 2020 I was copied into an email exchange with the Deputy Minister for Health and Social Services sending the updated guidance on the provision of community care, following the concerns that had been discussed at the ministerial meeting on social care, exhibit **AH/89-INQ000215341** refers, which the Deputy Minister approved the following day, making it clear that the modifications to the duties should only be exercised 'as a last resort'.

108. On 28 April 2020 at the daily call of Executive Directors, exhibited above as **AH/23-INQ000300091** I expressed my concern for care homes in relation to testing. It was important that the science and international learning was used in policy decisions.

109. On 29 April 2020, following the letter I sent jointly with the CMO 24 April 2020 (as previously exhibited) the Welsh Government published updated guidance on

discharge arrangements, namely the 'Additional step-up and step-down Guidance', exhibited at **AH/90-INQ000081080** together with an updated flowchart. The flowchart made it clear that a negative test was required before discharge to a care home. My team assisted with ensuring SSID input into this guidance. The key points from the guidance were:

- A patient could be discharged back to a care home where they had received a negative test and isolated for 14 days.
- The care home had to consider whether they could practically implement isolation, the risk to other service users and whether there was a confirmed Covid-19 outbreak.
- For those who were positive for Covid-19 in hospital or tested positive prior to discharge, they were to isolate for 14 days in a community hospital prior to admission to a care home.

110. On 29 April 2020 I attended the Covid-19 Core Group meeting, exhibit **AH/91-INQ000311831** refers. The CMO(W) reported that the transmission rate had reduced significantly which demonstrated that the lockdown measures were effective. There was evidence that people were becoming dissatisfied with restraints and there was developing evidence of hidden harms – people were not accessing usual health services. CMO(W) was still of the view that facemasks were of marginal value – it created mixed messaging and people with mild symptoms may decide to use masks rather than self-isolating. It would also divert supplies away from health and social care. If it was safe to lift the lockdown, facemasks were not needed.

111. On 30 April 2020 at the daily call between the Executive Directors, exhibit above **AH/23-INQ000300091,** it was noted that there was a lot of agitation in the social care sector on the issue of testing and that a decision was required. Discussions had been held with local authority chief executives and leaders. It would be necessary for PHW to change their plan of action on the back of advice that was being drafted. The First Minister and Minister for Health and Social Services were expecting a change in the approach to testing in the social care sector. I reiterated the view that I had previously expressed that more needed to be done to support the care home sector.

112. On 30 April 2020 a ministerial advice was submitted to the Minister for Health and Social Services, exhibit **AH/92-INQ000336476** and exhibit **AH/93-INQ000336479** refer and were copied to the First Minister. The advice noted that there was evidence

that community transmission of Covid-19 was reducing in general, but the care sector was seeing a large number of cases and outbreaks. 40% of care homes (422 in total) had reported cases or outbreaks of Covid-19; some of those outbreaks had been associated with high mortality rates. It noted that it was generally accepted that individuals may be infectious to others for up to two days prior to onset of symptoms and there was some evidence of asymptomatic transmission.

113. At §5 it identified the current testing policy in care homes as the testing of all individuals discharged from hospital and extending the testing to people who are being transferred between care homes and new admissions from the community. Individuals due to be discharged from hospital or transferred to a care home but who test positive were to be provided with appropriate step-down care in local settings, such as community hospitals. At §7 it stated that environmental health officers were working in partnership with social service colleagues, PHW, LHBs and CIW. 132 were now providing direct support to care homes in Wales. They were maintaining regular or frequent contact based on need and working with those who have not reported cases to ensure mitigation is being put into effect. At the time Scotland had no plans to expand their care home testing but England were blanket testing. §12 set out that the safety and protection of the most vulnerable had been central to WG response: "People living in care homes and other similar settings will be amongst the most vulnerable, with many relying on close personal care "At §13 it stated that although community transmission was reducing in care homes there was a large number of cases and outbreaks – 40% of care homes had reported cases or outbreaks with some association with high mortality rates. §16 dealt with the impact of asymptomatic residents and stated that it was generally accepted that individuals may be infectious for up to two days prior to the onset of symptoms and that there was some evidence that asymptotic patients were a source of infection, referring to a pilot carried out by PHE which found that 75% of residents in an outbreak were positive but 25% were symptomatic. The advice stated at §20:

> "*Modelling suggests that we would need to 25000 extra tests per week for care homes to be able to test all residents – that doesn't include care home workers. In the longer term, in line with plans to expand testing and more resources become available to us in Wales we will adapt our policies. We will continue to have to make choices about how we use our testing capacity even as that capacity increases. Inevitably that means trade-offs, for*

example the more tests we undertake in care homes the fewer tests available for surveillance. If we do not have sufficient surveillance capacity to give us close to real time information on the transmission rate we may not be able to respond in a timely manner and prevent the spread of the disease and in a worst case the curve going exponential. What we are not able to do at this point is model that trade off to know where the tipping point might be."

114. It further stated that expanding testing to asymptomatic individuals still lacks the evidence base to support this being the best use of testing capacity. The evidence instead points to testing people who are symptomatic, isolating them until the tests come back and if they are positive, assuming everyone in the closed system is positive. If we test people who aren't symptomatic too soon then there is a risk of a negative result and creating a false sense of security. It recommended targeted testing of care homes where there was an outbreak (which would include asymptomatic residents and staff). At §21 it stated that WG and PHW agreed that testing of asymptomatic care workers would help to prevent infections in care homes. At §25 it stated: "we know that there is not enough testing in care homes, that the referral process has been too slow, and more support is needed".

115. The policy was intended to strike a balance between an evidence-based approach and a risk-based approach - see §18. Doing nothing was not an option. Expanding testing to asymptomatic individuals still lacked an evidence base to support the best use of testing capacity with the evidence still pointing to testing those who were symptomatic and those who had been in close proximity with them. The best result in care homes did not reside in testing alone but rather on a package of measures which included, but went beyond, testing - see §24. The policy proposed thus included testing all on discharge from hospital to care homes and clear guidance for care homes on environmental and hygiene measures.

116. The First Minister's approval was confirmed by email dated 1 May 2020.

117. In a departure from England, it was not agreed that residents would undergo asymptomatic testing. Evidence suggested that the greatest risk of infection was from staff who were living and circulating in the community then entering care homes to work. Residents themselves were at low risk of brining the virus into the care home themselves. Given the intrusive nature of the testing (which was especially difficult

for residents with dementia) it was agreed to only undertake resident testing in care homes where there was a known outbreak.

118. On 1 May 2020 TAC met and the minutes, exhibited at **AH/94-INQ000336668**, record that the Welsh Government Office for Science shared a paper on testing in care homes. SAGE had set up a testing in care homes subgroup. It was agreed that the Child Health Senior Medical Officer would link with the SAGE sub-group at a policy level on testing in care homes and feedback. Testing in London care homes had shown asymptomatic residents who tested positive went on to spread the virus. Testing in care homes was considered by the meeting to be useful as an intervention rather than a surveillance tool. A consensus statement on testing in care homes was thought to be required. It was suggested that all policy areas should be considered before determining where to prioritise testing. The London care home study was considered in detail - it suggested multiple introductions of the virus into care homes. Discrete clusters were identified containing samples from multiple care homes suggesting transmission between care homes. Comparison with non-care home genomes revealed no large-scale clustering of viruses from care home settings, indicating multiple introductions from the wider community.

119. One of the papers before this meeting, 'Proposal for an Alternative Cardiff University Covid-19 Testing Pipeline' (29 April 2020) stated that around 40% of transmission was attributable to asymptomatic transmission.

120. Also before this meeting was a paper Testing in Care Homes by the Welsh Government Office for Science (29 April 2020). It quoted a number of academics on the issue of whether testing of asymptomatic residents would have led to a reduction in the number of deaths in care homes, as well as the Minister for Health and Social Services and the CMO(W) on their extant policy of not doing so. It noted that SAGE had very recently set up a sub-group on testing in care homes led by Dr Charlotte Watts.

121. On 2 May 2020 the Minister for Health and Social Services made a statement confirming that all residents and staff in care homes where there had been an outbreak of Covid-19 would be tested. His statement went on to state that the Welsh Government was implementing a 3-stage testing and rapid response plan to help care homes deal with coronavirus – this was a mixture of testing and environmental

and hygiene support measures. The written statement is exhibited at **AH/95-INQ000182440**.

122. On 5 May 2020, a TAC summary brief, exhibited at **AH/96-INQ000336545**, stated at p1 that SAGE reported that 33% of current Covid-19 cases are HCW to HCW or patient to community, suggesting a significant asymptomatic spread. It stated at p9 that there remained significant transmission in care homes, but numbers were plateauing. It stated at p13 that NHS England data showed 10-15% of new and newly confirmed hospital cases came from care homes, and it was estimated that a further 2-5% were from health and care workers.

123. On 6 May 2020 at the daily call between Executive Directors, exhibit above at **AH/23-INQ000300091** I raised that it had been challenging to ascertain good communication with PHW and slow to identify the correct PHW leads and contacts, and that clarification of their role was needed.

124. On 6 May 2020 I attended the Covid-19 Core Group meeting, exhibit **AH/97-INQ000336509** refers. The CMO(W) explained that although community transmission had slowed, transmission rates in care homes remained high. The Welsh Government had decided to test all residents in care homes where an outbreak had been identified. The science had become clearer on closed settings. Testing was also available in larger care homes because they were at greater risk given the footfall. Issues around the supply of PPE to the care sector had been resolved.

125. On 6 May 2020 TAG issued a consensus statement on care homes, exhibited at **AH/98-INQ000336503**. It stated that care homes were likely to have a high degree of internal transfer of infection, due to the mobility and unpredictability of patients. It recorded that a limited study by PHE pointed to care staff who work in more than one care home as a significant infection vector. It stated that mobility of care staff between homes should be prevented if at all possible. It also stated that a study in New York found that the majority of those in care homes who were asymptomatic and positive were symptomatic within 5 days. In this circumstance, an early decision was made suggesting that staff should be allowed to move between care settings. For the guidance to suggest otherwise would have meant inadequate staffing across the sector and would likely have resulted in the sector being unable to deliver basic levels of care due to the limited workforce at that time - caused by staff shielding, sickness absence, and childcare duties. As the year progressed during December

2020/January 2021 we actively advocated mutual aid to allow staff movement between neighbouring local authorities for this very reason. In terms of practice, it was an extremely difficult decision to consider and making such a professional judgement was absolutely crucial to ensuring the sector could continue caring for the most vulnerable and to potentially avoid an even greater harm, reflecting the ongoing need to balance the ability of the sector to provide care whilst making every effort to protect vulnerable people.

126. Also, on 6 May 2020 TAC met and the minutes, exhibited at **AH/99-INQ000336505**, record that it was a priority to reach a consensus view on whether they could advise the First Minister to relieve some of the regulations in advance of the bank holiday. It is recorded "*On care homes, as of next week there will be 8 mobile testing units across Wales with the expectation of serial testing where no positive case has been identified of staff in residence*". The care home consensus statement was discussed. The minute captures the evidence suggesting that there was value in testing everyone in the case of a new outbreak. The primary infection point was care workers coming in and out of care homes - the recommendation was that these people should be tested. If there was already an outbreak, then the assumption should be that everyone was infectious and proper social distancing should be in place. It was queried what evidence there was for mass testing of everyone within care homes as part of routine screening or following diagnosis, as England had stepped back from this. It is recorded that evidence suggested that there was value in testing for infections within care homes following first symptomatic case. Staff mobility between different care homes was also important in order to catch outbreak spread. Ideally guidance would be that staff should be restricted to a single care home. However, there were considerable implications on the adequacy of care if this were to be enforced and would likely have resulted in the sector being unable to deliver basic levels of care due to the limited workforce as a result of shielding requirements, sickness absence, and childcare responsibilities. In December 2020/January 2021 we advocated mutual aid to enable staff movement between neighbouring local authorities for this very reason. It is important to understand that in terms of practice it was an extremely challenging period and making such a professional judgement before advice was received or in potential conflict with it was crucial to ensuring the sector could continue providing even a basic level of service in caring for the most vulnerable. A Public Health England study had found that a significant number of Covid positive staff and residents did not have symptoms. Similarly, a further study found that the majority of those in care homes who were asymptomatic and positive

were symptomatic within 5 days. The meeting requested a volunteer to put together a statement for the First Minister and the Minister for Health and Social Services the next day. The consensus was that for new outbreaks, there was great value in testing the whole population in order to provide a barrier between care homes by stopping movement between them. This was likely to have financial and wellbeing implications for the workers themselves. Statement to be completed that day to avoid confusion.

127. On 7 May 2020 the CMO and I wrote to providers and responsible individuals of care home services, exhibit **AH/100-INQ000338302** refers, and separately to local authorities and local health boards, exhibit **AH/101-INQ000336510** refers, to draw attention to the updated Public Health Wales guidance (Version 3, dated 7 May). In the latter letter we stated that testing capacity had increased to 2250 tests per day and was increasing at pace and that the following groups of people continued to be prioritised: admissions to hospital with suspected Covid-19 infection; frontline health and social care staff; care home residents; and other critical workers. We stated that the latest evidence showed that we should extend testing in care homes to manage outbreaks. We should test all staff and residents in those care homes when an outbreak of coronavirus was identified. The evidence also suggested there was a greater prevalence of coronavirus in the larger care homes, where there were more people living and working.

128. On 11 May 2020 TAC met and dealt specifically with care homes. The note, exhibited at **AH/102-INQ000336533**, records that there had been several meetings of the care home sub-group of SPI-M. TAC was trying to get obtain the data so the same models could be used for Wales. Brendan Collins would be meeting with CIW to request it. A paper from the care home sub-group was expected to go to SAGE (it was unclear whether there was a Welsh representative on the group). It was suggested that PHW could also be part of this sub-group. A draft proposal paper was circulated by one of the Medical Directors. A paper was expected to come from PHW that day with a clear version of incidence reconciled with CIW data. TAG agreed that testing was unlikely to prevent or control outbreaks in homes and that emphasis should be on good infection control and good PPE. The question of the number of people in care homes who are asymptomatic or pre-symptomatic did need to be considered and this was the question that serial testing may be able to answer, that argument required additional discussion. One of the papers before this meeting was PHW's Response Plan which stated that it was known that asymptomatic transmission was occurring.

129. On 13 May 2020 TAC produced a summary briefing, exhibited at **AH/103-INQ000299676**, which stated at p2 that a SAGE paper on the scientific view on testing strategy to reduce transmission in care homes contained an assessment of current evidence on the types of homes that were the most vulnerable to Covid-19 outbreaks, optimal approaches to testing, and the potential value of other protection approaches. TAC agreed with the scientific advice in the paper, which accompanied the briefing document. It stated at p15 that viral load in patients (and so healthcare workers) was highest early during illness and possibly just prior to symptom onset. At p16 it noted a wide range of asymptomatic infection rates (2-25%) in screened healthcare workers and recommended that increased testing capacity was used to check for hidden / unsuspected Covid-19 in healthcare workers and that healthcare workers should not work across hospital zones.

130. Also, on 13 May 2020 TAG met, minutes exhibited at **AH/104-INQ000336547**, and it was suggested that TAG should agree to update the consensus statement that all care homes should be tested once, whilst recognising this may not be sufficient. The most reasonable approach would be to test once, then again following the incubation period and then move to surveillance testing. This would work but only if all care home workers in all homes that did not have outbreaks were tested. There was some scepticism of the value of mass testing in care homes when self-isolation was not possible, and it was agreed that evaluation would be needed. A move to this type of testing would put a huge demand on test capacity at the same time as testing to support contact tracing was looking to increase. One of the focuses of contact tracing should be to identify care staff who are likely to introduce the virus into homes. The evidence suggested the virus was present in most care homes already to some extent. Policy decisions to test everybody routinely were unlikely to be sustainable and would not add much value to understanding of the epidemiology or the ongoing clusters of outbreaks. "*If significant proportions of asymptomatic positives are identified and told to remain off work there is a risk of work force issues impacting the viability of homes and this will need to be considered outside TAG by policy officials*."

131. On 13 May 2020, a letter was issued, exhibited **at AH/105-INQ000336551**, on testing for Covid-19 in care homes that had an outbreak commencing before 2 May 2020, which stated that all staff and residents in such homes should be tested.

132. On 14 May 2020 a ministerial advice was submitted to the Minister and Deputy Minister for Health and Social Services, exhibit **AH/106-INQ000136783** refers,

recommending: (i) that all residents and staff are tested when a care home reports its first case; (ii) all residents and staff who have not previously tested positive should be tested where there was a recent / ongoing outbreak in a care home; and (iii) testing of all staff and residents where a care home has not reported a case. The advice noted the latest SAGE advice (TAC briefing 12 May 2020, exhibited above as **AH/103-INQ000299676**, on introduction of Covid-19 into care homes which was that there was a link between care homes and hospitals. Sage had high confidence that hospital discharges and visits may have been an important source of introduction of Covid-19 infection to care homes. We expected that the routine testing of patients leaving hospital would help address this, although there may have been a continued risk of infection from false negatives returning to homes. SAGE had medium confidence as to the connection between staff and community. By this point, SAGE were recommending that within homes, there was a strong scientific rationale to test all residents and staff, irrespective of whether symptomatic or not, given strong evidence of asymptomatic transmission in care homes. The recommendations were agreed by the Minister for Health and Social Services on 15 May 2020, exhibited at **AH/107-INQ000336556**.

133. On 15 May 2020 TAG issued an updated consensus statement, exhibited at **AH/108-INQ000066455**, on testing in care homes. There was evidence that there were outbreaks which had not yet been reported because people were asymptomatic or pre-symptomatic. It would therefore be valuable to test in selected care homes that had not reported an outbreak, so that the prevalence of those cases could be understood. There was some evidence that staff working in more than one care home at a time would increase the risk of infection. As of 13 May, in line with increased testing capacity, symptomatic and asymptomatic testing was already available to those who had never tested positive in a home where no outbreaks had been reported.

134. On 16 May 2020 a Welsh Government press release, exhibited at **AH/109-INQ000182446**, extended testing to all care homes following an announcement by the Minister for Health and Social Services. Testing was to include all residents and staff. The press release omitted to clarify that it was restricted to care homes who had not reported an outbreak in the past 28 days.

135. On 16 May 2020 the CMO(W) and I sent a joint letter, exhibit **AH/110-INQ000336549** refers, to care home providers and responsible individuals (adults and children)

confirming that all symptomatic and asymptomatic staff and residents with outbreaks in the 28 days prior to 2 May 2020 would be offered testing.

136. On 19 May 2020 the Deputy Minister for Health and Social Services issued a written statement, exhibited at **AH/111-INQ000338683**, on Older People's Rights and Coronavirus which set out that the Welsh Government was providing increased support to care homes e.g. regular PPE supplies and advice on hygiene. The statement referenced the ONS' figures that about 25% of coronavirus deaths in Wales were in care homes. WG committed to a rights-based approach and to continuing its work on a Strategy for an Ageing Society.

137. On 27 May 2020 I received an update on progress in care homes, exhibit **AH/112-INQ000336613** refers. A working group had been established to ensure residents received testing. All care homes will have been tested in the following 2 – 3 weeks. Officials were to consider testing of all care home workers on a weekly basis if there was no outbreak in a care home, in line with Scotland.

138. On 28 May 2020 TAC produced a summary brief, exhibited at **AH/113-INQ000336641**, which stated at p37 that care home workers, who have prolonged contact with many individuals and go into multiple homes, needed to be especially careful to avoid spreading infection inside and outside the workplace, in the community and at home. It gave guidance to the effect that they should avoid sharing different workspaces – new working patterns are recommended.

139. On 1 June 2020 the Deputy Minister for Health and Social Services wrote to the Older People's Commissioner. She set out that as testing in care homes was rolled out, priority was given to care home outbreaks followed by care homes with more than 50 registered beds as these were more greatly impacted. From 15 June 2020 all care home staff would be offered a weekly test for a 4-week period. The Welsh Government realised the importance of stopping the spread of the virus across and within care homes at the "*earliest opportunity…As mass testing comes on line, ensuring residents and staff in care homes can live and work in a safe environment is a priority…to ensure we are monitoring closely we have asked Local Health Boards to submit weekly situation reports*". I exhibit a copy of the letter at **AH/114-INQ000338305**.

140. In June 2020 my policy officials began work with a Care Home Visiting Stakeholder Group convened by Care Inspectorate Wales (CIW). The group had wide

representation from across the sector including Public Health Wales, providers of adult care home services and children's care home services, Care Forum Wales, the offices of the Older People's Commissioner and the Children's Commissioner and Social Care Wales. The group's views and feedback on the care home visiting guidance and proposed changes informed the advice to ministers. Other key work by the group included the following:

- On 1st June the group developed Recovery Planning and Developing Guidance for Enabling Visits to Care Homes.
- Co-produced guidance to support families and friends to visit loved ones in care homes.
- In January 2021 the stakeholders met to discuss forming the Supporting People to Stay Connected - Volunteer Scheme.
- In April 2021 they were a key part in creating the CMO/PHW action card for care homes to share with visitors.

141. In June 2020, based on SAGE advice, we introduced weekly testing of all staff in care homes across Wales, whether symptomatic or asymptomatic, to monitor the ongoing transmission of Covid-19. The weekly testing of staff in all care homes, including those yet to report an outbreak, was for a period of four weeks commencing on 15 June, with care homes with positive results undertaking repeat testing as appropriate. Based on the evidence gathered from the initial testing period, on 10 July 2020 a ministerial advice was submitted to the Minister and Deputy Minister for Health and Social Services, exhibit **AH/115-INQ000336817** refers, to continue with the weekly testing for staff in care homes, which the Minister agreed to. At this stage regular testing of care home residents was not recommended, notwithstanding that SAGE advised in June 2020 that care home residents should be tested every seven days. The advice was given when the prevalence of infection in the community was high, and should it arise again in the future in Wales we would be able to follow the SAGE advice. Based on the then current context of low prevalence rates among care home residents and staff, we were able to put forward a clear rationale for not undertaking regular testing of residents.

142. At this time, although weekly PCR testing was introduced, laboratory capacity was extremely limited and there was great frustration for the sector about the significantly long 'turnaround times' for test results. There were repeated reports of care home staff undertaking their next weekly test before the first result had been returned to them, which undermined confidence in the whole system. This poor performance of turnaround times continued for some time and impacted on the confidence of staff in

the testing regime. Officials carefully monitored nationally provided data in turnaround times and met regularly with DHSC officials to continue to keep pressure on the system to improve performance.

143. In terms of domiciliary care staff and the wider social care sector that were supporting vulnerable people in their own homes, it took much longer than it should have to establish them as a priority group for testing. Officials frequently put forward requests to TAC to set out the case for testing the domiciliary care workforce with the first written case being made on the 10 July 2020. The providers themselves were also extremely vocal in their frustration that they were not being prioritised despite the vulnerability of their clients and the potential risk of transmission. In some way to ease frustrations, the domiciliary care sector was invited to be part of an antibody test study to determine if this workforce had indeed been infected historically with the virus. I exhibit at **AH/116-INQ000336989** the draft proposal on social care antibody testing. This study proved to be limited as the nature of the testing was a blood test and only a small proportion of the workforce agreed to participate. However, with the later introduction of LFD testing access to tests became much easier.

144. On 30 July 2020 the Care Home Action Plan was published. The plan was a culmination of work lead by my team alongside a range of stakeholders, developed in response to requests made by the Older People's Commissioner for Wales and EHRC Wales. The plan covered our approach/action plan for a second wave of Covid-19 infections in Care Homes. We wanted to understand what worked well and why, and how good practice could be scaled up and expanded across Wales. Advice was provided to the Deputy Ministers for Health and Social Care regarding the action plan, and subsequently the publication of the plan. There were six themes in the plan: (1) infection prevention and control; (2) PPE; (3) general and clinical support for care homes; (4) resident's wellbeing; (5) social care workers' well-being; (6) financial stability which is exhibited here **AH/117-INQ000336943**. Professor John Bolton was also commissioned to carry out a rapid review of our response to the first wave which would be used to setting out our approach to learning from the first wave our subsequent response.

145. On 4 August 2020, updated Public Health Wales guidance for care home settings: '*Guidance to prevent COVID-19 among care home residents and manage cases, incidents, and outbreaks in residential settings in Wales'* was published and exhibited as **AH/118-INQ000338264**.

146. On 5 August 2020, the CMO and I wrote to registered providers and responsible individuals of care home services in Wales to alert them to the publication of updated Public Health Wales guidance for care home settings with the letter containing a summary of the changes to the updated Public Health Wales guidance, including updated guidance on visitors to residential settings, exhibited at **AH/119-INQ000336958**.

147. On 19 August 2020 I attended a meeting between the Minister and Deputy Minister for Health and Social Services and the Older Person's Commissioner for Wales and the Equality and Human Rights Commission, exhibited at **AH/120-INQ000337116**. The PHW report 'Risk Factors for Outbreaks of Covid-19 in Care Homes' demonstrated that the recent narrative around hospital discharge and its impact on Covid-19 transmission in care homes was not supported by the emerging scientific evidence. The Care Home Action Plan would respond to issues in the care home sector. The Older Person's Commissioner had met with Professor John Bolton as part of his rapid review. The Welsh Government's consolidated approach to impact assessments was discussed, which identified the disproportionate effect on older people.

148. On 25 August 2020 I attended a meeting of ExCovid, exhibited **AH/121-INQ000337022** refers. I reported that testing had been underway for some time in care homes with very low rates of positives in staff and residents. Consideration was given to opening care homes to visitors on 29 August.

149. On 28 August 2020 'Visits to care homes: guidance for providers – guidance for care home providers for adults and children on how to enable safe visiting during the coronavirus pandemic' was published and is exhibited at **AH/122-INQ000337012**.

150. On 8 September 2020 I attended a meeting of ExCovid, exhibit **AH/123-INQ000337043** refers. The CMO(W) reported that numbers were creeping upwards. The turnaround times for testing in care homes was slow. In preparation for the meeting with the Older People's Commissioner for Wales and EHRC Wales, we had identified 23 impact assessments.

151. On 10 September 2020 I had a meeting with the Older People's Commissioner for Wales to discuss the letter sent to the Minister for Health and Social Services in relation to human rights in care homes, exhibits **AH/124-INQ000337118** and **AH/125-**

INQ000337039 refer. The purpose of the meeting was to discuss the Welsh Government's response to the letter from EHRC on 20 July 2020, exhibit **AH/126-INQ000337038** refers. In relation to care homes, they wanted to see evidence on human rights considerations, equality considerations and evidence that informed policy decisions. The Commissioner was particularly interested in the policy on asymptomatic testing. The themes agreed upon for the response were testing, PPE and visits. Following the meeting I received a letter from them on 17 September 2020, exhibit **AH/127-INQ000337115** refers. I sent them a letter of reply on 4 November 2020. They requested further information on 30 November 2020, exhibit **AH/128-INQ000338303** refers.

152. On 21 September 2020 the Director of Housing and Regeneration and I wrote a joint letter to all directors of social services on the subject of supported living, exhibit **AH/129-INQ000338301** refers. It clarified that tenants in supported living were entitled to form extended households. All concerned should co-operate to assess the best interests of the person in supported living and take reasonable measures to reduce the risk of transmission. Where a person lacked capacity, their human rights and the public sector equality duty had to be considered.

153. On 2 October 2020 I sent a letter to all directors of social services on the issue of care home visits, exhibit **AH/130-INQ000337149** refers, in which I reminded them of the guidance published on 28 August 2020 and that decisions on visiting were a matter for them in accordance with the guidance. The guidance encouraged a risk assessment to inform decision-making. A balance needed to be struck between maintaining the safety of residents in care homes and their well-being.

154. On 6 October 2020 I attended a meeting of the Health Protection Advisory Group, a record of which is exhibited as **AH/131-INQ000338210**. The national situation was starting to deteriorate. An update was provided on nosocomial transmission – getting an immediate grip on an outbreak was essential as it was difficult to contain after 48 hours. Care homes were a priority and further surveillance would be carried out. They were the highest risk area and the Winter Protection Plan was framed around them. The position in relation to PPE was strong. Testing data was an issue, particularly around asymptomatic staff. Care homes should only be locked down where there was a clear outbreak as there were other harms to consider, such as mental health. Consideration should be given to a testing regime for visitors to prevent community transmission entering care homes (the Older People's

Commissioner for Wales had sent a letter asking for visitors to be tested). District nurses attending care homes were also causing concerns. Advice on increasing testing intensity was currently with the Minister, exhibited as **AH/132-INQ000136819**.

155. On 9 October 2020 I wrote to care homes and statutory partners in relation to a deep-dive that was being carried out into asymptomatic testing of care home staff, in conjunction with the CMO(W) and PHW, exhibit **AH/133-INQ000337184** refers. The ministerial advice approved by the Deputy Minister for Health and Social Services identified the purpose of the deep-dive as being to restore confidence, ensure compliance and settle the position on re-testing of workers, exhibited above at **AH/132-INQ000136819** refers. In the letter I reiterated that: it was crucial that Welsh Government were included in any decisions to change the frequency of asymptomatic testing of care home staff in order to be able to manage testing capacity; that a positive test should be treated as such without waiting for a re-test, given the rising community transmission; the testing on discharge policy remained in place; asymptomatic testing of residents was not in place, unless there was an outbreak.

156. On 13 October 2020 I attended an ExCovid meeting, exhibit **AH/134-INQ000338151** refers. There had been an increase in the rates of positive tests. The virus was behaving in a way similar to the first wave, and a firebreak was designed to slow exponential growth. Swansea were carrying out modelling of a 2 – 3 week firebreak.

157. On 20 October 2020 I attended an ExCovid meeting, exhibit **AH/135-INQ000337237** refers. TAC advised that there had been a large increase in positivity and Wales was in an epidemic state. It was noted that Wales was ahead of the curve in relation to the firebreak, and by imposing it earlier it was more likely to be successful. Issues in relation to affordability outside a UK-wide agreement had influenced decisions on the length of the firebreak in Wales. PPE supplies were at a good level and plans were in place to ensure care homes had good access to supplies.

158. On 3 November 2020 I attended an ExCovid meeting, exhibit **AH/136-INQ000337260** refers. The care home sector was seeing an increase in Covid-19 cases – if it was prevalent in the community, it would find its way into care homes. CIW were continuing to carry out inspections.

159. Also, on 3 November 2020 I attended a Health Protection Advisory Group meeting, exhibit **AH/137-INQ000337280** refers. There was an increase in infection rates in care homes. There were five outbreaks in care homes. Care homes had a 38%

excess death rate, which was worrying. There was a perception complacency may be a factor in the virus spread into care homes. Hospital discharges were backing up because of staff shortages in care homes, due to self-isolation. The timeliness of testing was still causing issues. LFTs were becoming available, and pilots would be developed.

160. On 11 November 2020 I attended an ExCovid meeting, exhibit **AH/138-INQ000337285** refers. The data demonstrated that the incidence was falling. It was highly likely that another firebreak would be needed at some point. However, there had been an increase in cases in care homes which needed monitoring, to be discussed at a future meeting.

161. On 17 November 2020 I attended an ExCovid meeting, exhibit **AH/139-INQ000337307** refers. The CSAH advised that although the infection rate had flattened, it would start increasing in the next few weeks. Cases were increasing in care homes but were not at the same levels as in March / April. 25% of deaths attributed to Covid-19 were in care homes. The need to protect the sector as the virus spread through the community was emphasised. A task and finish group had been established to consider Christmas easements to cover the period 24 – 28 December. The difficulty of making the case for easements was discussed, given that it would lead to an increase in infection rates and undo the gains of the firebreak – but people would mix over Christmas in any event and there was the increased potential of breaking the rules due to the festive season and compliance going forward had to be considered.

162. It was on 20 November 2020 that a ministerial advice recommended the introduction of asymptomatic testing for the wider social care workforce, including domiciliary care workers, alongside advice to introduce the same for health care workers. I exhibit the MA at **AH/140-INQ000144929**.

163. On 24 November 2020 I attended an ExCovid meeting, exhibit **AH/141-INQ000337326** refers. The number of cases has been reducing since the firebreak, but there had been some reversal in the last few days. An ONS survey supported the evidence from PHW that the firebreak had a positive effect on infection rates.

164. On 1 December 2020 I attended a Health Protection Advisory Group meeting, exhibit **AH/142-INQ000337361** refers. New significant restrictions on the hospitality sector were to take effect on 4 December. The traffic light system would be adopted for

alert levels after the Christmas period. The R rate had been rising since the firebreak ended and current metrics were close to the RWCS.

165. On 15 December 2020 I attended a Health Protection Advisory Group meeting, exhibit **AH/143-INQ000337384** refers. I expressed concern regarding resources in social services, including within care homes and community-based services. Mutual aid was being explored to provide more staffing. The Coronavirus Control Plan was published yesterday, setting out the new four-tiered system of restrictions. A number of indicators in Wales currently met level 4. LFTs were being delivered to social care staff to ensure infections and nosocomial transmission was caught.

166. On 15 December 2020, the Minister for Health and Social Services announced, exhibited at **AH/144-INQ000227285** a change to the requirements around discharging people from health care to social care settings. This was informed by a review of the latest TAC advice, exhibit **AH/145-INQ000227902** refers, about interpreting RT-PCR tests. This change was based on our guiding principle of getting people into the right place to facilitate the achievement of their well-being outcomes. In particular, the change moved to a more holistic assessment of discharge; the key point here was infectivity. The new criteria for determining that an individual was no longer infectious were lapse of time, absence of fever, improvement in other symptoms, and a test to indicate the degree of viral load.

167. The increasing availability of LFD tests also led to the introduction of testing for care home visitors in December 2020, exhibit **AH/140-INQ000144929** refers, which helped care home residents and loved ones have the contact they had so sadly been denied during lockdown and the intervening months. This was important for the well-being of residents and their loved ones.

168. Our testing policy in Wales was based on good intelligence and engagement with care sector providers, technical and scientific advice and sound public health advice. Through the Planning and Response Group we had weekly contact with key sector representatives.

169. We established a Social Care Testing and Infection Prevention and Control Group, the Terms of Reference of which are exhibited at **AH/147-INQ000198526** and which helped us to ensure coherent policy making across policy, public health, operational and scientific domains. The group met fortnightly with additional meetings called

when necessary and I initially chaired. Members included colleagues from Public Health Wales, the Chief Medical Officers team, the Social Care Policy Team, the Testing Policy team and Care Inspectorate Wales. The group was established to provide a forum for sharing information, intelligence and evidence in relation to policy design and implementation. It was further used to shape and develop testing and infection control strategy and policy for social care. This group developed a testing and infection prevention and control framework, exhibited at **AH/148-INQ000338496** specifically for the social care sector in Wales, which was very well received by providers and local authorities as it provided guidance on what measures should be in place at different levels of Covid-19 prevalence in the community.

170. However, I was aware of reported delays in turnaround time for testing results being provided due to the need to increase capacity within the Lighthouse Labs.

171. The need for re-testing due to the risk and impact of false positives actually led to a partial undermining of the testing regime and a lack of confidence by care workers and providers.

172. A strong distribution network for tests was established in Wales making good use of partnerships with local authorities. Weekly calls with local authority testing leads were established from December 2020 onwards to ensure good communications were established and distribution channels remained effective.

173. In terms of the Test, Trace, Protect response the mobile apps to record test results were initially cumbersome and difficult for people to use, especially for those staff who at one time were taking tests on a daily basis. This in turn prevented people from completing the reports and limiting the information available to the Welsh Government in terms of uptake of LFD tests and positivity rates in the sector.

174. At ExCovid on 12 January 2021, exhibit **AH/149-INQ INQ000220758** refers, I outlined that the biggest challenge facing care homes was the workforce. I had been working with local authorities to secure a redeployment of their staff to private homes to assist with the shortage. There were 344 homes with outbreaks – it was proving very difficult to keep Covid-19 out of care homes.

175. On 22 January 2021 I wrote to local authorities and stakeholders in the social care sector with the outcome of the rapid review into the use of the powers in the

Coronavirus Act 2020 relating to relaxation of requirements for community care, exhibit **AH/150-INQ000337473** refers. Carers had identified the impact of the loss of respite services on their well-being. There was a need to minimise adverse effects older and disabled people. It was positive that local authorities had not used the modifications so far. The majority of responses favoured suspending the provisions of the Act that allowed modifications, and that is what the Deputy Minister for Health and Social Services had decided to do.

176. On 26 January 2021 I attended a meeting of ExCovid, exhibit **AH/151-INQ000337485** refers. Numbers on both prevalence and positivity were both decreasing. All care homes were to be offered the vaccine by the end of January. Wales would remain at level 4.

177. On 25 February 2021 I received advice from PHW that they would support the managed relaxation of restrictions in care homes to allow one designated visitor, using PPE, social distancing, LFTs and in a designated room, exhibit **AH/152-INQ000337529** refers. I discussed potential indoor visiting with directors of social services the same day, exhibit **AH/153-INQ000337533** refers. Concerns were raised regarding the recent outbreaks in care homes only 6 weeks ago and they cautioned against a complete re-opening. I also met with the care home visitor guidance stakeholder group who were supportive of the proposal. A briefing was sent to the CMO(W) to seek agreement on 1 March 2021, exhibit **AH/154-INQ000337532** refers. On 3 March 2021 ministerial advice was sent to the Deputy Minister, exhibit **AH/155-INQ000198557** refers, and the amended guidance was sent to the Deputy Minister on 11 March, exhibit **AH/156-INQ000116680** refers.

178. On 2 March 2021 I attended a Health Protection Advisory Group meeting, exhibit **AH/157-INQ000337493** refers. Transmission rates were reducing but caution was being exercised over the impact of the new variant and the effectiveness of the vaccine.

179. On 21 May 2021 the CMO(W) and I provided a joint update on indoor care home visits, exhibit **AH/158-INQ000337677** refers. Revised visiting guidance had been published to support the lifting of restrictions on the overall number of designated indoor visits from 24 May, exhibit **AH/159-INQ000338239** refers. Risk assessments remained in place as did visitor testing and restrictions on the number of visitors at the same time to two people. Visits could take place in personal rooms if a designated

visiting area could not be used. The overall purpose of the guidance was to support visits taking place, rather than impeding them.

180. On 8 June 2021 I attended a meeting of the Health Protection Advisory Group, exhibit **AH/160-INQ000337688** refers. The delta variant had been reviewed and measures would be relaxed from level 2 to level 1 from 21 June. On care home visiting, it was noted that all residents and staff had been vaccinated, there were low rates of single cases, testing was still being undertaken and indoor visiting was allowed for a maximum of 2 people however it was still being kept under review.

181. On 15 June 2021 I attended a meeting of ExCovid, exhibit **AH/161-INQ000338152** refers. Wales was between level 2 and 1 on the Control Plan and decisions were subject to data on the spread of the delta variant. Although Wales was at the beginning of a third wave, with the availability of vaccines the circumstances were different. However, planning for stricter restrictions was required.

182. On 15 December 2021 I was copied into an email to the Deputy Minister for Social Services which attached ministerial advice on care home visits in light of the Omicron variant, exhibit **AH/162-INQ000337957** and **AH/163-INQ000337952** refers. The Minister and Deputy Minister approved the guidance.

183. On 26 January 2022 I was copied into an email sent to the Deputy Minister for Social Services, exhibit **AH/164-INQ000338023** refers, recommending that testing requirements were reduced back down to what they were at national alert level 0 – namely, twice-weekly LFTs for social care. The recommendation was approved by the Minister.

184. On 28 January 2022 the CMO(W) and I made a joint announcement on social care following the First Minister's announcement to move Wales to alert level 0. Guidance had been updated to the effect that Covid-19 was to be managed in-line with other respiratory diseases. Twice-weekly LFTs would remain the asymptomatic testing regime. Also, the visiting guidance was updated to allow routine visiting during outbreaks and facemasks may be removed when in a resident's room or designated visiting area. The discharge requirements were revised so that the period of self-isolation for asymptomatic patients was reduced from 14 days to 10 days, or day 3 if a negative LFT was produced.

G. Shielding

185. Whilst not directly involved in decisions related to shielding advice, members of my directorate attended regular vulnerable groups meetings. These discussions did not address the criteria for inclusion in the shielded group, but rather in the practicalities of arrangements to meet their needs and colleagues were able to input an element addressing the social care perspective implications of prolonged isolation and lockdown for those shielding and for the wider non-shielding vulnerable group. Much of the shielding guidance was communicated to the sector by the CMO, who was also the lead on shielding advice. The minute from these meeting is exhibited here: **AH/165-INQ000338691**.

Engagement with UK Government and Counterparts

186. The UK Government established a Four Nations group under the Chatham House rules where they and each devolved government could openly share information and highlight broad concerns around the pandemic and how they affected adult social care. A SSID official was tasked to be the liaison officer for these meetings and worked with other SSID colleagues to attend and contribute once the agenda was confirmed. If they were unable to attend because of other diary or work conflicts, officials provided the liaison officer with an update that was presented at the meeting. Any questions arising from this were fed back to SSID officials and the replies copied to all Group members.

187. Similar Four Nations meetings were set up to discuss specific key policy concerns such as PPE, vaccinations, guidance, etc. and other SSID officials were assigned to attend and contribute updates on those policy areas. Whilst no exact terms of reference were established, all parties agreed to use the meetings to update each other on actions being undertaken in their nations that assisted the social care sector. This included general updates on areas such as workforce, PPE and financial support being provided to the sector.

188. Meetings were held bi-weekly at the height of the pandemic. The UK Government acted as the secretariat for the meetings and made the arrangements for all members to include items onto the agenda for discussion. Those that raised the agenda item would begin the conversation by outlining the issue and discussions sought to understand if similar concerns were being raised with the other nations. As the

severity of the pandemic began to ease and as scientific knowledge improved the frequency of these meetings was reduced to one a month.

189. Engagement between the Four Nations during these meetings was open, direct and helpful for all parties to understand the issues facing the other nations. In the main all experienced similar concerns but there were some areas that were specific to each nation. Feedback on the issues raised and discussed at these meetings was shared with SSID colleagues promptly and helped inform officials of developments across the UK.

190. No direct decisions were made as part of these meetings, but it did help with sharing wider information and highlighting concerns arising from the pandemic and identifying areas of common concern. They also helped to act as a channel to remind policy colleagues to follow up with information where this had encountered delays and be a conduit to linking officials with counterparts across the UK.

191. Information sharing was clear and concise and where information could not be provided during the meeting, it was followed up and shared outside of the meeting as soon as convenient.

192. Information shared was often timely but there were some instances where data was delayed - both ways - as senior official or ministerial clearance was required before it could be shared. The group sought to help alleviate this issue where possible and provided a good line of open communication. As the pandemic progressed, it was clear that each nation had focused on specific issues that it felt held significant priority for itself and details of these were shared to inform the other nations – in Wales we introduced a special payment for social care staff to recognise and value the dedication and integrity of the work our social care workforce had displayed during this difficult period. This inspired other nations to also consider special payments for their workforce.

193. On areas where there were similar needs – i.e., providing financial support to ensure statutory sick pay for all in the social care sector – each nation outlined how it was meeting this need and the lessons they had learned in doing so. Some of this work expanded into developing more specific project groups to help ensure that there was a common approach. This group successfully helped ensure that the nations were aware of issues that were arising and how these were being dealt with. Where these might differ because of the devolved nature of the policy areas, officials ensured that

updates on the projects was shared, including lessons learned to help other nations who considered similar schemes be aware of potential concerns and how to overcome them.

194. My policy officials leading on care home visiting policy established contact with counterparts in England, Scotland, and Northern Ireland. Initially the meetings were organised and led by DHSC officials, but they evolved into regular meetings between officials in the four nations. They were an informal opportunity to share intelligence and discuss challenges relating to care home visiting. They were not decision-making meetings and were not minuted.

195. I participated in 4 nations social care professional lead officer meetings to informally share information and support each other during a difficult time. I found these discussions particularly informative and helpful, particularly where discussions related to how each nation was striving to protect the rights of citizens and to understand emerging issues such as impact of diverse vulnerable groups such as the Black, Asian and Minority Ethnic groups.

Informal Communications

196. In relation to informal communications, I can confirm I was not a participant in any WhatsApp or other messaging groups with Welsh Ministers, senior advisors, or senior civil servants concerning the Welsh Government's response to the pandemic or for any other work purposes. I can confirm that I have undertaken a search of my current work phone which was issued to me on 22 July 2021. My usage of this phone is low, and it is mostly used for phone calls and emails rather than informal messages. I can also confirm I have undertaken a search of my personal phone which I have had since 2017 and I cannot identify any relevant messages. Similarly, I would not have used my earlier work-issued phone which was issued to me prior to 2021 to send informal communications around the Welsh Government response to the pandemic. All my discussions relating to Welsh Government's response to the pandemic were conducted via official channels such as the meetings and email communications as detailed in this statement.

Divergence

197. The First Minister of Wales was very clear in his communications with the Welsh civil service that we would consider all actions and policy that were in the best interests of citizens in Wales. As such I am aware that Wales made a number of different approaches to lockdowns such as a local lockdown and a firebreak.

198. Sometimes divergence from the UK Government was necessary for practical as well as policy reasons. Devolution has meant that the structure and statutory responsibilities of social care in Wales sometimes differ from those in other administrations and there were times where decisions, including funding decisions, diverged as a consequence of a sometimes more cautious approach taken by the Welsh Government; which reflects the commitment by the First Minister to take decisions which had the needs and wellbeing of the people of Wales as the top priority. Another need for divergence is the demographic differences we see in Wales when compared to the UK as a whole. Wales has significantly higher proportion of rural communities, important linguistic differences, and a higher proportion of the Welsh population belonging to older age groups when compared to the other UK nations.

199. One such example of divergence was the supply and distribution of PPE to social care. The majority of social care providers in Wales are privately owned and are usually responsible for managing their own supplies of PPE. By mid-March 2020 it became apparent that the availability of PPE for the social care sector was becoming urgent. Rather than wholly aligning with the UK procurement plans for PPE, the Welsh Government engaged closely with the NHS Wales Shared Services Partnership to use their well-established procurement links to provide for the social care sector – a step not taken previously even for publicly owned provision. We utilised local authority contacts, identified during the Welsh Government's EU exit contingency planning, to quickly develop a collaborative network which delivered the recommended PPE to the front line of social care as quickly and efficiently as possible. For example, on the 2 April, the Minister for Health and Social Services for Wales attended the Healthcare Ministerial Implementation Group which discussed ensuring a consistent UK-wide approach to Covid-19 and distribution of PPE. These meetings were held regularly with a Welsh Government representative attending, including on the 7 May, where Lord Deighton's MAKE PPE initiative was reviewed.

200. I believe that the UK Government's approach was to only assist publicly owned social care providers with the increasing supply costs of PPE whereas we took the decision

not to differentiate between public and private providers. This meant that we were able to combat the risk that providers who were struggling to source appropriate supplies, or meet the escalating cost of PPE, would no longer be able to continue their services. I believe that this was a key divergence that kept more people safe and more services operating. Whilst this is an example of divergence, Welsh Government remained in contact with UK and devolved governments on the issue of PPE.

201. There was no divergence from the NPIs for children's social services. However, there was some divergence between England and Wales in respect of some processes associated with both adoption and fostering. The Welsh Government only made changes to the regulations as previously set out above. The UK Government, however, proposed and implemented a range of changes which would affect the adoption and fostering processes in England.

202. Welsh Government used its Children's Operational Guidance on the delivery of children's social care to help local authorities and partners continue to provide effective support to adoptive and fostering families, whilst maintaining their statutory duties during the Covid-19 pandemic. This guidance set out the measures that should be put in place to minimise the impact of the pandemic, during a time when resources available to cope with additional burdens are reduced.

203. It worked well because we were able to offer clear direction on flexibilities which could be implemented if needed, whilst also ensuring our services stayed within the confinements of our legislative framework.

204. In terms of care home visiting the approach was linked to the wider coronavirus restrictions and regulations in Wales and informed by advice from Public Health Wales. I was keen to ensure that people living in care homes in Wales, and their families, were not treated differently to those living in other parts of the UK without good reason. My policy officials maintained an awareness of the approach to care home visiting in other parts of the UK. Where appropriate, this informed our thinking and advice to ministers. For example, during Alert Level 4 routine indoor care home visits were restricted in Wales. We were, however, aware that other parts of the UK were planning to re-introduce a degree of routine indoor visiting in March 2021. Officials in Scottish Government had also shared research on the efficacy of the vaccine. Following discussions with Public Health Wales, and with the agreement of

ministers, visiting a care home was included as a reasonable excuse to gather indoors during Alert Level 4 and the care home visiting guidance was amended to include a designated indoor visitor (with a deputy) from 12 March 2021 – see the ministerial advice submitted to Cabinet relating to easement of restrictions on 11 March 2021 exhibit **AH/166-INQ000145542** refers.

205. In April 2021, the UK Government changed its approach to support 2 designated visitors and to enable more flexibility in relation to visits by children and babies. The care home visiting guidance in Wales was amended on 23 April 2021 to increase the number of designated visitors (to 2) from 26 April 2021 and to provide more flexibility in terms of visits by children and babies.

206. In May 2021 the UK Government increased the number of designated visitors to 5 people. Version 7 of the care home visiting guidance published on 17 May 2021 advised that the 2 designated visitors could visit at the same time and that face coverings could be removed if seated. This aligned with an easement for the wider population since 3 May which permitted 2 households to meet indoors. The guidance signalled the intention to move away from designated visitors altogether from 24 May 2021 but to maintain the advice that only 2 people visit at any one time. The intention here was to recognise the role and responsibility of care home providers in supporting safe, risk assessed visiting arrangements. We did not consider it helpful to set an arbitrary numeric figure for the number of designated visitors as a care home's capacity to support visitors and visitor numbers would depend on several factors. The approach in Wales sought to provide additional flexibility for providers, residents, and their families. For care homes that had insufficient space in managing care home visiting and infection prevention control, we were able to assist through additional provision in the form of visitor pods where ground space permitted.

207. One area of divergence related to the role of family carers/designated care givers who provide regular care and support were given a similar status to staff as far as training and testing are concerned. This approach was adopted in Northern Ireland. We were aware from correspondence that there was some support for this approach in Wales. This was given careful consideration but was not formally adopted as a policy in Wales on the basis that there was already sufficient flexibility for family members to take on a regular care giver role where this was appropriate.

K. Public Health Communications

208. Deputy Director Alistair Davey wrote to business managers of the Safeguarding Boards to issue advice on Welsh Government expectations of the role and functions of the Safeguarding Boards during the COVID-19 outbreak on 18 April 2020. I exhibit a copy of this letter at **AH/167-INQ000338311**.

209. A public facing national social services campaign to promote the reporting of safeguarding concerns was launched. There were three phases of implementation:

- a social media implementation which ran from 6 July to 16 August 2020,
- radio advertising from the 13 July to 9 August 2020, and
- digital advertising running from 6 July to 16 August 2020.
- The campaign ran a further two times including the 23 October 2020 and 22 December 2020 exhibit **AH/168-INQ000338704** refers.

210. Safeguarding referrals for children at risk and adults at risk reduced significantly at the start of lockdown, recovering as time went on but we anticipated hidden harm. A radio, social media, and digital advertising campaign to increase awareness that social services were still open despite the reduction in referrals and to encourage people to make a referral if they suspect someone is at risk of harm, abuse or neglect. The campaign ran three times in 2020.

211. On 23 December 2023 National Society for the Prevention of Cruelty to Children (NSPCC) and Childline were commissioned via email, exhibit **AH/169-INQ000337969** refers, to develop and publish information for children and young people on speaking out about abuse and how to get support to support children and young people in making disclosures about any harm experienced during lockdown periods, as they returned to education following lockdown periods. This information was promoted via relevant networks including the Children's Commissioner for Wales and safeguarding networks across agencies.

212. On 18 April 2022, a communications campaign on intrafamilial financial abuse affecting older people was also launched. As lockdown for the shielding group began to ease it was recognised that the isolation period offered increased opportunities for financial abuse in general. There was a recorded increase in the incidence of domestic abuse, including coercive control. Older people, because of the increased vulnerability to Covid, experienced greater isolation and were therefore more at risk

of the sort of financial abuse perpetrated by family members. In March/April 2022 radio, print, social-media, pharmacy bags and bus panels were utilised to ensure the messages reached those without access to social media. Messages were under the 'Live Fear Free' banner.

213. Given my leadership role in relation to social care, I issued communications to the sector, including jointly with the Chief Medical Officer and/or Chief Nursing Officer. These were mainly directed at sector partners. When it became evident that Covid-19 would require an extraordinary government response, and that public communications and sector engagement would play an integral role in that response, I ensured my SSID communications team was prioritised and assigned significant additional resource. In the midst of the pandemic, I oversaw major communications activity led by my team, and this included:

    a. The #MaketheCallWales campaign. This campaign addressed increasing fears of the rise in instances of abuse, harm, or neglect since the onset of lockdown and the lack of routine access to community figures such as teachers and health professionals. It was figure headed by a popular Welsh celebrity, Rhod Gilbert, and urged people to be more vigilant in looking out for their friends, families, and neighbours. It reminded people via radio, social media, and other digital platforms, that social services were still on hand to offer help and support with any concerns and also direct people to call 101 if they were worried. The campaign's success in terms of reaching more than 90% of the target audience of Welsh adults aged 35-55 led to it being repeated at appropriate times throughout the pandemic including the "Firebreak" period in October/November 2020 and the 20-21 Christmas and New Year period.

    b. The #CheckYourRisk campaign. The All-Wales Covid Risk Assessment Tool was developed following the scientific evidence revealing factors that could make people more vulnerable to the serious physical effects of Covid-19. It was originally designed to be used in the NHS and social care workplace by employers to manage the risk of individual employees and endeavour to implement appropriate adjustments to mitigate these. A substantial and sustained communications campaign needed to raise awareness within these sectors about the tool's availability as well as its benefits. Two distinct audiences of health and social care staff and health and social care employees were targeted with Black, Asian and Minority ethnic groups to be a specific priority within the staff audience. Close partnership working and engagement with the NHS and social care sector, and a media schedule encompassing

targeted digital and social media activity (and later radio), signposted the audience to further information and an accessible and engaging suite of supporting information in relation to the tool. The communications had ministerial support through various owned channels. The activity was developed for each stage of the pandemic, and another iteration of the campaign urged people to keep using the tool despite vaccination. By October 2020, the tool was in the top five most downloaded Welsh Government Covid-19 documents.

c. A communications package to signpost those suffering with issues relating to their mental health or loneliness to CALL (mental health helpline for Wales) or to the Welsh Government "Looking out for each other" sub site which was created during the pandemic onset. The site featured information on safeguarding, emotional support, and volunteering.

d. Pandemic recovery work guided by emerging data trends including a Live Fear Free campaign supporting older people to recognise and access help if they are experiencing intra familial financial abuse.

e. Enabling and supporting our closest sector partners to undertake significant communications work where a sector rather than government lead was more appropriate, was also paramount.

214. Social Care Wales and Welsh Government co-produced the product and communications in relation to a digital ID card for social care workers (which granted them priority for some services during the strict lockdown, and parity with their NHS counterparts). More recently the WeCare.Wales social care recruitment and retention campaign has been produced and promoted in collaboration. The communication of clear messages about the changing rules around care home visiting was delivered consistently in the timeliest of fashions. Without exception we worked closely with our partners (including but not exclusively press office, Care Inspectorate Wales, Care Forum Wales, Public Health Wales) using all available and appropriate communications channels and tools to reach the intended audiences.

215. The SSID communications team quickly established a virtual social care communicators group which reflected the membership of the Covid-19 Social Care Planning and Response Subgroup, this met regularly to ensure that the most important public messages were being heard loudly and clearly as members ensured all communications activity was aligned and supported through all available and appropriate channels.

216. Many high-profile issues emerging over the pandemic were not exclusive to social services so communications in areas such as PPE, vaccination and testing were led by the wider Health and Social Services Group. The social care communications team remained engaged and worked alongside their colleagues on these issues to provide input, insight, and support where appropriate.

217. After taking on the Chief Social Care Officer for Wales role, my most public facing communications task was to represent the voice of the social care profession in the latter part of the pandemic looking towards the recovery of the sector. I assumed a higher communications profile appearing in official Welsh Government social media communications materials and undertaking press interviews where appropriate. Specific examples of this could include recording videos to support the WeCare.Wales campaign to recruit more staff into the sector as well as writing a newspaper column (for Wales' main daily paper, the Western Mail) during Apprenticeship Week. Throughout the pandemic I appeared on our owned Welsh Government social media channels in support of the social care sector to try and support and pay tribute to them for their incredible commitment over this period.

L. Legislation

218. As well as involvement in the Coronavirus Act 2020, the SSID also advised Ministers to take forward some change in relation to subordinate legislation on social care. Specifically this related to relaxing burdens on providers (e.g. around annual returns required under the Regulation and Inspection of Social Care Act 2016) and also facilitating recruitment of staff, maximisation of existing sector capacity (e.g. in relation to creation of additional rooms and sharing of rooms in residential accommodation) and also creating extra capacity (in the form of permitting the establishment of emergency Covid-related residential and domiciliary care services for adults). The context for this was very substantial concerns that the social care sector would be swamped by additional demand as a result of Covid-19 and that people's health and wellbeing would suffer as a result. Particular concerns related to the ability of providers to recruit staff and the ability of the sector to create new emergency social care settings, as a counterpart to the new field hospitals then being set up.

219. The purpose of amending Part 2 of the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017, under section 2(3) of the

Regulation and Inspection of Social Care Act 2016 Act, via the Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) (Coronavirus) Regulations 2020, was to provide that certain types of service were not to be treated as "regulated services" for the purpose of responding to the Covid-19 pandemic. As such, in specified circumstances, these services would not be required to register with and be regulated by Care Inspectorate Wales as a care home or domiciliary support service.

220. This enabled new care and support services of the types specified in the 2020 Regulations to be established quickly, if needed as a result of the spread of coronavirus, to respond to anticipated pressures on hospitals, care homes (wholly or mainly for adults) and domiciliary support services for adults.

221. The purpose of amending regulation 35 of the Regulated Services Regulations, via the 2020 Regulations, was to relax specified requirements on service providers to undertake certain pre-employment checks on workers in care home services provided wholly or mainly to adults, or domiciliary support services provided for adults. These amendments aimed to support measures being taken to address the anticipated need for additional workers or to permit the filling of vacancies during the Covid-19 outbreak.

222. The purpose of amending regulation 45 of the Regulated Services Regulations, via the 2020 Regulations, was to relax conditions which limit the number of adults which may be accommodated in shared rooms in care homes for adults. It enabled providers of care home services to vary their registration to exceed 15% of the total number of adults accommodated by the service in shared rooms, where accommodation needed to be provided because of the spread of coronavirus. Social distancing measures were taken into consideration when this decision was made and it was expected that facilities caring for vulnerable people would follow the existing IP&C guidance in respect of respiratory viruses, ensuring physical distancing was adhered to, and isolation/cohorting for care receivers with suspected/confirmed infection remained in place.

223. These provisions were developed and consulted upon at pace in the spring and early summer of 2020 and came into effect in early June 2020. The provisions were revoked in 2022. At each stage the proposals were supported by advice to the Deputy Minister for Health and Social Services, which was discussed with me as needed.

224. On 23 March 2020 ministers received and agreed advice on suspending the requirement for Annual Returns, exhibit **AH/170-INQ000097594** refers. Meanwhile, advice to ministers on evidence holding requirements around pre-employment checks and exempting specific emergency covid-19 services from registration was agreed by ministers on 26 March 2020 exhibit **AH/171-INQ000338224** refers. Following further consideration my policy colleagues with CIW identified that it might be desirable to enable providers to create additional capacity/shared rooms, and Legal Services colleagues were instructed accordingly.

225. On 3 April 2020 a consultation letter was sent out to key stakeholders and on 30 April 2020 agreement was reached to split off the annual returns' elements into separate Regulations for timing reasons, exhibit **AH/172-INQ000336474** refers.

226. On 4 May 2020, the Regulated Services (Service Providers and Responsible Individuals) (Wales) (Amendment) (Coronavirus) Regulations 2020 cleared by the Deputy Minister for laying on 6 May 2020, exhibit **AH/173-INQ000253590** refers.

Reflections

227. I believe that social services policy officials and local government counterparts ensured that the interests of vulnerable children were raised where necessary and taken account of in key decision-making and other fora through the course of the pandemic. To complement this, the fora set up by Welsh Government to coordinate the sectoral response to Covid, such as the Social Care Sub-Group of the Health and Social Services Planning and Response Group, also contained members from organisations representing vulnerable children and young people, to ensure that these voices were reflected in discussions and decisions passing through such groups.

228. I feel that the Welsh Government understood the seriousness of the risk as it developed and took appropriate steps to respond accordingly. In relation to the timing of interventions, I was not involved in the decision-making process related to decisions to lockdown and I don't have informed opinion on the timing of the March lockdown. Regarding the firebreak, as community prevalence went up, so did the death rate. Despite the fact we had infection controls, the death rate continued to climb, including for people in care homes. I found it immensely difficult because we couldn't prevent the deaths, and emotionally it was the most challenging time of my

career to date. I expressed a view that the firebreak should have been longer, but it can be seen from some of the meetings at around this time that the length of the firebreak was influenced by the decision of HM Treasury not to bring forward financial support to the start of the firebreak in Wales. Leading up to Christmas 2020 I was focused on when we would go into a further lockdown due to community prevalence. I recall that Neath, Port Talbot and Swansea Local Authorities made representations regarding lockdown due to the prevalence of covid in the community and impact on their local resources including workforce.

229. I do not recall an occasion when my advice was not followed by the Welsh Ministers. We maintained excellent engagement throughout the pandemic, and I met almost daily with the Deputy Minister for Social Services during the earlier stages, followed by at least once weekly thereafter. We continue to maintain this arrangement even now as the benefits of such regular contact are clear. It is rare that Ministers deviate significantly from the advice of their officials and when this occurs it should be recorded. As stated I have no recollection of such an event concerning any advice I provided to Ministers throughout the pandemic.

230. Andrea Street, Deputy Director led the Social Care Subgroup of the Covid Advisory Group chaired by Judge Ray Singh, and initially attended the Black, Asian and Minority Ethnic Covid-19 Advisory Group, followed by another of my officials at a later point. This advisory group developed the Black, Asian and Minority Ethnic Risk Assessment tool launched by the First Minister on 27 May 2020. The tool was used to assess the impact of Covid on different communities in a workforce environment and it was used within the social care sector and promoted across the public and private care sector through open online events and seminars. Progress was continuously shared at the Planning and Response Social Care subgroup, of which I was aware and maintained oversight.

Lessons Learned

Children's Services

231. Work to support children's services during the pandemic was taken forward and co-produced with key stakeholders. It worked well because there were robust mechanisms in place for working with partners and engaging across sectors and organisations. Strong relationships enabled honest discussion, dialogue and solution

focussed approaches to resolve issues brought about by the pandemic. Communication was key throughout.

232. Weekly meetings with Local Authority Heads of Childrens Services (HOCS) provided opportunities to share and work through issues in real time. Regional meetings also provided a sense of shared challenges and opportunities to discuss and work through. Examples of notes from these meetings are exhibited here as **AH/174-INQ000336475** and **AH/175-INQ000338700**.

233. It was beneficial to have close working relationship with Children's Commissioner for Wales during this time and this was acknowledged in discussions by her office representatives. The Commissioner's office was able to sense check work through a Children's Rights lens which provided assurance and reassurance that children and young people's best interests remained a central tenant. This was particularly welcomed in respect of easements to the adoption and fostering processes.

234. We also benefited from a close working relationship with the Older People's Commissioner (OPC). I met frequently, often weekly, with the OPC throughout the pandemic to discuss the needs of older people, specifically those living in care homes who were identified as at a high risk of infection. These discussions helped to inform Covid policy and planning and placed a specific focus on upholding the rights of older people, in line with the commissioner's statutory duties to challenge discrimination and to encourage best practice in the treatment of older people in Wales. The Older People's Commissioner was actively involved and commented on developing policy relating to visiting in care homes, in order to ensure residents did not experience unnecessary levels of social isolation that affected their health and well-being. This collaboration was invaluable in informing policy direction. My directorates Older People and Carers team worked across government to develop and implement policy to support older people and carers, with a specific focus on upholding and protecting their rights. This team also worked closely with the OPC's office during the pandemic.

235. Also engaging with wider stakeholders outside more immediate partners helped support Welsh Government approaches. An example is working with the Chair of the Royal College of GPs (RCGPs) to raise awareness with GP practices in Wales of the importance of undertaking medical health assessments for prospective foster carers either face to face or via remote technology. A joint statement from RCGP and BMA

in Wales was issued to support medical health assessments in April 2021, exhibit **AH/176-INQ000338699** and **AH/177-INQ000338690** refer.

236. The cross governmental Vulnerable Children, Young People and Safeguarding Workstream supported the timely sharing of evidence, intelligence and information and the mobilisation of responses to safeguarding children in changing situations as we entered and left periods of lockdown. The workstream also took and shared evidence from the third sector and other external partners.

237. The ability to meet with the National Safeguarding Board, Regional Safeguarding Boards, Heads of Children's Services and CIW on a very regular basis supported officials in understanding the emerging picture of the impact of Covid-19 arrangements on safeguarding and work with external partners to identify solutions in an agile way.

Financial viability of providers

238. Providers informed us that the financial support available to them in Wales compared favourably to other parts of the UK. We set up a strong national scheme to provide support for all providers' additional running costs via a supplement to commissioning rates, and for care homes where occupancy levels reduced. This was essential to provider viability. It was reported to us that this enabled providers to focus on keeping people safe and that this saved lives. The funding was largely administered through the Welsh Government Local Government Hardship Scheme. As we understand it, no provider closed in Wales during the most challenging phase of the pandemic due to financial non-viability.

Other issues

239. I am not aware of any evidence that was withheld from me as a key lead officer, however the timeliness of receiving public health advice, during the earlier stages of the pandemic did present some challenges. For example, on 1 April 2020, the joint public health authorities informed me and my officials that they were undertaking a review of the PPE recommendations for the health and social care workforce. The guidance was published the following day and contained an additional table outlining the PPE recommendations that should be followed in the event of 'sustained community transmission' being confirmed. A note was issued on 8 April 2020

confirming 'sustained community transmission' but it was not shared with my team until the following day when conversations with representatives with NHS Wales Shared Services Partnership through the Health Countermeasures Group indicated that they were not prepared for the volume of PPE supplies now recommended for social care. I then escalated this matter directly with the Shared Services Partnership to ensure that all possible supplies could be provided. Following this, through the inclusion of social care policy representation on emerging working groups, the lines of communication between the Shared Services Partnership, Public Health Wales and internal Welsh Government departments improved significantly.

240. I believe that some lessons learned in respect of the use and provision of PPE were made throughout the pandemic. In respect of the pandemic stockpile, we now recognise that social care should be factored into their modelling arrangements. This was particularly important as it may have been commonplace for NHS services to maintain in-house levels of all types of PPE, social care providers in the main had generally limited their PPE supplies to aprons and gloves. This meant that at the introduction of PPE recommendations, many social care providers become wholly reliant on the supplies we were able to distribute to them. The stockpile itself was distributed to Local Authority Joint Equipment Stores, which operated as local distribution hubs, in specially compiled 'packs' suitable for an individual social care worker to be issued with. Following reports that not all the packs contained the appropriate type or quantity of recommended PPE, we introduced an additional step for Joint Equipment Stores, to double check each pack as they arrived from the NHS Wales Shared Services Partnership. This meant that we were able to combat any potential delays in social care services being provided because of a lack of suitable PPE.

241. Internal lessons learned exercises noted that there was a lack of granular and real time data on the emerging situation such as data on which care homes were experiencing an active outbreak at the time; though it was pointed out that in this example there is likely data available within other organisations but was not openly accessible at the time, pointing to an inconsistency of accessibility, exhibit **AH/178-INQ000338686** refers. For example, social care services were enabled to notify CIW of confirmed/suspected outbreaks or cases of Covid-19 in services users and/or staff following changes to an online notification system. This data was used to build an excel based dashboard to track outbreaks/cases and was refined over time to enable early identification of trends in outbreaks/cases and the volume of cases per

service. This information was initially produced on a daily basis, with the frequency changed to weekly as the impact of the pandemic reduced. These reports were shared with various WG directorates including The Knowledge and Analytical Services (KAS) and the Emergency Coordination Centre (ECC(W)).

242. Covid related deaths data was also produced on a daily basis; this was also incorporated into the Covid Notifications report as it was reviewed and refined over time. This data was also shared with KAS. This data was then incorporated into a data dashboard which was shared with health and social care staff and stakeholders.

243. CIW also introduced check-in calls between Inspectors and services which helped CIW to understand the pressures on services. This data was collected via a survey tool and periodic reports were produced and shared with WG HSS, health boards and LAs.

244. It would be a fair reflection to say that myself and my teams were almost overwhelmed at times during the pandemic but we set up the coordination hub to ensure effective communication across key partners – this stood the test of the duration. We didn't have all the information available to us as it was a rapidly developing and evolving situation - so establishing a core network of partners and having an efficient method of communication to and from these were important. Using a central coordination point was useful to ensure that we had a clear method of managing these messages. It was a particular need given that other partners were also affected by the evolving situation and needed to rethink their workforce allocation and how they operated from home instead of office based.

245. There were initial difficulties in establishing key contacts for advice on care homes in Public Health Wales, as evidence at exhibits **AH/179-INQ000336346** and **AH/180-INQ000336342**. Once the relationships were established the policy team worked with Public Health Wales to ensure that policy approaches were underpinned by public health advice.

246. The Vulnerable People Cross Departmental Group supported the timely sharing of information, intelligence and evidence and enabled the mobilisation of responses to mitigate against the impact of self-isolation on vulnerable people (older people, carers, people with a learning disability/autism or physical and sensory disability) in terms of both practical support (food and medical supplies, transport) and emotional/social support (advice lines, telephone befriending, mental health,

technology), linking in with the third sector. The group consisted of representatives across Welsh Government departments. The group was a weekly event looking at support and services for vulnerable shielding or self-isolating. Work from this group included:

e. Development of the Self-Isolation Support Scheme, namely modelling and discussions around monitoring data to take stock of how the scheme is implemented and its impact.
f. Categorising shielding patients and issuing guidance to those falling under that remit.
g. Funding and distribution of food parcels to vulnerable people including mapping of food requirements.

A note from the October 2020 meeting of the group is exhibited at **AH/181-INQ000338565**.

247. Our approach to introducing or re-introducing safety measures from late 2020 onward were directly influenced by the lessons we learned. For example, a rapid review of care home interventions undertaken by my department in conjunction with Professor John Bolton, in Summer 2020 highlighted the importance of balancing the public health advice with the wider wellbeing needs of care home residents. This led to the decision to dedicate some of the Welsh Government's Lateral Flow Test supplies to the testing of visitors to care homes, allowing vulnerable residents to restart face to face contact with their families in time for Christmas 2020.

248. The Planning and Response Group undertook lessons learned exercises which, as a member of the Executive Director Team, I authorised. In answer to the review, feedback was provided via a questionnaire that was circulated to all chairs of planning and response sub-groups, which I attach as exhibit **AH/182-INQ000338812**.

249. I also caused a legacy reporting and chronology exercise to be undertaken across the directorate's Covid-19 workstreams. This had a lessons-learned element. An example would be the legislation workstream's lessons learned, which included lessons relating to adequacy of resourcing (provision of a suitable number of staff members with relevant skills), ownership of some policy areas, and the importance of thorough consideration of legislative interventions at the formative stage.

250. Professor John Bolton produced a rapid review of the operational experience of care homes between March and June 2020. The report exhibited at **AH/183-INQ000253708** captures the initial logistical difficulties that care homes encountered. They were private entities receiving patients from hospital who would be funded by the State in the form of local authorities and/or health boards. They were caring for a cohort who often by reason of age or underlying condition were the most vulnerable without access to warehoused supplies of PPE or the ability to purchase tests in bulk. The report's recommendations underline the need for government agencies (local authorities and health boards) in the future to work closely in partnership with the private sector who own and run the majority of care homes. The partnership should consider how in the future they will support the private care home sector should it face similar pressures in the future. The report's recommendations include the need to support care homes to have infection control plans and to support the care homes to have a business continuity plan which ensures that they have sufficient staff available to meet residents' needs at all times. The partnership between the health boards and the local authorities should ensure that in the future care homes have sufficient protective equipment and access to tests for staff and residents who may have the virus. The partnership between the local authorities and the health board should look to see how they can support the well-being of care home staff. §4.2.9 of Prof Bolton's report specifically considers the discharge of patients into care homes. He recommends that each partnership between the local health board and the local authority in question should consider the provision of short-term beds for those who are ready for discharge but need to self-isolate to ensure they do not spread the virus. Equally, going forward acute hospitals need to understand and use the local partnership arrangements to support the discharge of patients into private care homes.

251. *Risk Factors for Outbreaks of Covid-19 in care homes following hospital discharge: a national cohort analysis*, exhibited here as **AH/184-INQ000336980** and written by key experts in PHW which was published in August 2020. They examined 3115 hospital discharges to 1068 Welsh care homes between 22 February 2020 and 27 June 2020. They looked to assess the impact of time-dependent exposure to hospital discharge on the incidence of the first known outbreak, over a 7 - 21-day window. 330 homes experienced an outbreak, and 544 homes received a discharge from hospital. The exposure to discharge from hospital was not associated with a significant increase in the risk of a new outbreak after adjusting for care home characteristics. Care home size was considered by this study to be the most

significant predictor. Care home size is relevant because larger homes have more community contacts and were thus probably at greater risk.

252. A consensus statement was issued on 25 May 2022, exhibits **AH/185-INQ000338173** and exhibit **AH/186-INQ000338174** refer, which comments on the association between discharge of patients from hospitals and Covid-19 in care homes in wave 1 in the context of building capacity in the NHS. The challenge identified was very limited testing of asymptomatic cases in wave 1. The statement also noted that hospital discharge was not the only mode of seeding – staff, visitors, new residents and visiting professionals all had the ability to seed and re-seed. That combined with limited testing in the general population and no mass testing in care homes where cases had been identified until the summer of 2020 made it difficult for the authors to be certain when and how Covid-19 entered care homes in wave 1.

N. Transcripts of evidence

253. I have exhibited below the Senedd Committees which I attended during the relevant period and during which the pandemic was addressed.

Health, Social Care and Sport Committee – Fifth Senedd

- 4 June 2020: the transcript is exhibited at **AH/187-INQ000338694.**
- 16 July 2020: the transcript is exhibited at **AH/188-INQ000338696.**
- 30 September 2020: the transcript is exhibited at **AH/189-INQ000338698.**
- 13 January 2021: the transcript is exhibited at **AH/190-INQ000338695.**
- 27 January 2021: the transcript is exhibited at **AH/191-INQ000338697.**

Children, Young People and Education Committee – Fifth Senedd

- 5 May 2020: and the transcript is exhibited at **AH/192-INQ000338687.**

Health and Social Care Committee – Sixth Senedd

- 23 September 2021: and the transcript is exhibited at **AH/193-INQ000338692.**
- 24 March 2022: and the transcript is exhibited at **AH/194-INQ000338693.**

Children, Young People and Education Committee – Sixth Senedd

- 7 October 2021: and the transcript is exhibited at **AH/195-INQ000338688.**

- 13 October 2021: and the transcript is exhibited at **AH/196-INQ000338689.**

Public Accounts and Public Administration Committee – Sixth Senedd

- 17 November 2021: and the transcript is exhibited at **AH/197-INQ000338701.**
- 25 February 2022: and the transcript is exhibited at **AH/198-INQ000338702.**

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 27 November 2023