Tuesday, 15 July 2025

(10.00 am)

LADY HALLETT: Good morning, Ms Paisley.

MS PAISLEY: Good morning, my Lady.

LADY HALLETT: Can you hear me?

MS PAISLEY: Yes, I can. I'm afraid I can't see you at the moment.

LADY HALLETT: Ah, probably no bad thing.

Can you see Mr Gething?

MS PAISLEY: No.

My Lady, we think there might be an issue with the Internet.

Ah, my Lady, I can see you both now.

Thank you, my Lady. The next witness is Vaughan Gething.

MR VAUGHAN GETHING (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Good morning, Mr Gething, welcome back.

THE WITNESS: Good morning, my Lady. Good to see you again.

MS PAISLEY: Thank you for attending the Inquiry today, Mr Gething, and good morning. I believe this is the fifth time you have provided evidence to this Inquiry. Thank you for providing your witness statement to this module, dated 3 April 2025. My questions today will focus specifically on the response in relation to the

adult social care sector.

By way of brief background, and you give further detail in your written statement, you have been a member of the Senedd since May 2011. You were first appointed as a deputy minister in June 2013, and during the pandemic you held two ministerial roles; firstly, you were the Minister for Health and Social Services, a position you held prior to the pandemic and held until May 2021, and you were then appointed as Minister for the Economy; is that correct?

A. That is correct.

Q. You explain at paragraph 11 of your statement that your responsibilities in relation to social care were fundamentally different to your responsibilities in relation to health. The Welsh ministers are responsible for the promotion and provision of a comprehensive health service in Wales, which includes the provision of hospitals and other services or facilities as required for the diagnosis and treatment of illness.

There is no equivalent statutory duty in relation to social care, although Welsh ministers do have a range of powers and functions under the 2014 Act and are therefore responsible for the decisions made with regards to those functions.

And you explain that statutory responsibilities are

vested in local authorities, and that social services and social care are funded in a different way to health services; is that all accurate?

A. That is correct.

Q. Mr Hancock, when he gave evidence to the Inquiry in this module, said there was a hodgepodge of accountability that meant that the levers we had at the centre were weak in respect of social care. Is that something you felt to be the case in Wales?

A. I wouldn't put it in quite those pejorative terms. The accountability lines are different. The NHS is essentially line-managed by the Welsh Government; social care is a function of local authority. So the levers are different.

The sector, though, is organised in a very different way, and as I said in my statement, and others, I'm sure, have as well, there are challenges about the way that the sector is organised, about directly provided care, and indeed the range of private providers that are commissioned by either the local government or the NHS.

Q. Can you provide an overview of any difficulties caused in respect of the organisation of the sector in as far as the response to the pandemic, please?

A. Yes, I think I covered this in my statement, there were at the time about 1200 care homes in Wales of a variety

of sizes. Most of those are privately run. You have quite small care homes in some instances, essentially converted large houses, and the odd purpose-built care homes that are much larger, so there's a variety of providers. There are some fairly significant groups of provision, and very individual care homes as well. Some of those are residents who directly pay for their own care, others have commissioned care, largely by local authorities, and when there is nursing care available, sometimes it is the NHS that is commissioning that care, as well.

So the sector is in a difficult position compared to the NHS where you have one stream of accountability going through the service. And, of course, it is not one that the Welsh Government directly line-manages either. We do have overview responsibilities, as I set out in my statement.

The sector is also relatively poorly funded and we have challenges around staff, age of staff, some post-Brexit challenges about the numbers of staff, and I just want to raise the esteem in which the service is held -- and regular challenges about pay, as well. It's a relatively low-paid sector of the economy.

Q. Mr Gething, some have described the social care sector as the "Cinderella" service of public services,

including the adult (sic) Directors of Social Services Cymru; is that a statement you would agree with?

A. I recognise where that comes from because it's relatively low paid but actually it's hugely important. It employs very large numbers of people. Most of those are women. And I think the public don't really appreciate the residential social care sector and the domiciliary care sector, because it is not as visible as the health service. And I think when people interact with that sector, they're then surprised that it doesn't have more to it.

And, you know, it's a sector I'm familiar with myself, not just as a minister, but, you know, I've got family who interact with the sector as well.

Q. Two more general questions, please. Firstly, in your view, did pre-pandemic plans and indeed the response over the pandemic in Wales in any way overlook the domiciliary care sector?

A. I wouldn't want to say yes with confidence to that. You see, the domiciliary care sector, where care is provided in someone's private home as opposed to a care home, although for some residents, the care home is their home, I think there's always a challenge about the variety of the tasks the domiciliary care sector undertake, from relatively intimate ones to lower level

tasks, as well, but actually, from a funding point of view, actually, the provision of that care from a local authority commission service, the need level has gone up, not down. But there's always a challenge in, and I'm sure it's one of the things we'll look at in terms of lessons learned, about factoring in both care home provision as well as domiciliary care in someone's own private home as well.

Q. Can I ask, please, the same question in respect of the response with unpaid carers. So did pre-pandemic plans and the response over the pandemic in any way overlook the provision of unpaid care?

A. I think the scale of unpaid carers was something that was very apparent in our mind in a whole range of areas, but when it came to pandemic planning, I think it is again one of the lessons to learn about how do you support unpaid carers.

The voice of unpaid carers was, I think, pretty significant throughout the pandemic. In all of our weekly press conferences there were representatives of unpaid carers asking questions, so it was regularly a feature in the minds of ministers that were going through it. But I do think for the future it's an area to focus on again, to think about how do you properly support the very large numbers of unpaid carers. And,

you know, to be blunt, there are plenty of ministers who are acting as unpaid carers in roles within their own families. Not of the range of significance that you might hear described through the evidence, but it's a sector that I think does bear greater attention in the future.

Q. Mr Gething, can I please now move on to hospital discharge in March 2020. Now, you have given evidence about this topic, including the emerging evidence on asymptomatic transmission in other modules of this Inquiry, and the Inquiry will of course consider all the evidence you've provided, but I do have a few questions arising, please.

In your Module 2B statement at paragraph 493, you explained that at the time of your announcement of the framework of actions on 13 March 2020, the testing of asymptomatic patients being discharged from hospital was not discussed with you. You say in the same statement, at paragraph 171, that there was a paper from SAGE on 3 March 2020 which said that asymptomatic transmission could not be ruled out.

In Module 7 this year, on 20 May, you were asked if you were aware of the possibility of asymptomatic transmission by the time of Mr Drakeford's statement to the Senedd on 24 March 2020, in which he said:

"... while you [were] asymptomatic you could be passing the virus on to somebody who [was] much more vulnerable."

And that fed into the decision to stay at home.

And you said it was a possibility.

Even if it was not specifically discussed with you in respect of the framework on 13 March, would you agree by that date, that you were aware of the possibility of asymptomatic transmission, and that it could not be ruled out?

A. I'm not sure that by 13 March I could say that I was aware of the possibility of asymptomatic transmission. We've discussed transmission, and the clear evidence and advice was: symptomatic people were at risk. But that doesn't mean that it couldn't be ruled out. So I think that's a fair answer to the question you put, that I certainly wasn't aware of asymptomatic transmission being a real risk, but that doesn't mean that I could say it had been positively ruled out. And that's the level of uncertainty upon which decisions have to be made.

Q. I'm grateful, Mr Gething. So you accept that it couldn't be ruled out. That's a fair way of putting it?

A. I think that's a fair way of putting it.

Q. When you made the announcement on 13 March, had you

queried or challenged the advice you were receiving, given the implications that the possibility or, in your words, the fact that asymptomatic transmission could not be ruled out? So the impact that may have on the adult social care sector in the light of expedited discharge?

A. I think the challenge is that, in agreeing that framework of actions on 13 March, the clarity of advice is around symptomatic people, and they are a definite vector, potential vector, about being infectious. It's also because, by this point, the really harrowing scenes in northern Italy had played out and the risk isn't neatly packaged up in one part of society.

As we know that Covid is spreading through the UK, largely from an introduction from Europe from February half-term visits, there's risks in hospitals, there's risk in the community and there's risks in every other sector outside hospitals as well. And we know, I'm afraid -- well, we're pretty certain -- that if people who don't need to be in a hospital any more are still in that hospital, then not only is there a risk in normal times of them coming to harm, that's what happens with delayed discharges, but actually, if we're having more people with Covid who need an acute hospital bed, then we will see harm throughout our sector, and that is disproportionately harm that affects older people.

It's -- the core business of NHS hospitals is older people at any one point in time, in terms of people in a bed. So you're dealing with risk right across the spectrum. And it's about where and how you balance that risk, knowing that the majority of that risk is going to come into your hospital in the coming days ahead.

Q. Mr Gething, do you agree from 13 March 2020, at the very least, there should have been a policy for all new admissions to care homes who had not been tested and were going to be discharged into a care home, that they should have been isolated upon admission?

A. Well, that wasn't the evidence and the advice we had at the time, and it depends on whether you're asking me based on what I knew at the time, the advice I received at the time, compared to what I know now. Because they're two different points, aren't they? The advice and the evidence at the time was that this was the way, the right way to strike a balance. And there was no advice that came to me saying, "You should test everyone who was leaving a hospital". That advice was never provided to me at this point in time.

And I think it's very hard to re-second-guess all that and say at the time you should have known? Well, actually, I didn't. Looking back, though, of course in hindsight you can see that actually you could have

reduced risk if you had been able to test on discharge, and that would also have relied on not just capacity but the speed of turnaround of testing as well, because if you test someone and you get the results back 36 hours later, there's no guarantee you've eliminated the risk.

So at the time that wasn't the advice. It wasn't in front of me, so I don't think I would be able to say that I could and should have gone behind and around that advice, but in hindsight there's plainly a different range of considerations that we could have made at the time.

Q. And therefore looking forwards, which is part of the purpose of this Inquiry, in these circumstances, do you agree that it would be sensible to have that precaution in place in the future?

A. Yes, but there's a but, and it's a pretty significant but. It does depend on whether you've got the tests available, the speed of the tests available, and you still have to look at the balance of harm and risk. Because as I say, if you know you're going to have lots of people coming into a hospital who need care and will suffer and potentially die without that care, you've got to balance that against what you do across the whole sector, and it also depends on the nature and the state of the scientific evidence and advice at the time,

because I can't predict for you now what the next pandemic will be.

It could be something, because coronavirus up to this point wasn't thought to be transmissible unless people were symptomatic. It might not be a coronavirus in the future. If we were dealing with a transmissible disease where asymptomatic transmission was a possibility, and you have the ability to test, and to test rapidly, then yes, it's something you should do at the start. But whoever the decision maker is will need to deal with the level of certainty and uncertainty they have in the face of the next pandemic.

But in hindsight with this pandemic, if we'd been able to test on discharge from hospital, we could have eliminated risk and as importantly, I think, maintain confidence within the residential care sector as well.

Q. Thank you. I think we may be conflating two separate issues. At the moment, in respect of the fact that there was not enough testing capacity, in your evidence, at that time, do you agree that in those circumstances, where there is limited testing capacity, it would be sensible to isolate people if there isn't an opportunity to test them?

A. If there isn't an opportunity to test, then using isolation as a part of that, yes. And then you're into

making sure you have adequate PPE for people and you need step-down facilities for people to go into. And more modern care homes do have isolation facilities. If you're looking at other isolation facilities, you've got to identify where they are and how you protect a resident population in any closed setting. So they're different factors, aren't they?

If you have enough tests there's one thing you can do, particularly on the speed of the test. If you don't have enough tests, then you've got to consider isolation as one of the additional measures.

Q. Thank you. And one of the steps taken in Wales from 29 April was step-up/step-down guidance. Is that something you think should have been brought in earlier than 29 April?

A. I think we made a concession on this, haven't we, in terms of the fact that once a decision has been made, I think on 15, 16 April, and is then communicated in a letter to care homes --

Q. Yes.

A. -- about what we're going to be doing, I think that's 22 April that letter goes out, or the guidance still is another week. It is also still about making sure you've got enough step-up and step-down provision and where that provision is actually located, because some care

homes have more of a challenge with doing that and then in some parts of the country you may be able to use other NHS facilities as a step up and step down.

Q. And would you agree that this is something that needs to be thought about in planning for a future pandemic, the availability of those settings to care homes that may not be able to offer isolation?

A. Yes, and it also goes in with your means and ability to do so, how quickly you can do it. So for example, when we created a field hospital network in Wales, it took time to do that. You've got to identify the areas, you've got to get them staffed and ready. But that then essentially gives you more flexibility to do this with the numbers you potentially need, as well. But part of our challenge is that we don't build into the way we run our health and social care system lots of additional capacity that is unused.

So, you know, care homes need 90% occupancy plus to be financially viable at present. So there isn't lots of additional capacity built in to flex around that. If you're facing a pandemic, though, and you recognise you need more, it is entirely reasonable to plan for: how could you flex up and provide more step-up and step-down capacity, you need to have somewhere outside of an acute hospital setting to care for people before they return

to either their own private home on a normal street or flat, or indeed, if their home is a care home, when and how they return there.

Q. Can we now, please, and I think you have just touched upon it, the decision about testing and the capacity. And in Module 7 you said:

"Not testing patients on discharge as a matter of routine was in line with advice from Public Health Wales and [SAGE] on prioritising tests for best effect. This was ... based on understanding of transmission at the time."

And I think your evidence to us today is that that was the evidence you were receiving at the time; is that right?

A. Correct.

Q. Now, in Module 2B, when discussing asymptomatic transmission more generally, you gave evidence that you think, actually, if you have greater testing capacity, you can do a great deal more. And then just finally one more piece of background before my next question. In a press conference in June 2020 you said that testing capacity had no bearing on the original decision not to test people without symptoms going into care homes, and you said:

"If we'd trebled the amount of testing capacity at

any point in time, then that was still the evidence and advice we had on how to make use of all of our resources. We did not get advice that said 'You really should do this but can't because we don't have ... capacity.' To make a link between testing capacity and the choice we made is not borne out by the facts."

So my question is: if in fact you did have treble the testing capacity or more testing capacity, do you think that could have impacted on the decisions that were made, or do you stand by those comments made in June 2020?

A. No, I think it's still the case that that was the evidence and advice at the time, and it would be wrong for me to try to recast my evidence based on the advice we had at the time. Separate to that, it is of course possible that if you have lots more testing capacity, how you use it and how you prioritise that can change and give you more flexibility because that testing capacity isn't just for Covid. I think we've been through this before in my previous evidence. That testing, that lab capacity is also testing for a range of other conditions the health service needs to be able to provide for, including during the pandemic. But if you have more capacity, then the way that you prioritise the use of those resources, based on the advice, can

change, as well.

And so, you know, it isn't just my evidence on the state or not of asymptomatic transmission, I know Chris Whitty, his Module 2B evidence runs through the changing, understanding and knowledge about transmission.

So at the time that was the advice, and that was the choice I made based on that advice, but if we had had more capacity then we would have run through our list of priorities of how to use that capacity in a way in which we could have done.

Q. So perhaps your evidence today is not quite as strong as the statement made in June 2020 that you definitely wouldn't have done it. You might have done it; is that fair?

A. But the statement I made in June 2020 was reiterated. That was the evidence and advice I had at the time. And I didn't have alternative advice that says, "Use this in a different way", and actually trying to forecast what you might do with different resources is actually really hard and I think you're getting into a really hypothetical position there.

When you're giving and delivering that press statement, particularly with the challenges that the country is facing, then it's very hard to engage in

hypotheticals, because part of your job is to both explain choices and provide a level of reassurance about the evidence base you have to work with. And that's what I was doing.

Q. Professor Khaw of Public Health Wales told the Inquiry earlier in this module that Public Health Wales did not have access to the numbers of hospital discharges to care homes. Given that they were responsible for advising on testing, do you agree that, in the future, that's important information that they should have access to?

A. I think it's important that Public Health Wales are properly part of the way in which we deliver a response to a pandemic in all aspects. That's hospital discharge and a range of other things as well.

In terms of the initial period of response, I think it is fair to say that we needed to draw our system together in a way that we hadn't had to before, because Public Health Wales has led on localised outbreaks but they couldn't lead in that same way on this national pandemic. So understanding that data would be helpful for everyone, but of course, on a local level, where we had incident management teams, Public Health Wales were engaged in that as well. And it's really about what data we're talking about, and when it needs to be

provided.

And of course Public Health Wales are, if you like, leading the way on the guidance for care homes at the time. In fact it's Public Health Wales's guidance that is essentially published and delivered for care homes at this point in time.

Q. So specifically, then, the numbers of hospital discharges to care homes, you would agree that that would be useful for them to have in the future?

A. I can see how it would be useful, but not just in itself, because it is both the number of discharges, our understanding of the science on discharge in itself with or without a test, our ability to do that, what the pandemic is in front of us, and how that affects the ability of those care homes to handle those patients. Because there is a point given of reasonable contest: can every care home manage every patient? And in normal times they can't.

In the pandemic that's also a factor as -- I know that came up in conversation with a range of stakeholders.

So it isn't just about providing more data; it's data for a purpose, to try to give you a more joined-up answer.

I think my understanding is that's essentially what

Professor Khaw was saying, and I don't take any dispute with that.

Q. Just a few more short questions, please, on 13 March before we move on. Mr Gething, you've frozen on my screen -- thank you, you're back.

At paragraph 95 of your Module 6 statement you say that in the briefing you received on 13 March 2020 it said:

"... the national Pandemic Flu plan provided a framework of actions and that every health organisation had an extant plan which they had been in the process of reviewing and amending the preceding month."

Did you ask whether there were any similar plans in respect of the care sector about how they would cope with the implications of such a framework?

A. My understanding is that for the pandemic plan, that care homes had plans around what to do with flu -- with a flu pandemic and the intake for that. And of course, we're -- in normal times, in the middle of March, you're at the end of the normal flu season and, you know, sadly flu takes the lives of people every year, including in the residential care sector. And when you have infectious conditions, whether it's flu or D&V, in a care home, part of the challenge is there are supposed

to be existing isolation facilities.

I think the challenge here was the scale of those isolation facilities and the adequacy of them in each care home, because this is a bigger and even more important consideration.

But it's the point about having the plan about the way that the local NHS and social care providers are supposed to be able to work together to implement those plans for a pandemic.

Q. And you've said it's your understanding that there were plans. Were they shared with you or did you ask to review them before making that announcement?

A. No, it would have been unreasonable for me to have said that I want to review seven different health board area plans or potentially 22 local authority plans.

Q. Do you know if anybody reviewed them?

A. The health boards were due to review their plans. They're supposed to have a framework of actions to review and amend, and they'd been asked to review and amend those in the preceding month. So the review of those plans should already have taken place.

And actually, by the middle of March, the speed of decision making and the progress of the pandemic is such that -- your normal time frame in government for reviewing things rapidly -- if you do something rapidly

within a month, that's pretty extraordinary. Actually, a month is a very long time in the pandemic. And the speed of decision making required means you have to make choices.

So yes, it was my understanding, and that's what this section of the -- this paragraph in my statement is trying to get over: that even the pandemic flu plan, people have been asked to review those in the preceding months and amend those within the preceding months. So by this point there should have been content about what to do. The challenge is the scale of what's required and the speed of what's required.

Q. Just finally then, please, on the framework of actions. Looking back, do you think there was a strong enough voice, or indeed any voice, in those discussions representing the care sector as opposed to the hospital sector?

A. The way the government works is, our health and social services directorate is made up of health and social care, so it's not simply an NHS department that has social care tagged on. And it is about how you deal with risk for the country, not just one sector of it, as well. It's the point made earlier about the risk in someone's home, the risk of someone in an ambulance at the front door of a hospital, in a hospital, and then

when they need to leave as well, and the risk when people return to wherever their home is, including a care home itself.

And I still think the framework of actions was based on our best understanding of knowledge at the time, and there are definitely strong social care voices within the government when all of these conversations are taking place. I know you're going to hear from Mr Heaney later today.

Q. I was about to ask, who was the strong voice in those discussions; would that have been Mr Heaney?

A. Yeah, he was the deputy director, so the number 2 in the department. And, you know, we have a team of people within the department. They're also in conversations with Care Inspectorate Wales as well.

So there's always a demand for more people to be involved in conversations. And in normal times you'd have gone and talked to local authorities and the care providers forum as well. The luxury of the time that would take isn't available to us as we're going through this.

Q. Can I move on now, please, to 8 April, and can we please have on screen INQ000551798 at page 89. And this is an extract from Albert Heaney's statement to this module, and at paragraph 308 it says, and this in respect of

8 April:

"It was clear that if discharges were made, hospitals would not be able to function effectively, which would inevitably lead to increased deaths. In the absence of advice to the contrary from health experts ... and evidence regarding the possibility of asymptomatic transmission, while testing of all patients would have been preferred, without sufficient testing capacity, it was not possible."

Do you agree with what Mr Heaney says there that at this date, testing of all patients would have been preferred?

A. In hindsight, yes, but this is a conversation -- I think Mr Heaney is describing a conversation between officials because certainly on 8 April no advice comes to me that testing of all patients upon discharge will be preferred, but there is not the capacity to do so. But you expect your officials to have robust and honest discussions, and I think the point is that if discharges are not made, there will be increased deaths, and --

Q. Is there a possibility then --

A. -- there's an awful certainty about that, in addition to not just deaths in hospital, but you'll find deaths for people who don't make it into an NHS bed.

Q. Is there a possibility, then, that there was

a conversation between officials about this, and that's something we can clarify with Mr Heaney?

A. It's entirely possible. And ministers don't get to see every conversation officials have, but actually you expect officials to have robust conversations, and then to provide a view for ministers that either sets out areas of disagreement or areas of agreement for ministers to make decisions on, but I couldn't tell you the detail of that part of Mr Heaney's statement. I'm sure you'll take it up with him this afternoon.

Q. That document can come down. Thank you.

On 10 April you asked that a note be issued by the Chief Medical Officer for Wales to Care Forum Wales to provide clarity and reassurance around the testing of patients being discharged from hospitals into care homes. Why did you feel that that was something that was necessary?

A. We'd had a letter I think on 8 April, Care Forum Wales had written to the First Minister, copied to myself and Julie Morgan, the Deputy Minister responsible for social care. And they'd expressed concern about the position. And the concern isn't irrational, you know, people are reasonably and rationally worried about what is happening, in every aspect of their lives.

So Care Forum Wales, as the largest organisation of

private sector providers, are making representations directly saying, "We are concerned about this." So my request to the Chief Medical Officer is to provide reassurance about why the decisions are being made as they are, the underlying public health advice that goes into that advice, and to try to give as much reassurance as possible.

It's both about the position on the state of knowledge at the time, but it's also that you need confidence for your system to function effectively, because if the system breaks down, you can guarantee that harm will be caused to both staff and potential patients or residents. I think social care refer to them as clients.

Q. In an email from your Private Secretary on the same date, so 10 April, to Sir Frank Atherton and others, it was recorded that the ministers would like to receive daily or every other day updates from Data Wales on the testing numbers as a whole and broken down into health and social care. They realised there may be a confidentiality concern, but it should be easy to provide this information to both the minister and deputy minister on a daily basis.

So by that date, on 10 April, do you consider that there was a gap in the data that you were receiving

about testing figures?

A. My recollection of this is that this relates to the testing of staff, as much as anyone else. So we had looked to create a system for frontline staff to be prioritised with testing, and one of the complaints at the time was that, I think it was 15 per local authority, was relatively low. In fact, we weren't seeing a take-up of all 15 of those tests, so I do recall that I was asked about this in one of the regular press conferences about what was happening.

Having agreed to create a system to do that, because of the understandable priority for social care staff in particular, to not see that taken up was frustrating, so it's part of understanding, is this being taken up or is this a provision that is more than is required? And I think there were complaints about how easy the system was to use, but I expected the system to be used and maximised because that would then mean that if staff were concerned, they could isolate. And if they got a negative test they could return to the workplace with some confidence. And if the system isn't being used, then we need to understand why. So there's a bit of push and pull in doing this as well, and that's part of the overall, and you've seen, I think, my messages around this through April, around are we making best use

of the capacity we have, and is there a reluctance to use that capacity for reasons that aren't coming through to me?

Because PPE is actually a bigger concern at this point in time, in terms of things that across my desk, but of course I'm aware of the challenge around testing and the need to increase it, because it's also a very difficult time in terms of our ability or inability to increase our testing resources more generally.

Q. And we'll come on to that in a little bit more detail but just specifically in respect of the lack of data on testing, do you think that information should have been provided to you earlier than 10 April, if you're querying it at this point? Would it have been helpful?

A. It would always be helpful to have more data in front of you than is useful, and it was because, and I recall there being a challenge around we're not getting enough tests. I thought we'd resolved that by having a system to have prioritised tests and, actually, the feedback was they weren't all being taken up. So I'd asked for the data so I could understand and see in front of me, are these tests being used, are they being maximised out, or is it a case that we're not getting people to use the system that we have to its best effect?

Q. Now, at paragraph 109 you explain that:

"Following the ministerial meeting [on 15 April 2020] Public Health Wales was informed that the Chief Medical Officer for Wales and the Deputy Director General, Health and Social Services wanted a revised approach to testing to be put in place as soon as possible, to include testing on hospital discharge ..."

You explain you sent an email the next day to express your general concern that "at that point I did not have clarity about why we had testing commitments that we could not meet ..."

And you say:

"These issues included ... testing of care home residents on release from hospital ..."

Putting aside capacity concerns for the moment, but just dealing with the decision on 15 April, were you a party to the decision to test all patients on discharge, or was that taken by officials?

A. No, so paragraph 108 of my statement goes through the discussion that took place between the first minister and a range of ministers, definitely myself and the Deputy Minister for Social Care. It's also the day that the UK Government announced their plan for social care and they say that they will test all patients before discharge.

Now, we didn't receive advance notice of that or the

basis upon which that was done, so you have these twin challenges of: is the evidence base changing around transmission and the ability to test? And, of course, the evidence base around asymptomatic transmission is changing all the time through April. Sorry, I'll try and speak slower, I regularly get warnings about it.

As well as the evidence base changing, England then have a significant intervention where they say, "We are going to do this" and it's a surprise to us, and by this point, particularly following the letter from Care Forum Wales, and representations to the local authority leaders, we're concerned that regardless of the evidence on testing, we may not be able to maintain the confidence needed for the system to keep on working.

If local authorities or significant care providers say, "Look, we don't care what you say about the evidence, we're just not doing this, we're too worried" then, actually, that is the point at which you know your system is breaking down, and you can guarantee harm will come, harm to those people who need not to be in a hospital, because a hospital, in normal times is the right place to be when you're really ill, and it's very quickly the wrong place to be, you can get decommissioned and harm caused to you when you don't need to be there.

In the pandemic we are confident in April, remember, we're having significant numbers of people testing positive, more people coming into hospital needing the provision that only an acute bed in the NHS can provide, if your system breaks down at the back door your normal risk and delayed discharges are even more significant, and that's when you potentially get undignified care but also the risk of an increased amount of mortality that is potentially avoidable.

So maintaining confidence in the system is hugely important.

Q. Can I just pause you there, Mr Gething. I understand that's the reasons why the decision was taken, but it doesn't seem, from the note of the ministerial meeting on 15 April that the decision was actually taken in that meeting, so can you help us with who actually took the decision and whether you were involved in the taking of the decision on that day?

A. No, I think that meeting gives a directive for officials to go and look at changing the policy. So in 109, when it says that Public Health Wales are told that the CMO and the Deputy Director General want a revised approach, that comes from the ministerial meeting. And I'm pretty sure that Frank Atherton certainly is involved in that meeting. I can't recollect because I haven't seen the

notes but I would be surprised if Albert Heaney wasn't also dialled into the meeting as well, but the direct approach comes from the CMO and the Deputy Director, the senior officer in the government on social care to Public Health Wales, saying: we need to revise our approach -- (overspeaking) --

Q. Would it be fair to say it was a ministerial decision, then?

A. Yes, I think it is. And if you go back to the concession the Welsh Government has made, it recognises ministers made a decision and the guidance wasn't provided until two weeks later, you know, a letter went out a week later to care homes saying: this is what's going to happen -- (overspeaking) --

Q. Can we explore that then -- sorry, Mr Gething.

A. Yes.

Q. Can we explore that then, please? Yes, as you say, the decision was taken on 15 April and the subsequent guidance was not published until 29 April. Do you accept, along with the Welsh Government, that that was a delay that simply shouldn't have happened?

A. Yes, it's part of the concession that I don't attempt to walk away from. From the decision to the guidance going out, I think it has to be accepted that the guidance could have been provided earlier. And of course we

wrote to care homes, wrote to the sector on 22 April, that's not the same as having the guidance available.

So the practice started earlier than the guidance, but the consistency and successful -- successfully implementing the decision, having the guidance earlier, would obviously have helped that. And I think it's perfectly right and proper the concession has been made.

Q. Public Health Wales told the Inquiry that there would have been capacity to implement that specific decision, so testing all patients on discharge, from 15 April. Is that something you're aware of, or can you disagree with that in any way?

A. No, I wasn't aware that was the view of Public Health Wales.

Q. And so in that respect, why did the Welsh Government need to wait for guidance? Why could it not have implemented the change from 15 April, given the significance?

A. So once ministers make the decision, there's then the conversation with Public Health Wales about being able to do this. And, again, I know my statement refers to the chronology in Albert Heaney's statement, the letter that then went out on 22 April -- I understand Gillian Baranski has confirmed this in her evidence last week -- that actually they were starting to see that there were

tests being undertaken from a week later and the challenge is about how quickly that can be done and communicated.

If we'd simply announced on 15 April this is going to happen, you're into the "where and which". If you announce a decision and implement it afterwards, you potentially have a more chaotic approach to it, and we want the system to be ready and get on with delivering it.

The concession is that actually, having made the decision it should have been delivered earlier. So I can't give an exact day about when that would have happened and I can't tell you why Public Health Wales, who don't actually operationalise all these decisions, would be able to say that could have been dealt with on a certain point in time. But I accept that it could have been done earlier following the ministerial decision and that's consistent with the concession that's been made.

Q. I'm grateful, Mr Gething. You've touched on this before and you say there wasn't the sharing of information you'd have expected between the Department of Health and others, and you've touched on the position in England on 15 April. But we're aware that there was earlier testing of all patients on discharge in both Scotland

and Northern Ireland. Do you say that this did in fact cause a particular delay in Wales specifically?

A. Sorry, I don't understand the question.

Q. You explain that one of the reasons why there was difficulty is that because the Welsh Government wasn't aware that the English government was going to change its position -- or that the UK Government was going to change its position. And your quote is:

[As read] "It's one of the areas where there wasn't the sharing of information you'd have expected between Department of Health and others, but if the same information had been shared with us, instead of being announced, then I think we could have been in a different position."

And so my question is: did the delay in the DoH passing on that information actually lead to any delay in Wales? Because both Scotland and Northern Ireland were able to implement the policy quicker than Wales.

A. It's part about the -- the evidential base about the science, the public health advice, about whether this is the right thing to do, and it's also then about confidence in your system as well, to maintain that confidence.

If England were intending to do this, there wasn't a sharing of scientific or public health advice, and

"This is the justification for it", and I think we've been through that before, it's part of the conversation between health ministers as well. But if you're trying to hold a -- if you're trying to hold a position that is based on the evidence and then your neighbour with a porous border goes the other way, then actually your ability to maintain confidence is undermined. And you can't be in a finger in the dyke position, because, as I said, you know, the risk -- and's a real risk that is on my mind throughout this particular part of the crisis -- is, if we can't get people moving in and around the health and social care system as they need to, then we could have a northern Italy situation on our hands and we could have lots of people dying who don't need to.

So all of those things are in my mind. And, you know, even if had been a conversation between officials before they'd announced it, the day before, even the morning when they were announcing it, we would have been in a better position.

The earlier the information is shared, the earlier we can take that into account, and of course, those decisions do affect the choices we make for more than one reason, as I've said.

Q. So would it be fair to say then that your evidence is it

put Wales perhaps on the back foot but it's not the reason why there was then the 14-day delay in Wales? Is that a fair summary?

A. I think that is fair. I wouldn't try to say the decision in England is the reason for the 14-day delay from the ministers making decisions to the guidance going out. That would certainly not be fair. But it is fair to say that of course it put us on the back foot and we could have been in a better position if we'd had earlier notice.

Q. Reflecting, then, on the discharge policy, please, and at paragraph 120 you refer to the 6 May 2020 SAGE consensus statement on the association between the discharge of patients from hospitals and Covid-19 in care homes, and you say:

"... Covid-19 in care homes was not solely imported from hospital."

Do you therefore accept that the discharge of patients to care homes without a test did lead to at least some cases of Covid-19 being introduced into care homes?

A. Yeah, I think it would be impossible for me to say otherwise, because what we now know and have much more confidence on in asymptomatic transmission is, it's entirely possible that that was a factor in Covid

getting into some care homes, even if it wasn't the dominant factor. And this is about understanding all of your different risks, and how you try to address those, both at the time and looking back.

Which is why, from your earlier questions and making the point around if you can provide asymptomatic testing to help with hospital discharge, there are good reasons to do so, particularly given our experience of this pandemic.

Q. Do you agree that -- I think you've just acknowledged this -- the extent of how many cases were imported thorough this route is difficult to determine particularly in light of the lack of testing generally in March and April? Is that fair?

A. I think it is difficult to determine. As part of the SAGE consensus statement you referred to in paragraph 120, Public Health Wales did a large study looking at 3,000 discharges, and they come to the same conclusion that the SAGE consensus statement does: that you can't rule out it being a factor but you -- there are a range of hospital -- homes that have hospital discharges that don't have an outbreak. It's not the sole factor. It's not the dominant factor. But I think you'd have to accept that it is a factor in how Covid got into some care homes in Wales.

And I -- you know, I certainly don't want to try to avoid that conclusion, because I think that has to be right, doesn't it? It would be illogical to think otherwise.

Q. The Inquiry has heard evidence about another route of transmission into care homes, which was through the movement of staff, particularly agency staff, those on zero-hours contracts. Mr Hancock, when he gave evidence to the Inquiry, discussed the significance of staff movement, and said you could easily rejig the employment arrangements to reduce staff movement.

Do you think the reduction of staff movement between care homes was something that was desirable in Wales? And reflecting back on your experiences over the pandemic, are there any practical ways something like that could be achieved?

A. Well, I think this is a real problem and a real factor. People going into care homes are what changed the nature of Covid in care homes. And, you know, the staff are one of the factors.

That's not a criticism of staff, who made extraordinary sacrifices, but if you've got people working between three care homes, then it's much more likely to be a factor.

We did go thorough this between health ministers and

in calls. And part of the challenge, I think, is I don't think it is as simple as just rejigging employment being something that's easy to do. Actually what you need to do is you need to do something about sick pay and you need to do something about terms and conditions within the sector more generally.

If you work three jobs in three different care homes, it almost certainly isn't because you love working in three different settings. It's about how you make your wages up to be able to feed your family and put a roof over your head. If the pay in care homes doesn't mean you can do that in a single employment, people will work more than one job. That's -- you know, that's not, I think, contestable.

When you don't have sick pay, then actually part of your problem is that you're giving people a perverse incentive not to isolate, not to take themselves out. But it's a -- I go through this in my statement in this module and in Module 2B, it's a rational thing for a person to do, to consider: do I go into work and recognise that I won't be able to feed my family at the end of the week, or do I not go into work and -- because I'm worried about what might happen if I go in if I'm not feeling a hundred per cent?

If you don't have reasonable levels of sick pay,

then you understand why people make different choices. And it was part of our frustration in conversations with the UK, that we couldn't do something to actually deliver sick pay through the sector. And the challenge on wages is part of a longer-term reform I think the sector needs.

Q. Perhaps while we're on this topic, then, if we can move to funding. You confirm in your statement that as early as March you had received correspondence from trade unions drawing your attention to the fact that those who worked in social care who were required to self-isolate or who fell ill would only receive Statutory Sick Pay and so would not be able to afford to take time off work. And I think this is something you say had your sympathies from early on in the pandemic; is that right?

A. That's correct.

Q. You outline in your statement and the Inquiry has heard evidence that the UK Government announced the infection control fund in May 2020, and part of the purpose of the fund was to ensure that staff who were isolating received their normal wages while doing so. And in fact, in Wales, it was recommended in the *'Black, Asian and Minority Ethnic COVID-19 socioeconomic subgroup: report'* that thought should be given to funding, particularly for those who needed to isolate in

the social care sector.

However, as you've told the Inquiry in your evidence, the [Covid-19] Statutory Sick Pay Enhancement Scheme in Wales did not come in until November 2020, and this was later than all other parts of the UK had addressed this issue.

Now, I appreciate you cover this in your statement in your written evidence, but can you please explain why it was that this scheme came in later in Wales, please.

A. Because of the uncertainty around what happens with Barnett consequentials.

So an announcement is made in England, we're told roughly there'll be a consequential, but that consequential can change later in the year. So you don't have all the financial certainty to make choices. That is a real factor.

It's also, I think, linked to the suggestion about an additional payment for social care workers as well. Now, the level of certainty that we needed to be able to make the choice on sick pay wasn't there until later in the year, and I go through in my statement about the range of funding pressures that were available. I would have liked us to have been in a position to have confirmed the position on sick pay earlier, but there was a level of real caution and concern that our budgets

would be changed later in the year and we would find ourselves not able to meet the commitments that we wanted to make.

So it's a real point of unhappiness and frustration that we weren't able to do this earlier. If we'd had greater certainty on funding and that the funding wouldn't be clawed back, we could have acted earlier.

LADY HALLETT: Mr Gething, I'm sorry to interrupt, but Ms Paisley's question was carefully phrased. The Statutory Sick Pay scheme in Wales didn't come in until November 2020, later than the other parts of the United Kingdom, including the other two devolved nations, all of whom are subject to the same kind of challenges you have just described.

So could you please now try to address why the Welsh scheme came in later than Northern Ireland or Scotland and England.

A. Yes, there's still a level of caution. It's about how quickly we're able to move with the work that's being done in Wales. I think it is fair to say that I would have liked that scheme to have come in much earlier, and the conversations that we're having with the whole sector. So yeah, I think it's reasonable to say that I would definitely have wanted that scheme to have come in earlier than it did.

We couldn't do it immediately, when the announcement was made in England, and that caution around trying to understand where is the realistic level of possibility that this money can be clawed back, and when do we have certainty to go ahead and deliver the scheme, as well?

MS PAISLEY: Can I ask, were there conversations with Scottish and Northern Ireland ministers, or indeed between officials, to ask how it was that Scotland and Northern Ireland had found a way through these problems, and if there wasn't, would that have helped?

A. I think our officials did have conversations with counterparts in Scotland in particular, but the officials working on that were the -- having those conversations with officials working on the scheme in Wales as well and having conversations with stakeholders in the sector.

Q. Given the significance of this matter, in the event of a future pandemic, how could such a scheme be introduced quicker?

A. It's one of the points that I've made in I think Module 2 as well as this one, that actually addressing Statutory Sick Pay in the care sector -- if it isn't already addressed, the permanent part of terms and conditions, then addressing this early in a future pandemic would be important, because you're allowing

people to make the right choice without having to factor in their own personal circumstances in a way that I think it's credible did take place in this pandemic. So the earlier and the more certainty, the better.

And you could simply have a UK scheme that ensures that this is being delivered, because you could then make sure that it adds up with the tax and benefits system, of course. The benefits -- (overspeaking) --

Q. So would your evidence then be that the UK scheme would be the way to address the delay?

A. I think you need the four nations of the UK to have a grown-up conversation about how to do this, and then for the Inquiry to make the recommendation that this should be addressed, whether it's by an individual UK scheme or by the four governments working together to make sure that the way that this service is organised (unclear) the four nations is able to do this, then you can have UK-wide consistency, which I think is the objective that should be high on the priority list for a future pandemic.

Obviously it's a matter for the Inquiry to decide what recommendations it wishes to make.

Q. Finally, please, on funding, in Wales the Carers Support Fund was introduced and funding was provided to unpaid carers. Is it your view that that fund achieved its aim

and that sufficient funding was provided through that?

A. It's my understanding because we had the approach from the relevant carers organisation in Wales, who said that they could administer a fund directly to unpaid carers, because they were -- they're the main support group for those carers, they understand who they are and how to administer the fund in a way that is efficient and rapid. And, you know, we did make changes to the scheme that we had, where there were -- I think I cover this in my statement -- when there was additional demand in different parts of the country, we were able to shift money around.

Obviously, understanding from people who were unpaid carers what a future pandemic might look like, not just with PPE, but the practical support that they would need, monies passed that -- for some of them, not for all of them, and understanding how you deliver that. I think it's hard to deliver a single scheme that doesn't have elements of discretion in it, but actually I think that the answer we came up with in not using the discretionary assistance fund was the right one to do, because you wouldn't expect unpaid carers to engage in a fund they may never had heard of, and never had interaction with, whereas they were familiar with the carers organisation that we partnered with.

Q. Thank you. And I think this is something you covered in quite a bit of detail in your statement so I don't have any more questions about that, but can I return, please, to May 2020, and I'm going to return to developments in testing.

Can we have on screen, please, INQ000327582_0016.

This is an entry you made in your notebook, and we can't see the date on this page but it's 5 May 2020, and from the initials we can see -- perhaps if we can zoom out just to see a little bit more of the page.

We can see the initials JF, RS and MH -- thank you -- and so can we deduce that this was a four nations health ministers meeting on the basis of those initials?

A. Correct. RS is Robin Swann, MH is Matt Hancock, JF is Jeane Freeman.

Q. Thank you.

Now, you write next to your initials, VG, so I think we can take it that this is something you raised in the meeting:

"science on testing in care homes; not seen added evidence. Advice to test in every care home. Would want that shared if it exists, ideally with CMOs."

It then says:

"MH [which I take to be Matt Hancock] -- CMO England, advised him to test across care homes --

advice updated within last week."

And it then says:

"VG -- not shared with CMO Wales and obvious difference to test whole sector as opposed to test homes with symptomatic or confirmed cases."

Firstly, following this meeting, are you aware as to whether the advice Mr Hancock had received was in fact shared with Sir Frank Atherton?

A. No, my understanding is that there was no additional advice note that was shared between CMOs. Frank Atherton was particularly exercised and unhappy about it. I think it's best to be polite about the level of his unhappiness.

Q. So would it have been helpful if these advice notes were in existence and might be applicable across the four nations for such evidence to be shared as quickly as possible?

A. Of course, and you'll see the next note, Robin Swann and Jeane Freeman agreed, and the advice should be shared between chief medical officers who were meeting that evening. But my understanding is there was no advice note that was shared, and I don't think it's the sort of thing that Sir Frank Atherton would have kept secret to himself.

Q. No.

A. This was a highly pressurised environment, highly contested with lots of attention and it's frustrating even now looking back -- because I remember where I was taking these calls and everything that was happening at the time, and it really would have been helpful for all of us if that advice existed, for it to have been shared with all chief medical officers.

Q. Did Mr Hancock offer any reason as to why such significant evidence wasn't being shared that you can recall? Or he didn't know either?

A. No, he said, "My CMOs advised me." And that was it. It wasn't that "I got this note and I'll send it to you myself".

Q. I'm grateful. That document can come down, thank you.

On 2 May 2020 you had issued a statement in Wales in which you noted that at that point the scientific advice did not support blanket testing. Fast forward, then, to this meeting on 5 May. Did you question the scientific advice you were in receipt of, if it appeared the UK Government had access to different advice?

A. That's the whole point, isn't it? It's about going back and saying, "I've had this call, this is what's going on, is there an advice note?" And there's a fairly, like I said, a fairly lively and exercised conversation between officials including the Chief Medical Officer

about saying, "No, there is no additional advice that we have received."

So you need to be able to trust each other to work together and to share information, and this was a really good example. And where that isn't done, you used a good deal of time, energy and effort from your senior decision makers and advisers in chasing something that doesn't appear to exist or isn't being shared. And so you're still reliant on: well, here is the evidence and advice that we have. And I don't think a brief disclosure in a four-nation health ministers call is a sound basis to upend the advice that you're working on and the evidence you have.

I don't understand why, if that advice existed, why it wasn't shared at the time, why it wasn't shared between CMOs. But again, it's another pebble in the pond that has a real practical impact in terms of public confidence around what is being done at the time.

Q. Can I please touch, again, on some evidence that you gave in Module 7, again with the further focus on the issues being explored in this module. And you were asked in Module 7 about the decision to extend asymptomatic testing to all care homes which was announced on 16 May 2020, and that was an update on a former announcement that had been made in May. And

you said:

[As read] "I know there are -- somebody said we should have been testing asymptomatically at a much earlier point, but at that point the advice and the evidence wasn't there to test asymptomatically. If we had had that evidence we would have had a very practical challenge of how to prioritise the tests, so even if we'd had that advice at a much earlier stage, we would still have had to prioritise about who we were testing and why."

And you referenced, in response to some questions, a statement made by Mr Drakeford in the Senedd Chamber and you said:

[As read] "The nuance or cut and thrust of the debating chamber doesn't always translate well into having a more forensic examination of it. Mr Drakeford, the First Minister at the time, was setting out that the advice doesn't say that we should do this."

And so can I please just clarify, do you accept that prior to 6 May 2020, the Welsh Government had received at least some advice that there was value in asymptomatic testing for care homes, and as one of those examples, there was a 1 May ministerial advice and you deal with that in your statement at 113 to 114.

A. Yes, so I'm setting out that we've had advice in that MA

that sets out the range of certainty and uncertainty that exists around asymptomatic testing. We had previously moved on treating an individual case as an outbreak in a care home, and so you go and try and deal with all residents, at that time, and staff. So we'd had a fairly significant amount of coverage for care homes affected, and that then means that you are testing asymptomatic residents where there has been a positive case in a care home.

My point around the point in the debating chamber is that there are times you respond when actually, if you were reflecting and providing a written response, you probably wouldn't use all the same words that are used in the chamber. You know, people do misspeak from time to time. The advice that I'd received is as has been disclosed to the Inquiry, and that's the advice I was dealing with and making decisions from.

Q. Thank you.

Can you please confirm, then, was the reason that asymptomatic testing for all care homes not introduced prior to 16 May because the evidence and advice received didn't support asymptomatic testing generally, or was it because at that stage, the advice in light of capacity meant that that shouldn't be prioritised at that stage?

A. No, it's that at that point in time, the evidence

doesn't support general asymptomatic testing. We've moved on testing residents where there is a Covid case in a care home, but we're not testing everyone where there is no Covid case in a care home from staff or residents. So that's the advice on whether this is the right thing to do in, if you like, scientific and public health terms.

Actually, though, I'm trying to recognise in my evidence to the Inquiry that if that were the advice at that time, it would require a significant increase in tests. I think the advice note you're referring to talked about 25,000 tests being needed to do so, and the scale-up of that kind in the programme isn't there, and if we announce that we're going to do it, we should be able to deliver it.

And if we'd announced we're going to do that on the next day, then we would have been able to do it on the next day, we needed to scale up our ability to get tests to people and to get them back. So, you know, when England then made other announcements, I think the announcements said they were going to do everything. In fact they'd agreed a prioritised rollout of testing, as well.

Q. So I think --

A. So that's the -- that's the way in which I made choices.

Q. Is this, then, the distinction: because you were being advised that you would need 25,000 more tests so you would need a lot more capacity, but the advice note on 1 May, and it made reference to the Easter 6 study in Public Health England, do you not agree that that advice note made it plain that there was value but you'd need 25,000 more tests to do it? That is the distinction I'm wondering about.

A. Yeah, no, it -- from earlier in the pandemic where the advice is much clearer: look, this isn't really a high-value use of the tests. The advice on asymptomatic transmission is shifting, and through April it shifts quite a lot, actually. And so there's a recognition that there would be some value in asymptomatic testing at that point. It's part of the reason why we'd moved on where there were Covid cases in care homes to then test the rest of the residents, as well, because of that recognition. And it is still then, though, the advice is still set out in the advice not, the public health and scientific advice at that point doesn't support testing every care home on a regular asymptomatic basis.

It doesn't mean there's no value in doing it, but it doesn't support taking that choice, but if you wanted to do that, then you would need significantly more tests to

do it.

Q. And in Module 7 on that section of your evidence you ended it by saying, "With the knowledge we have now, we would make different choices. And I think it's important to acknowledge that."

So I appreciate these are views with hindsight, but what choices, even with hindsight, may have been different so that we can learn from them for a future response?

A. So with hindsight, both on the hospital discharge, with hindsight, I think it's the point you made earlier about testing there, there's then the point about whether you have -- when and how you introduce surveillance testing in care homes, that's asymptomatic testing with or without a case being available, and also then stratifying where higher risk homes are, and most of the evidence suggests that larger care homes with larger movements of people in and out of them, which is inevitable, are a higher risk, and so if you had to stratify where to start that testing, you'd start with your larger homes and homes that had positive cases within them.

So how you would prioritise that would be, regardless of your resource, I think it's fair to say that you would bump up the list, the opportunity to have

some form of surveillance testing within closed settings, which care homes are an obvious one.

Q. Can I briefly then touch upon testing capacity. And it's right that you challenged underuse of testing capacity a number of times with those advising you, and you go through this in some detail in your statement, and you sent an email on 16 April, and you noted "My concern that I was the public face for the Covid-19 testing strategy and responsible for explaining matters to the public", and we touched on this email earlier. You said:

[As read] "At this point I had not been clearly told why we had commitments that we could not meet and I did not have a sustainable position to offer on increasing capacity and usage, apart from repeating my very real frustration that we were not maximising use of capacity that we had."

Now, in your Module 7 statement you explain when you challenged this you were told by officials that there were three main reasons why maximum capacity could not be used at this time, and to paraphrase, you were told: firstly, we could not plan to use it all as some flexibility was needed; secondly, we were not able to run and maintain the equipment at full tilt, and confirm how long it would reliably run; thirdly was, of course,

laboratory capacity.

And if we can please have on screen INQ000530780, and I'm close to finishing this topical with you, Mr Gething, just couple more questions, please.

Now, at page 3, the daily figure of tests that could be undertaken was 2,100 and we can see on this date, 4 May, only 892 tests were used, and then scrolling up, on 5 May we can see that 743 tests were used, and again, this was dealt with briefly in Module 7 and you said you continued to challenge it. Specifically in respect of what this meant to the adult social care sector, do you feel that you sufficiently challenged why some of these under-used tests could not be redirected to the care sector that so desperately needed it?

A. I don't think that my challenge and questioning in writing and in conversation with officials could be anything less than pointed and robust, but the challenge always is about making sure that as a minister you're properly equipped with information about what's happening, and then able to challenge and redirect where required.

So the explanations provided to me were rational around the number of tests, the number of purposes, but there wasn't, then, an explanation about "You need to have this number or proportion of tests available to

undertake these other functions within the health service, and here's the assessment on the amount of reasonable running capacity." Because the problem is that then -- my frustration, I explained it, was, that number of 2,100 isn't real then, is it? Because actually, if that's running at full tilt, well, actually, what is the reasonable, regular run rate that you could actually have? And we'd be better off saying that rather than the theoretical number than I'm then advised if we carried on doing that, would make our system fall over.

So it's not helpful, I found, to have a number that isn't achievable and then a significant under-utilisation of that maximum number without there being an explanation as to why. And actually, some of this is difficult to go out and explain, it says this but there's a reason why we're not doing that, but at least I'm equipped to make choices about how to explain that to the public. The bigger issue is actually our inability to scale up the testing programme.

Q. And is it your evidence then at this point more tests could and should have been allocated to the care sector, or is your evidence that it wasn't possible at this time?

A. Well, at this time, I wasn't aware that we had extra

capacity to allocate anywhere else beyond our priorities. But I still had the -- I forget the date of the tests you showed me, forgive me, counsel, but it still goes back into the evidence we had at the time about where and how to deploy your tests regards how many you have them. So it's by this point --

Q. 4 and 5 May.

A. By this point I think we'd had I think the ability to use the tests, not just in the social care sector, but if we'd had more tests we probably would have used more tests, I think. But that's also why I'm concerned that the figure is 740 and this time, you know, just over a third of our available testing capacity is being used. I need to know, of that nearly two-thirds, do we need to maintain a third of it for other NHS uses? Do we need to maintain half of it? I then have an understanding, or would have an understanding, of how much capacity we could reasonably use on a regular basis in Covid testing, and where and how that could be prioritised. That may not be used fully on every individual day, but I'd have a better idea about how those tests could be used, and that's the point I was trying to make in the conversations I was having, as well as in the emails I was sending, because I need to go out and explain the position, which is contested because we had a testing

plan that envisaged us being able to significantly increase our testing capacity, that we'd not been able to meet.

And the Roche element of that was only one element of it. As we then -- it suddenly came out that, actually, there were things we couldn't say in public, about equipment that had been held up in different parts of the world, as well, that when it arrived, did allow us to increase the Public Health Wales laboratory testing capacity that we had independent of Lighthouse Labs.

MS PAISLEY: Thank you, Mr Gething.

I wonder if, my Lady, now is good time to take a short break.

LADY HALLETT: Definitely, Ms Paisley. I shall return at 11.35.

MS PAISLEY: Thank you.

(11.19 am)

(A short break)

(11.37 am)

LADY HALLETT: Ms Paisley.

MS PAISLEY: Thank you, my Lady. I'm just waiting for everyone to appear on the screen.

LADY HALLETT: Mr Gething is there for me. Is he there for you?

MS PAISLEY: Not yet.
LADY HALLETT: Am I?
MS PAISLEY: No.
Ah, my Lady, you are now there. I'm just waiting on Mr Gething.
THE WITNESS: I'm definitely here.
MS PAISLEY: I'm grateful. I can see you now, Mr Gething, thank you.
Just two more short questions on testing, please. On 23 November 2020 you agreed that domiciliary care workers should be included in the asymptomatic testing programme for frontline health workers. Do you think that they should have been introduced in that programme earlier, please?
A. We had literally just introduced the asymptomatic testing programme for health workers, and that was on the basis of having lateral flow devices available. So we trialled those. It's possible we could have introduced it a day or two earlier, I won't demur from that, but it was about the same time frames. There wasn't a giant time lag compared to health workers.
Q. When the programme of routine asymptomatic testing was put in place, how were you provided assurances in regards to both residential care and domiciliary care that that testing was in fact taking place?

A. So we did have problems, so, so the asymptomatic programmes that were introduced, so the regular testing in care homes, we initially had weekly testing in care homes, and that led to two-weekly and then actually Covid rates started to rise, so that changed. It was delivered through Lighthouse labs and the portal of delivery.
Now, we did have challenges on the delivery of that and I think I cover it in my evidence, in September at some point, myself and Jeane Freeman wrote to Matt Hancock and I think it's common ground that there were problems with Lighthouse labs at some point, they couldn't cope with the volume of tests, and that actually some of the tests had to be redone because the swabs weren't -- you couldn't use them to test because the delay from taking the swabs to actually testing them was too great.
So I think I cover this in my statement as well, and in previous evidence about needing to re-maintain confidence, we managed to flex some of our resource available from the increased availability of Public Health Wales lab tests at that time, as well.
Q. Thank you. Three shorter topics, please. The first of those is vaccination as a condition of deployment.
Now, the Welsh Government, in contrast to the

UK Government, did not impose vaccination as a condition of deployment in the care sector. Can you please briefly explain the main reason the Welsh Government took that decision and whether you think it was the right decision?
A. I think it was the right decision, because our vaccination programme had been successful in reaching a much higher number, well above the minimum levels of percentage vaccination that SAGE recommended was required. So we were comfortably above both of the markers that SAGE had set. So it wasn't a factor for us to consider. If vaccination as a condition of deployment had been introduced then we potentially could have lost some of our staff, as well.
England had a different challenge. We were in a different position because of the relative success and speed of our own vaccination programme.
Q. The next topic, please, is DNACPR decisions. Was it ever the intention of the Welsh Government that any of its decisions or policies should lead to the implementation of blanket DNACPR decisions?
A. No, that was never our intention. In fact, that was clarified on more than one occasion, both when an incident did arise around a general practice in Bridgend that I've covered in my previous evidence; also from the

ethics group, and, indeed, I think two pieces of correspondence that went out from the Chief Medical Officer and the Chief Nurse reiterating that they had to be individual and informed discussions and decisions and that age, disability or other factors were not to be used to justify blanket imposition of DNACPRs, which did not happen in Wales, as far as I'm aware, but there was concern about it.
Q. Now, the Inquiry's Every Story Matters received evidence, and a care home worker in Wales said, "Our local doctor put a blanket DNACPR on all his patients to stop them taking up beds in the hospitals, which families contested." So were those matters ever brought to your attention, that there was some evidence it was taking place?
A. So we had one incident that I cover in my evidence. I don't know if the Every Story Matters covers the same issue, but it sounds similar. And when that was brought to my attention we acted quickly, my officials got in touch with the practice, they reversed the position they'd taken, and that led to a broader system-wide reminder of the fact that DNACPRs should not be used on a blanket basis.
Beyond that one incident, no other incidents were brought to my attention, but because of the concern that

existed, as I said, we did issue a further system-wide reminder on the appropriate and inappropriate use of DNACPRs.

Q. And the third of my briefer topics, please, is the regulatory inspection regime, and a number of Core Participants, including in their corporate statement the Covid Bereaved Families for Justice Cymru, they've raised concerns about the suspension and general reduction of regulatory inspections over the course of the pandemic and their concern is that without regulatory oversight it's difficult to know whether their loved ones were provided with proper care.

How were you assured about the care being provided in Wales in the absence of inspections?

A. So there was remote interface between Care Inspectorate Wales and care homes. I think Gillian Baranski has covered this in her evidence.

It's also important to reflect, though, that reducing the number of visits to care homes was an important factor in trying to minimise the risk of Covid getting into care homes in the first place. I think it would have been pretty unusual to have a couple of inspectors turn up in the middle of April saying they wanted to undertake a normal inspection for a home that was undertaking tasks that were anything but normal.

But it's one of those uncomfortable realities of managing the risk means you take decisions you wouldn't normally take in normal times.

I think it was the right thing to do but I recognise that that is -- that does not -- come with downsides for people seeking assurance, but the remote contact was part of what we were looking at. And of course care homes were regularly in contact with us and other stakeholders because of the nature of the pandemic and the guidance. There was a regular stream of contact. It wasn't as if care homes were left to their own devices to do what they wanted when they wanted.

Q. Can I then, please, move on to personal protective equipment for the care sector.

Now, in Module 5, Andrew Slade told the Inquiry:

"And I think we've already said, as a government, that in a future pandemic we would immediately move to involving provision for care settings into the work of the Shared Services Partnership."

Is that something you agree with and support as well?

A. Yeah, I think I've said in my own evidence that Shared Services was a success, and if you had the same situation, where supply lines collapsed, that, actually, moving to a central purchasing service, which is Shared

Services at present, would be a sensible thing to do. And it was, overall, a successful story. And that's also the view of Audit Wales as well.

Q. Can I please ask about some of the specifics.

So, on 19 March 2020, you issued the written statement to announce that the NHS Wales Shared Services Partnership's remit would be extended to secure and supply PPE to social care settings in Wales.

Now, the announcement also explained that if PPE could not be accessed while the partnership prepared itself to distribute stock to local authorities, arrangements had been made that care providers could approach local health boards for urgent assistance. What were the practical preparations that had to be made?

A. Well, every care home has a relationship with its local NHS, so it's not as if this was an entirely unknown relationship that exists. The practical circumstances were having -- giving instructions for the pandemic stocks to be released. We'd then need to replenish them and resupply them. And it's about giving confidence to people, because some care homes, having their own established supplies that have collapsed, were genuinely concerned. They talked to colleague care home providers, they talked to the local authority and they

talked to the health service as well.

So the state was reiterating that if the health board has supply, care homes should approach their health board. And that would -- and they could do that through their general practitioner, through the care -- through the health board, where they will all have contacts with their health board, seeking assurance around the supply of items. And that obviously depends on what the items are then as well.

Q. Could we then have on screen INQ000349300, page 4.

Which is an email you sent to various officials on 3 April 2020, and this had followed a meeting with council leaders, and you explain in that email:

"I will want an update on how our current stocks are being used and how much we have left as soon as we have anything useful about the actual demand and need across health and social care."

Was there then limited information reaching you about stock levels and how much was needed across the sector?

A. Yes, so I wanted to have -- and I did then get -- a regular understanding of the amount of stock. But the problem is, having a figure of X hundred thousand or X million items isn't particularly helpful, because you need to understand the burn rate, the use rate of those

items. And we did then eventually get more granular detail on the number of days of supply we had left for each of the items. And I'm sure we've disclosed to the Inquiry an example of how that was provided.

It's also about the level of demand, and that's really important, because demand and need across the sector were different in different places. Some providers will have more stocks available to them. Not everyone's supply line had collapsed by this point. But it is understanding: where that's a challenge, how do you then meet it?

And, you know, every sector outside the NHS is always a bit concerned that: is the NHS being prioritised over and above us? And are we really being listened to?

And council leaders, as you'd expect, were raising that issue. And I know one of them is mentioned in this email. So it was important to not just be sensitive to that concern but to want to get some reassurance about the level of supply we have and how that's being used. That's why we changed from the published information on the amount of supplies we were giving out, to be clear about the level of supplies that were going into social care as well.

Q. And going into, you know, the possibility of a future

pandemic, is that the minister who has responsibility for this having access to that data is something that should be available as early as possible?

A. Yes, it would be helpful. I think Alan Brace gave evidence on this in Module 5. He was really helpful in getting to grips with what was happening within the system, and in the making sure that we had a proper understanding of the usage rate, the amount of stock that we then had for the use at that time -- because our pandemic stocks had been created on the basis there should be six months' supply, and given in a previous answer I think we went through them in half that time. So we didn't have six months' space to get this sorted out at all. So understanding, not just that you have the stock you have built up, but in the pandemic you're facing how quickly can you understand the amount of stock you've got, how long that will last, how many days of supply have you got, and are you then supplying just the health sector or are you then having to take on social care supply as well?

And also the clarity of not receiving the information that comes to the ministers, but on -- I think it's important that you have a way of publishing and making available publicly what you're doing on that as well, because that is one of the things that can help

to maintain confidence across the health and social care sector. And I think when that was published it was welcomed not just by them but also by trade unions as well.

Q. Just a few more questions, please, on this email chain. You received advice from Chris Jones, and on page 3 he said:

"The risk to care workers in care homes and other close communities is likely to be less than in hospital settings since residents are self-isolating and visitors are banned."

However, as we've discussed, expedited discharge at this stage was already taking place.

So did you accept the advice that the risk to care homes was less than hospitals?

A. Yes, because some hospital settings plainly do have a higher risk level to them. If you're dealing with acutely well -- acutely unwell people, then that is a different level of risk to care homes. It does not mean there is no risk in a care home. Far from it. That depends on the tasks that are being undertaken as well, but it is about how you stratify and prioritise.

Even within the NHS, even within a hospital, there will be different levels of risk depending on the task you're doing. A hospital porter has a level of risk,

but actually that won't necessarily be the same as someone who is in a theatre or dealing or working in an emergency department with acutely unwell people as well. So it's trying to understand the risk for the task that someone is undertaking.

And this is a general point around what takes place in a hospital setting compared to a residential home, but it doesn't mean that there's no risk. Far from it.

Q. The advice also said the risk to care workers in the community who are visiting people who are being shielded or who are in self-isolation is also low, provided they observe guidance on hand washing.

However, at paragraph 1 of that response, on page 2, it's confirmed that community transmission was occurring across Wales and the UK. So domiciliary care workers may themselves then have been exposed to the virus, and indeed perhaps many of their clients. So do you think you accepted that advice at that stage?

A. You know, this was the advice from the Deputy Chief Medical Officer, but it's on the basis that you're able to successfully implement the measures that are set out.

Now, if you're going into someone's home and undertaking personal care tasks, your risk shifts, doesn't it? That's natural. But it depends on the tasks you're undertaking and whether you can

successfully undertake the tasks that he refers to. Can you socially distance? Do you need to hand wash? Have you got the appropriate PPE? And that is the point around the relative level of risk.

And again, this all tiered, depending on the tasks you're undertaking and the jobs you're doing, rather than "care workers are low risk, healthcare workers are high risk". That sort of crude description isn't what this guidance is trying to set out.

Q. In the event of a future pandemic with similar characteristics, is there anything that can be learned surrounding the provision of PPE for the care sector when community transmission is known to be occurring?

A. Yes, I think some of this comes back to what we know about this pandemic and the changing evidence basis around a range of control measures. So if you can undertake social distancing, that is a control measure that protects you and the person you're potentially undertaking tasks for. If you can't do that, then in particular, the changing nature of what we're able to do on face masks, I mean, fluid resistant ones would be important, as well. The points around ventilation, to ensure that if it's possible to be in a well-ventilated setting, that reduces the risks for everyone who is undertaking those tasks, as well.

So I do think there are areas of learning both about the understanding of the risk about the task that is being undertaken, whether you can practise some of the control measures, and if you can't, how PPE is used to protect both you as the worker and the person you're undertaking those tasks for, and those other control measures, as I say, including PPE and otherwise. This would mean, as we got to, that there would be an increase in the demand for PPE itself. So it goes back into, with this type of pandemic, you need to have certainty about your supply lines and ideally a larger stock than we had at the start of this pandemic, as well.

Q. Can I just pick up on something you said, please, which was the importance of ventilation. Do you think, during this pandemic, Welsh ministers had enough access to information about the ability of care homes to ventilate, or is that also an area of learning?

A. I think it's an area of learning because our understanding of ventilation developed through the pandemic. If you consider the conversations we were having in April compared to June 2020, compared to December 2020, there's quite a lot of moving on. I don't know if you recall that on one of the May bank holidays, I think the late May bank holiday, a number of

people went out and had a drink, and there were regular reports of social distancing disappearing after the second or third drink. There was lots of concern that that would lead to a spike in Covid in another three weeks' time.

Part of the reason why that didn't happen is, that, actually, when people were drinking outside then, actually, you're much more protected than being in an indoor setting, as well, so our understanding of the benefit of ventilation shifted significantly through a period of months.

Having well-ventilated spaces in care homes, either for visiting pods outside the normal care home or how to facilitate indoor visits, our understanding has shifted significantly.

A similar pandemic, we could undertake different measures at a much earlier point that would enable low-risk contact with people, whether that's for care or, indeed, for visits.

Q. Two more questions, please, on PPE. By 7 May 2020, which was seven weeks after your written statement on 19 March that we have looked at, two-thirds of the social care sector's PPE needs were being met by the NHS Shared Services Partnership arrangements.

Now, you explain that you consider that the

availability of PPE to the sector had improved considerably. Now, whilst it may have improved, that did mean that one-third of the sector's PPE needs were not being met. And so my question is, can you provide an overview of your understanding as to why that was the position and how that position could be avoided in the future?

A. I don't agree with the premise of the question. My statement that two-thirds of the PPE needs were being met by Shared Services shows the amount that was being delivered by Shared Services. The other third, we didn't receive complaints there was no PPE available and people were managing without it, it was actually about how they were securing, potentially through alternative means, their own PPE supplies.

So we're taking up the slack -- well, the challenge are the two-thirds of the sector at this point in time and it's being done through Shared Services with no cost to those care homes that require it, but other care homes are still managing to get some PPE for themselves. So that's the point I'm trying to make, rather than a third of care homes are left without PPE. I wouldn't want to leave that impression out there because that's not what I'm trying to get over in my evidence.

Q. I'm grateful for the distinction, Mr Gething. The

Inquiry has heard evidence, however, that throughout April there were difficulties, and what I'm seeking to address is, getting this programme off the ground, is there any learning for the future about the original delays? I appreciate what you're saying in respect of May, but throughout April, is there any learning about why there were shortages as it was being established?

A. Well, I think that is really about how quickly you're able to significantly increase supply, and not just the global supply that comes into a country, but actually how you then distribute that as well. So we made use of the joint equipment stores that local authorities had, because people were used, in a local authority area, to accessing information and supplies to and from that and distribution from local authorities.

How quickly people actually bought into wanting and needing to have supplies provided by NHS Shared Services, it's not just Carmarthenshire that said it would go alone and then had to come back because it couldn't source those supplies. So I think the learning is how quickly are you able to make a choice that you need to be able to source supply in a different way and the myriad procurement arrangements are not going to hold up to the pressure that they'll be under.

It's then also about where and how do you get that

outside of the UK, and how quickly can you scale up home production of that? Because, you know, lots of PPE that is produced in the UK is more expensive than sourcing it internationally. And so the tyranny of numbers and budgets means that you are going to supply that in normal times by procuring it from overseas. If those supply lines are breaking, how quickly can you get up supply here in the UK and for private businesses to repurpose what they're doing?

So I think there is learning in that, but it still relies on your understanding of the pandemic you're facing, the stock you have available to you, and how quickly you're able to interact with an international market with a purchaser, a procurer, that has a success track record, and then your points earlier about the amount of stock and how that gives confidence within the system with the wider public, I think are relevant too.

Q. I'm going to change topic again, please, and can I move on to visiting.

Now, you explain in your statement at paragraph 207 that the first piece of guidance for the care sector on visiting was communicated on 23 March 2020 which advised that visits to care homes should only take place when absolutely essential and not part of routine visiting. What was the intention behind the phrasing "absolutely

essential" and do you think that guidance could have explained more clearly the intention behind what that meant?

A. So we were thinking about compassionate visits, and that would include end-of-life care. And I think later guidance clarified that. So if, in the first iteration, we'd been able to describe what we subsequently did, that could have helped. So it's -- I think it's reasonable to accept that that description, if it was provided early, would have helped everyone.

Q. Would you agree, similarly, in respect of end of life, because the Inquiry has heard evidence that that was interpreted in some cases to mean the last few hours or the last few days, whereas some providers interpreted that more widely. Do you think it would have been helpful to give a definition or more guidance on interpreting end of life?

A. I can see that. I think there's a note of caution here in that the level of detail you go into in the guidance can give you certainty up to a point, but you need people to understand and implement the guidance. The longer and more complex the guidance, the harder it is to successfully and consistently implement. So there is a balance to be struck here. But I think as we go through the pandemic, we're learning more about what

helps to meet the needs of providers and the public who are interacting with the sector. But I think it is important to put on record that it's important to strike a balance on that because otherwise, if you write a telephone directory of guidance covering everything, that's not a fair fight for a care home provider to go through that, understand it, and implement it with the speed that was required.

Q. To what extent was the impact on disabled people and those with dementia, who often relied upon their family members to advocate on their behalf in respect of care, considered particularly in respect of those blanket bans, for example from 23 March?

A. It was really difficult, because again, you have this balance of -- for people and their general sense of wellbeing, the visits are a part of what helps to maintain that. When you interrupt that, that will impact residents. The alternative challenge is, though, that if you have regular visiting continuing, then you'll see more Covid in more care homes, with all of the consequences that come with that.

So, you know, this isn't straightforward, and you're trying to balance and manage all those risks and rights, and at the same time, at this point, the real and reasonable fear is that if you don't put more protection

to restrict the number of people that go into care homes, then you will see harm go into those care homes that you can't undo.

Q. If the Welsh Government was to approach this situation again now, in the future, are any lessons learned from the experience of visiting, and would you do anything different next time?

A. Yes, so I think with the benefit of hindsight and the learning we've got, the point I made earlier around ventilation is important and relevant because you could undertake more visiting at an earlier point, successfully, or with an acceptable level of low risk. Because I think it's important to recognise that visiting is an activity that comes with risk, but there's a balance with that risk about what happens to the resident without visiting, as well.

When you have the ability to visit outdoors, that of course is safer, as we now know. So I think there are things that you could do, to think about the position we reached on visiting where outdoor visits, particularly in times of lower prevalence, were managed successfully, even in times of higher prevalence, visiting with social distancing was possible outdoors and in the pods that we helped to procure as well. Where people couldn't move outdoors, the control measures you could be undertaking,

including ventilation, to allow visiting to take place. It's much like when we think about visiting as an accompaniment for healthcare services, think about people who were pregnant and weren't able to have their birth partner with them, we've recognised before in different modules that we want to revisit that and in the future do that differently.

In care home visiting I think it's important to recognise that the knowledge we now have, we'd have a different approach to it. The counterfactual of course is a confidence in what you're doing. Some people were so desperately concerned, and rationally so, that the idea that large numbers of visitors were still coming into care homes would be something they would be unhappy about, but if you are able to point out, we think, this pandemic, there are control measures we can undertake, ventilation is one of them, adequate supply of PPE is another, and we now have rapid lateral flow type tests that mean that we can help reduce the risk further, then you could have a very different approach to visiting much earlier and that would definitely benefit residents who, I accept, had their wellbeing compromised by the control measures that were introduced at various points in the pandemic.

Q. Can I briefly ask, please, about timeliness of guidance,

visiting guidance.

Now, on 5 June, a letter was written to the sector following the move to Stay Local on 1 June, so that was five days later, and you say this prompted a lot of queries regarding the position on care home visits.

Looking back, do you think it would have been helpful to consider and produce guidance ahead of those types of larger moves for the rest of the community?

A. Yeah, I think the capacity of the government to do everything all at the same time, and to work with different stakeholders, and -- you know, as we go through, when you think about where we were in May and the amount of headroom we thought we had to make changes, to get all that ready, to get the guidance ready, you've got to anticipate that and look at that earlier.

If there was future pandemic I think we would be anticipating this and there would be an opportunity to do this sooner. But I think at the time -- at the time, I don't think it would have been reasonable for me to say that we would have been able to do this much, much earlier. In the future, though, it would be a different consideration because of what we learnt in this pandemic, and the ability to apply that in the future.

Q. Regarding responsibility for visiting decisions or the

guidance that's produced, Ms Herklots told the Inquiry yesterday:

"I think ultimately it needs to be a clear decision by Welsh Government, because it is the body that can coordinate what is happening.

"It felt to me that they were waiting on advice from Public Health Wales, and therefore it felt like, maybe almost by default, it was a sort of Public Health Wales decision. So I think in -- in any pandemic in the future, I think, you know, governments need to own those decisions, and they need to be clear about where they're taking advice and then the decisions that they're making as a government on that basis."

Do you have any comments on what she said, please?

A. Well, the government does own the decisions we made. And, you know, you have to take advice and guidance from people with expertise, and Public Health Wales are there for that purpose. The challenge then is how you communicate that, and how quickly and rapidly and consistently you can communicate that as well.

So if the suggestion is that we essentially devolved our responsibility, I don't accept that. We took decisions and we had to explain those decisions, as we did on a regular basis.

In the future, as I've said in answer to your

previous question, I think we'd be able to make some of those choices earlier, to draw in stakeholders, both Public Health Wales but also stakeholders within the sector as well, to understand, with a pandemic that's in front of you at that point in time, how quickly can you move.

And then, of course, we move to a position where local authority level decisions were able to be made on changing visiting as well. Because a situation in Gwynedd could be radically different from a situation in Bridgend, and so trying to make a national choice about all of those would actually get in the way of making the right choice. But the incident management team process is important to make sure you've got local public health advice from Public Health Wales and your health board, together with the local authority and the homes, to understand what choice you're making, so it commands support from all of the stakeholders who need to be there to make it work. And I know that we had a couple of instances where that didn't happen.

Q. Thank you, Mr Gething. I have just two final questions for you, please.

Firstly, the Welsh Government produced a Care Homes Action Plan, which focused on six areas: infection prevention and control, personal protective equipment,

general and clinical support for care homes, residents' wellbeing, and social care sectors' wellbeing, and financial sustainability.

And the Inquiry understands that there were regular updates provided to the deputy minister on progress. Do you think that would be a useful tool for the future and did you find that beneficial?

A. I think so. The Care Homes Action Plan was drawn together with learning from the first phase in the pandemic about what had worked and what hadn't worked. And the fact that we had someone with expertise and understanding in the sector to do that fairly quickly was also, I think, fairly helpful, and I think it did help with the level of buy-in.

If you're looking at a future pandemic with the level of learning we have now, it would be possible to take an earlier look at what is happening practically within the care homes, to understand how the pandemic planning that we as a nation would have at that point is being implemented, how successfully or not, and how to understand and deliver learning.

The warning note I think to sound is, and I think it's a reasonable one, is that if you're going to do that you need to have the space and the time to do it. If people are dealing with the emergency in that moment,

and all of their energy is invested in doing that, to then say we want to have a new action plan delivered on top of that, you've got to make certain there's capacity to do it and the ability to learn, to then see if you need to do something differently as well.

And I think the earlier demands, you know, on the Older People's Commissioner were at a time where actually it wasn't the right thing to do, but we did do it over the summer and, like I said, those relatively low prevalence levels gave us the space to do that, to try to be in a better position for the autumn, but that learning, that is now there, and I hope that both with this Inquiry and what we're doing anyway, that learning won't be forgotten and will inform future action.

Q. My final question, please: other than anything we've already covered in your evidence, are there any particular recommendations you think are important for these Inquiry to consider? Specific to this module, please.

A. Right at the end of my statement I've set out a range of -- I think I've invested in three, and I think one we haven't covered is the consistency of isolation facilities in residential and nursing homes.

There's a point there about future reform in the sector, but this would be something that I think would

be relevant to every flu season, and every outbreak of an infectious condition in normal times, and would also provide, I hope, a greater success rate about the ability to isolate residents in a supported environment in the future as well.

That would require both a review of the sector and also some investment on a consistent basis, on how those facilities are maintained, as well.

MS PAISLEY: I'm grateful, Mr Gething.

My Lady, I've no further questions but there are some Core Participant questions.

LADY HALLETT: Thank you very much, Ms Paisley.

Mr Gething, as you know, there will now be some questions from the Core Participants. I only allot them a certain amount of time so I'm sure they'll be grateful and I'd be grateful if you keep your answers as short as you reasonably can.

Mr Stanton.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

Good afternoon, Mr Gething.

A. Good afternoon, prynhawn da.

Q. As you know, I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. I have a small number of topics to cover with you and the first relates

to the decision that you took on 25 November 2020 to delay the use of the Pfizer vaccine in care homes for the first four weeks of delivery.

You address this issue at paragraphs 302 to 321 of your statement, and at paragraph 304 you acknowledge that the advice of the Joint Committee on Vaccination and Immunisation, on 25 September 2020, was that the first priority group for vaccination should be older adult residents of care homes.

The reason elderly care home residents were the first priority group was because of their extreme vulnerability, and in this respect, scientific studies record the case fatality rate of elderly, unvaccinated care home residents as high as 36%. That is, approximately one in three infections proved fatal.

And for the Inquiry record, this data is taken from the research paper authored by Professor Shallcross and others at INQ000544928, which identified that of 607 residents with confirmed infections, 217 died.

Mr Gething, given these alarming statistics, do you accept that by not following JCVI advice to prioritise care home residents for vaccination, you failed to protect them?

A. No, I don't accept the formulation of the question.

If you look at all of the evidence I have provided

and -- in my statement, not just paragraphs 304 but paragraphs 305 and 306 as well, I'm setting out the challenges of delivery of the Pfizer vaccine. It was very different to the AstraZeneca one, which was much more portable. We needed ultra-low freezer storage and actually the ability to successfully deliver that. So this was a point that I discussed with officials delivering the programme. I know Dr Richardson gave evidence on this in the vaccines module as well, and on paragraph 306 there's the pilot for the rollout, where we looked at a care home in Betsi Cadwaladr, and the learning from that to understand how that would then be introduced as quickly as possible, because I always understood that vaccination, in the absence of a curative treatment, was going to be essential for us to get out of the pandemic.

Q. Thank you.

Mr Gething, could we have a look, please, at the statement of Dr Richardson. You just mentioned her evidence in your answer just now.

Can we have up on screen, please, INQ000501330_0018.

Hopefully you have that.

A. I have that in front of me, yes.

Q. Thank you.

Mr Gething, at the second sentence of paragraph 67

you'll see it reads:

"... on 25 August 2020, it was recorded that there was a significant risk of insufficient freezer storage being available to store a vaccine requiring a temperature of -70 degrees centigrade, should such a vaccine receive regulatory approval. The mitigating action was 'assess current and identify additional sources of appropriate freezer capacity' ..."

And if we could separately look at some data provided to Care Inspectorate Wales around the notification of deaths in care homes around this time.

At INQ000198645 at tab 9.

Again, hopefully you have that before you.

Mr Gething, if I could draw your attention to columns D and E and rows 10 through to 16, you'll see there suspected and confirmed Covid deaths are recorded, and we can quite clearly see the tail end of wave 1, and then through July, August, September, numbers remaining relatively low, before starting, sadly, to build again in October, through November and December, and then reaching a peak in January.

I'd suggest to you, Mr Gething, that the summer and early autumn of 2020 provided an opportunity to take action in respect of the need for refrigeration and other measures in order to be able to deliver the Pfizer

vaccine. Would you accept, Mr Gething, that more action ought to have been taken in this period to ensure you were in a position to vaccinate the most vulnerable?

A. I think when you look at all of Dr Richardson's evidence, it does go through the fact that the Vaccination Programme Board were looking at how to try to manage the Pfizer vaccine. It wasn't certain this would be the first candidate vaccine. That was never a discussion I had until much later. There were real challenges, though, that the Vaccine Programme Board had with not just the ultra-low freezer element of it but actually the ability to move it around and get it from one care home to another. So there were real practical challenges in how to do that.

And when we look at the figures that you've highlighted, this is -- the fact that this is the reality of the fact that more Covid in circulation and, by this point, in November, December, January, with the more transmissible variant as well, that's when these figures are showing.

Now, of course, if we'd been able to introduce any successful vaccine earlier, we could have seen an impact in these mortality figures, but we needed to be able to deliver that vaccine safely to all of the people who needed it. And that's what we tried to do.

Q. Thank you, Mr Gething.

Vaccinations in Wales commenced on 8 December 2020. However, by the end of January, nearly two months later, you'd only vaccinated 11,000 care home residents or around 67% of the population. This is confirmed in the vaccines weekly update of 26 January 2021, which is at INQ000508504. However, I don't think we'll need to go to this document because you deal with this issue, Mr Gething, in paragraph 310 of your statement.

At page 2 of this update, it's also confirmed that some 290,000 people had been vaccinated in Wales by this time, which means that care home residents had been leapfrogged by several other priority groups. And in this regard, Mr Gething, please can I refer you to evidence which I'll ask is brought up on screen of Professor Lim that was given to the Inquiry during the Module 4 hearings.

This is at PHT000000143_0023.

And when you have that, Mr Gething, the section I'd like to refer you to is at page 89 of the transcript from line 17, and it reads:

"... the number needed to vaccinate to prevent one person from dying in cohort 1 was calculated by the institute of actuaries as 20. In other words, if we vaccinated 20 people who are residents in an old age

care home, we would protect one life.

"The same number needed ... to protect one person from dying in a 65-year old cohort was 1,000, and the number needed to vaccinate ... to save one life in the 50-plus cohort is 8,000."

Mr Gething, having regard to this information, do you accept that had care home residents been vaccinated promptly in accordance with JCVI advice, many more lives could have been saved?

A. Our vaccination programme acted in accordance with JCVI advice. If there's a suggestion that we ignored that, that is one that I do not agree with, and I don't think the evidence bears that out. You put to me paragraph 310 of my statement, and in paragraph 310 of my statement I explain why we hadn't been able to vaccinate 70% of people over 80 and in care homes. There'd been a range of factors in that that were beyond our control, but if you can't vaccinate residents in care homes it doesn't mean you should not vaccinate other people in those top two risk groups, because the JCVI advice was to vaccinate people in the top two risk groups. And that's how the cohorts were working and that's what we did.

So, and when you look at what we did in our vaccination programme, we were successful in getting to

large numbers of people, really quite quickly, and the scale and the pace of the vaccination programme significantly increased through January and February, as the lessons learnt from practical delivery were applied in practice.

Q. Thank you, Mr Gething.

Just in respect of an answer you gave there that you were following JCVI advice, Wales was the only country to delay provision of the vaccine and indeed, other UK countries had noted that, Westminster Government noting, in a meeting on 12 January, that the Welsh Government was different to other nations and they had prioritised NHS staff. So I'm not sure I accept what you say in respect of following JCVI advice.

A. We didn't delay the delivery of the vaccine, and I certainly wouldn't take as gospel a statement by the UK Government. You'll recall this was a highly contested political environment at the time. I undertook a huge amount of work practically with the Vaccine Delivery Group. This is a part of the pandemic I recall really vividly. The amount of time and different days, using my son's bedroom to run meetings to understand where we were, to understand the pace we could inject, and at the same time, there was quite difficult and sharply political criticising within Wales

and outside, and I do reject the suggestion which I find offensive that we were sitting on the vaccine, and failing to meet our obligations and work in accordance with JCVI advice.

And if you look at what we did in the vaccination programme in Wales, we had an efficient and fast rollout of the vaccine, and we covered our most vulnerable groups at real pace that led to us being able to make choices to leave the extraordinary lockdown they experienced in winter 2020 to '21.

Q. Thank you, Mr Gething.

I'll take you to another decision around this time, please, that I suggest similarly failed to protect and prioritise care home residents, namely the decision on 15 December to allow what has been described as low-positive testing patients to be discharged from hospital to care homes.

Your statement announcing this decision is at INQ000227285, which we don't need to bring up.

The timing of this decision is at a point when you had suspended Pfizer vaccines in care homes and at a time, as we've just seen, when deaths were rising within care homes. Can I ask you, what impact did this change in policy have on infections and deaths in care homes in Wales?

A. The change was made based on the advice that low-positivity readings were -- the low-positivity readings that we had changed advice on were ones where people were no longer infectious. It's covered in my statement, it's covered in the statement I issued at the time, and it's also referred into Professor Khaw's evidence that he's given to this Inquiry as well. The suggestion that that had somehow lead to an increase in infections in care homes is not one that is borne out by the evidence.

Q. Can I then, please, Mr Gething, please take you, and have up on screen, to the advice of the Technical Advisory Group of 11 December 2020 upon which your decision was based.

That's at INQ000350671_0002. And at the top of that page, when you have it, you'll see the statement:

"There remains uncertainty around the period of infectivity for individuals infected with SARS-CoV-2."

This document does go on to indicate that there was high confidence in the decision around low-level positive testing. However, nevertheless, there remained a risk. My question to you is, given the extreme vulnerability of care home residents, the way that the virus, once it was seeded within care homes, rapidly spread within it, the fact that care homes were ill

equipped to cope with infection breakouts, and at a time when vaccinations had been suspended in care homes, why were you willing to take this risk, even a small risk?

A. Just coming back to where and how you judge risk and harm, if you have someone who is low positive, and keep them in a hospital setting, then that person is at risk of greater harm. And the evidence that we point to here does not justify keeping that person in that state.

There is risk from care home staff going into a care home every day, but you understand those people have to go into the care home to undertake their work. And this is a decision that is based on the evidence at the time, and I have not seen any evidence that this decision led to infections in care homes.

And, you know, this is the point about learning what to do in a future pandemic. And if you want to take zero risk choices, then those choices will in themselves cause harm. And this is both the harm for the person who is in the wrong place, but also the harm to the person who can't get into a hospital when it should be the right place for their care and treatment to take place, and I have responsibility for the whole country, not one section of it. So this is an evidence-based choice, and I think it's important decision makers in the future make choices based on the evidence.

Q. Thank you, Mr Gething.

My final question relates to paragraph 96 of your witness statement which I'd be grateful if we could have up on screen, please. That's at INQ000587254_0023.

And you'll see there, Mr Gething, the first line of that paragraph:

"As ever, the most vulnerable people in Wales were at the heart of the decision-making process ..."

Mr Gething, having regard to the risks taken with the safety of elderly people in care homes just described, can you legitimately make this claim?

A. Yes. If you look at the choices we made, we made whole-society choices to protect the most vulnerable people and we knew that Covid as a condition, was something that affected people with particular additional healthcare conditions, and age was a significant factor. And that's why the JCVI advice on vaccination placed a high regard on the age of individuals.

So in an NHS hospital, on any day, the people in a hospital bed are overwhelmingly older people. Those people are vulnerable when hospital is no longer the right place for them. Those people living in their own homes, outside of a hospital, are more vulnerable if they get Covid. If those people need to move from their

home, into a hospital, you need to have a hospital bed for them. You need to do this in a way that recognises the risks in the community, in an ambulance, in a hospital, in a care home, and those people are then returning to their own home as well, and all of the staff who are engaged in that as well, and that is why we made whole-society choices on what to do to manage those risks, to understand the balance of harm in every choice that you have to make.

And that is the way that I approach making choices, and those are still the concerns I have in approaching this Inquiry about how you understand how not just the choices we made, but the choices you could make in the future, with a similar or even a different pandemic, and the choices that inevitably any decision maker will have to face.

MR STANTON: Thank you, Mr Gething.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Stanton.

Ms Morris.

Questions from MS MORRIS KC

MS MORRIS: Thank you, my Lady.

Mr Gething, can you see and hear me okay?

A. I can indeed.

Q. Thank you, good afternoon. My question is about

visiting restrictions, please, and the Inquiry has heard evidence, and has evidence before it, from Heléna Herklots, the Older People's Commissioner for Wales that in her view the initial guidance did not take account of the harm to health and wellbeing from older people of being isolated and, in fact, you said in your statement that as of August 2020 you were aware of the growing concern expressed by the Older People's Commissioner and others about the negative impact that the restrictions on visiting and physical separation from loved ones was continuing to have.

Is it fair to say that there was a lack of understanding about care homes and the rights of older people in visiting guidance, particularly in the initial stages?

A. No, I don't think so because in the initial stages, you will recall, in March, we were just going into lockdown, and we have a transmissible condition that is more likely to affect older people in particular, and we don't understand everything about how it is transmitted but we do know that there are real risks, and we're facing up to a reasonable worst-case scenario where over half a million people could die.

So the choices made at that point were rational. You then understand the more direct impact of those

choices as you get deeper into the pandemic, and of course the Older People's Commissioner was also saying at various points in time that she wanted more protection around care homes. Well, visiting is part of the risk. It's also part of how you maintain a general sense of wellbeing in the health of people in those care homes. It's about striking the balance that's important. And I said in my statement that we would need to consider how that balance is struck, and in earlier evidence about how that balance could have been struck at an earlier point to enable visiting with a much lower level of risk than we understood in March 2020.

Q. So in hindsight, ought the focus to have been on enabling safe visiting, rather than a blanket ban?

A. Well, in hindsight I think we could have moved faster on enabling safer visiting, low-risk visiting. That's the point I made in answer to the Inquiry. But in March 2020, when we go into lockdown, and when the restrictions come in place, we're not aware that we can enable safe, low-risk visiting generally, but there is still a provision for compassionate visiting. We've gone through the issues around exceptional circumstance visiting and how the guidance could have been written in a way that enabled people to understand more clearly

what that was.

So I don't seek to change the evidence I've given in that regard, but I don't think it's fair to say that in March 2020, just after going into lockdown, we could have enabled safe visiting at that point in time, because we just didn't have the knowledge base to do so. A future pandemic, we have different considerations to take into account about how to have a lower level of risk to enable more visiting to take place, whether outdoors or potentially indoors, as I've described in earlier evidence.

MS MORRIS: Thank you very much.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Morris.

Ms Peacock.

Questions from MS PEACOCK

MS PEACOCK: Thank you, my Lady.

Good afternoon, Mr Gething. I ask questions on behalf of the Trades Union Congress. My questions relate to the concerns raised about PPE provision in the social care sector, and if we could bring up your witness statement on screen. It's at paragraph 175.

Hopefully you have that in front of you?

A. I do.

Q. You describe:

"Concerns about PPE were also raised by Trade Unions representing the care sector. On 30 March ... I received a letter from the GMB union ..."

And then you go on to say several lines below:

"My initial response to the letter was that some of the demands set out were unachievable; on PPE, I commented that 'It is an odd position to be put in when the GMB are demanding that we equip the private sector staff with PPE that I assume the employer is legally responsible for from the public purse.' In effect, the letter was seeking priority over publicly funded provision we were more directly responsible for us to [provide] the sector over."

If we could bring that letter up on screen, it's at INQ000180891, at page 1.

Hopefully you now have that on screen.

The letter states on the first line of the first page:

"GMB Union represents members right across Social Care, both public and private employees.

"We understand that these are exceptional times and advice and guidance is changing daily."

Then if we could turn over to the second page, the second paragraph, regarding PPE and social care, states:

"Our members in the independent private sector feel

let down at a time when they have put themselves on the frontline. GMB has been contacted by Managers in despair at feeling they are putting their staff in harm's way and are unable to do anything to protect them, as I seems the PPE that you have requested be released isn't getting through to ... those that need it ..."

Then in the final sentence of that paragraph, it states:

"The health and safety of key workers must remain a priority ...

"1. Can you please advise me of what you are doing to address this crisis within a crisis?"

I just want to clarify the request made in that letter from GMB. Can you agree that there is no request in that letter for one set of workers to be given priority for PPE over another set of workers? In fact, the letter simply raises a serious issue around access to PPE in the private sector for care workers, and asks for an explanation from Welsh Government of their approach to the issue?

A. No, well, I think the letter points out that their particular concern is about members in the independent private sector, and of course it calls on workers remaining a priority whilst -- government and all

employers.

Now, this goes back to who we are and aren't legally responsible for, but also the fact that the government is the last resort. Well, if the government can't resolve it, you call in the military. Which we did, of course, during the pandemic. So it's about a demand that PPE is released to the independent sector, but that then means are we -- my concern is do we have enough to deal with all those people we are responsible for?

It's about trying to understand what we can do and how quickly we can do it, and the challenge of maintaining confidence and making sure that people do get supplies of PPE that they need. And as I've said in previous evidence, I think we did this rapidly through Shared Services, and fairly successfully, but that doesn't mean that there weren't uncomfortable circumstances for staff at the time, which I recognised both in my evidence to this Inquiry and indeed at the time -- I think I said that PPE was a bigger concern for me at various points in time than testing because of my concern that we wouldn't have adequate PPE for frontline workers to use.

Q. Thank you for your explanation about the concerns which you had arising from the letter, but I just want to be very clear that the request made by the GMB is not that

priority given is to one particular set of workers. In fact, the GMB explicitly mentions that they represent both public and private employees, and the request is that the health and safety of all key workers must remain a priority rather than suggesting that one are given a priority over the other; is that right?

A. It then goes on to give examples only from the independent sector as well. We're not legally responsible to the independent sector, for the provision of PPE. This is about how the resources of the government are used. And if we need PPE that is available for people who we're directly responsible for, then we've got a responsibility to do that. That's the point I'm trying to make in my email correspondence. I should point out I'm a member of the GMB. I know it's in my statement, but --

Q. I am grateful. I just wanted to be very clear about what the request from the GMB was in that letter. And you acknowledge in your statement at that same paragraph we've touched upon that supply chains for PPE collapsed. Do you agree that in those circumstances, in a pandemic where private employers are seeking to, but are unable to provide their employers with PPE, it's reasonable to ask the government to step in and address supply?

A. Which is what we did.

MS PEACOCK: I'm grateful.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Peacock.

It's now Ms Jones.

Questions from MS JONES

MS JONES: Thank you, my Lady.

Mr Gething, I ask questions on behalf of John's Campaign, The Patients Association and Care Rights UK. You said in your evidence this morning that the voice of unpaid carers was significant throughout the pandemic, but the experience of the organisations I represent was that there was little support provided for unpaid carers, including the millions of people who newly found themselves providing unpaid care to loved ones during the pandemic and who were simply expected to step up and fill the gaps created when healthcare, care and respite services were suspended.

My question is this: to what extent did you and the Welsh Government consider the impact on unpaid carers of decisions like expedited hospital discharges at the same time that other services were being suspended, and what, if anything, did you and the Welsh Government do to reduce the strain being put on unpaid carers?

A. This developed through the pandemic, and I think I've gone through this several times in evidence in writing

and in different modules as well as today. The decision on the 13th is about how you manage the risk that the whole country is facing and the harm that the whole country is facing. And if you're not prepared to act, then you're essentially accepting that your health and social care system is going to break down, with potentially catastrophic harm to staff and to the public.

And in understanding what you can do to support unpaid carers, we had a range of things that we did, from food delivery to the work that we did with the Carers Trust, and that came on the back of not just having a regular voice in press conferences but actually engagement with carers organisations about how you try to provide practical support for them.

And you're right, there were people who had new responsibilities they hadn't had before, but those were driven by, I think, unavoidable choices to the way the health and social care system needed to change rapidly to avoid being overrun.

In a future pandemic, I think we'd be better prepared for what that means for different groups of people. I've said myself, I've had to take on new responsibilities, relatively low level, but I had to do those and my job because there wasn't alternative

provision in place, because the advice we were giving people meant they had to stay in their own home.

So, you know, that's a pretty significant undertaking for everyone, and it comes with a level of discomfort. And I do hope that when the Inquiry comes to reach its conclusions, there can be something about not just understanding what happened with unpaid carers but are there practical ways that we could provide support earlier?

And I think where we reached with the scheme we provided, through a carers organisation, in hindsight, and if you're looking at a future pandemic, we could have been able to do something about that earlier to provide more practical support for the role that unpaid carers were undertaking.

Q. Thank you, Mr Gething.

My next topic is about the problems with data about the care sector. You recognise at paragraph 79 of your witness statement for this module that data across the care sector was fragmented, and that is supported by evidence that the Inquiry has received from other witnesses in this module as well.

Do you agree that the response to the pandemic in adult social care sector was hampered by a lack of reliable data about the adult social care sector?

A. Yes, it -- if we'd had more reliable data, then it would have allowed us to have a better overview of the sector, potentially where and how we get information but also resources to parts of that sector as well. I don't think there's any dispute with that.

Q. Thank you.

And in terms of the kind of data that might be necessary, the organisations I represent are concerned that there are particular holes around lack of data about bed capacity, number and identity of staff, and the type of services that are provided at different care settings, but also that there's a lack of qualitative data reflecting the views of people who draw on care and, for example, the impact on them of things like the Covid-19 visitor restrictions.

From your experience during the pandemic, do you agree that these are areas where better data collection is necessary and do you have any views on how such data could be collected in order to inform decisions that were made?

A. So the understanding of bed numbers and settings, having a clearer handle on that would obviously be useful. You understand more about what you're able to do in terms of flow through the whole health and social care system. The recommendation that I've made, that Counsel to the

Inquiry allowed me to highlight, around individual isolation for infection prevention and control, that's quite important as well.

When you're then talking about the qualitative experience, I think that should be a regular feature the way the health and social care system runs in terms of the access to whether it's patient care or the care that takes place in a social care setting and the value of it and, when that's withdrawn or is restricted, the impact that has, because that then allows you to understand more clearly the balance of harms that you've got to try to balance.

I still think it was inevitable there was going to be a restriction on visiting, because otherwise, you'd have imported much greater risk of harm into all those care settings. So it's about how do you enable some form of contact to be made? So we eventually, you'll recall this in my statement, that we provided a range of devices to homes that didn't have them to allow remote contact to take place, which isn't the same as in-person contact, and also the evidence I've given about whether you can take lessons from this pandemic to allow visiting to take place in a much lower-risk environment in the future, and I'm sure that (unclear words) the Inquiry will consider that when making its

recommendations.
Q. Thank you, Mr Gething.
Can I just follow up on whether you have any views on how that data could be collected or which bodies are the organisations that you think should be collecting it for future?
A. Well, it's different in Wales and England because our systems are different, the same with Scotland. I think the information inspectorate has its importance. But it's also, I think, important for local authorities with statutory responsibility to have access to predictable and reliable data they can share with the Welsh Government, as well, on those homes. Then the qualitative data, I think when you're dealing with a pandemic that has an infectious condition, it's really hard to have that face-to-face contact to get that qualitative data, as well. So you're going to be reliant on how your normal systems, where it's face-to-face it normally does, it can stand up to an interruption of that.
So I think some remote conversations about that, both with staff and with residents, would help in doing that, and making sure that your snapshot is a reasonable one.
I think there's a role for local authorities in all

of this, because the commissioner isn't going to be able to provide that comprehensive view.
MS JONES: Thank you, Mr Gething. Those are all of my questions.
LADY HALLETT: Thank you, Ms Jones.
Ms Beattie.
MS BEATTIE: My Lady, I do not have any questions, thank you.
LADY HALLETT: Oh, right, sorry, have I misread it?
Well, thank you very much anyway.
Mr Gething, that completes the questions that we have for you for this module. I'm afraid I cannot give you any guarantees we won't be calling on you again. I know we've called on you, is it five times already? But like Mr Hancock, you played such a role during the pandemic, I'm afraid there's no alternative. But I promise you, we'll limit any burden on you that we can.
Thank you very much indeed for your help.
THE WITNESS: Thank you.
LADY HALLETT: Very well, we shall break now and I shall return at 1.50.
(12.48 pm)
(The Short Adjournment)
(1.50 pm)
MS CECIL: Good afternoon, my Lady. May I please --

LADY HALLETT: Sorry, I overspoke. Good afternoon.
MS CECIL: May I please call Albert Heaney.
MR ALBERT HEANEY (affirmed)
Questions from COUNSEL TO THE INQUIRY
LADY HALLETT: Good afternoon, Mr Heaney, I hope we haven't kept you waiting too long.
THE WITNESS: Not at all. Thank you very much, my Lady.
MS CECIL: Thank you, Mr Heaney. You're here today to give evidence in relation to the role that you played during the pandemic as -- and may I just confirm, you are now the Chief Social Care Officer for Wales.
A. Yes, indeed.
Q. And I'm just going to go through a little bit of your background. I'm not going to go through it in detail because it's set out within your very helpful witness statement but, in short, you began working as a social worker within a local authority in Wales all the way back in 1980?
A. 1988.
Q. 1988.
A. Yes.
Q. Thank you very much. Since then you've held various wider roles, including the president of the Association of Directors of Social Services Cymru, ADASS, Wales; is that correct?

A. Yes, indeed.
Q. Lead Director for Children, Lead Director for Safeguarding and Prevention, you've chaired numerous boards and committees with regard to safeguarding and adult protection, and been the Corporate Director of Social Services leading on children's and adults' services?
A. Yes, that is true. Thank you.
Q. And immediately prior to the pandemic you were the Director of Social Services and Integration within the Welsh Government?
A. I was indeed.
Q. Turning to your role, then, in the pandemic and I'm really focusing now on your role between March 2020 until June, initially June 2021, you were the Deputy Director General to the Health and Social Services Group; is that correct?
A. That's correct.
Q. And you were the deputy to Andrew Goodall; is that right?
A. Yes, indeed.
Q. And then in June 2021 you became the Chief Social Care Officer along with the Director of Social Services and Integration. You held those roles concurrently?
A. Yes.

Q. Thank you. In terms of how that sat within the Welsh Government, I just want to break that down a little bit because, on the face of it, it looks a little bit complicated.

So in terms of the Welsh Government, we have the Minister for Health and Social Services who holds responsibility for adult social care?

A. Yes, indeed.

Q. That was Vaughan Gething until May 2021 and then Eluned Morgan.

A. It was.

Q. And then in addition to that, there's also a deputy minister that focuses on Social Services and that was Julie Morgan throughout the relevant period?

A. Yes, indeed.

Q. Here, what we're concerned with is the Health and Social Services Group that reported in to the minister; is that right?

A. That's correct.

Q. At the time, as I've said, the Director General there was Dr Andrew Goodall succeeded by Judith Paget?

A. Yes.

Q. And at that point, and this is relevant to why your role changed, Dr Goodall was also chief executive of NHS Wales; is that right?

A. Indeed so.

Q. So he held these two positions and as a consequence of that, that's one of the reasons why you were made Deputy Director, to take upon some of those burdens and responsibilities?

A. Yes, Deputy Director General to support him in his capacity.

Q. And the Social Services and Integration Directorate is one directorate within the HSSG?

A. It is indeed.

Q. And that is responsible for policy within the adult social care sector, but it's not responsible for delivery and implementation.

A. No.

Q. And whose responsibility is that?

A. The responsibility for the delivery, then, for social care in Wales rests with the 22 local authorities.

Q. Thank you. And in relation to the Social Services and Integration Directorate, that had three divisions, but in addition to those during the pandemic, there was a Social Care Coordination Hub created; is that right?

A. Yes, indeed.

Q. Was that a new structure or was that one envisaged pre-pandemic with regard to potential pandemic or emergency situation use?

A. That was a new structure designed to respond to the pandemic.

Q. Thank you. And that had various workstreams and we're going to touch on some of them but testing, PPE, vaccination, visiting, all of those types of areas.

A. Yes. So although it may not lead on all of those policy areas within the group, they were clearly areas of interest and importance to the directorate.

Q. Thank you. And when you say you may not lead on those, so what we do have are other government departments and groups leading on those different issues, you providing support or collaboration on your specific areas of expertise?

A. Indeed, and also ensuring that the social care perspective is then understood and taken into account.

Q. Thank you very much.

Turning, then, in relation to the adult social care sector, could you just provide us with a short summary of how you saw the sector at the point of when the pandemic began? So we're looking at between January to March 2020. Just a very short overview.

A. Yeah, thank you. Thank you for the question.

My succinct overview would be that it was a very fragile system, high turnover of staff, social care staff, very low-paid workforce, and therefore went into

the pandemic in a fragile, more vulnerable state.

Q. Thank you very much.

And just looking at capacity within the adult social care sector, were there concerns with workforce capacity? Were there sufficient members of staff, effectively, to occupy that sector?

A. In terms of sector, it's a very fragmented sector. So it has local authority provision, it has private providers, independent sector, and it is fair to say that staff -- workforce staff turnover, it's been a constant -- is a constant challenge to the sector. So it is a struggling sector going into it on terms of workforce.

Q. Thank you. If I can just turn, then, to preparedness in relation to the pandemic, you set out, in some detail actually, the various exercises that the department and the government, the Welsh Government, were generally involved in, and those that pertained specifically with aspects of adult social care. I'm not going to go through those in great detail with you but what you do explain is that aspects of that was paused owing to Brexit preparations, and that's something that my Lady has heard about previously.

But in relation to the pandemic planning at that time, again, as we've heard on in other modules, that

was predominantly focused on pandemic flu, and the primary pandemic preparedness group was the Wales Pandemic Flu Preparedness Group, and that last met prior to the pandemic in November 2018; is that right?
A. That is true.
Q. It reconvened then in January of 2020. And if I could just call up INQ000180621, please, we see here a 23 January paper that was prepared for that purpose. But can I just be clear about this, it does not appear that this is actually connected to Covid-19 specifically; is that right?
A. That is right.
Q. There is no mention of Covid-19, so this is really talking about general contingency planning at this point?
A. Yes, indeed.
Q. It states:
[As read] "Countermeasures and consumables to meet planning assumptions."
A reference to the PPE stockpile. There's a reference to workstreams. We see healthcare demand, where they talk about surge demand for critical care, and in that regard hospital discharge was always envisaged; is that right?
A. Yes.

Q. We see adult social care demand. Again, surge?
A. **(Witness nodded)**
Q. Resilience. But whereas healthcare is specifically mentioned, if I can go to 003, please, where we see that healthcare is specifically mentioned, there is no mention of adult social care there at all, is there?
A. No.
Q. And the remainder deals with excess deaths, communications and legislation. As I say, I don't intend to go through any of that in detail.
One consequence of all of the planning being based on pandemic flu was that you said that the guidance that had been produced was not designed for an emerging disease pandemic lasting more than two years. To your mind, does that represent a lack of preparation for the sector?
A. In my mind, it represents a focus on a certain type of pandemic, but once we moved into Covid-19, then the requirements and demand were very different for that preparation. And indeed, I think that is potentially a real learning point for the future.
Q. Indeed. To what extent, therefore, were then the existing plans for adult social care adequate?
A. They were adequate in so much as, had it have been a pandemic flu that we were dealing with, then I think

it would be fair to say a great deal of thought had gone into that across the sector, but in terms of the Covid-19, then I think my view would be that that preparation didn't enable us to be well placed when the pandemic took place.
Q. In terms of practical consequences, did that mean that you were not quite starting from scratch but certainly had to begin, in terms of guidance and policies, from a very different starting point from what we'd hope to have been envisaged?
A. Yes, indeed.
Q. If I can just talk, therefore, now, to move to the pandemic itself, I don't know if you can help us with this at all, but on 25 February of 2020, Public Health England produced guidance for the care home sector. Are you aware as to whether or not the Welsh Government did the same?
A. By that date I believe our guidance began to emerge in the March period.
Q. Thank you. Now, if I may, I'd like to talk about or ask you questions, rather, about the hospital discharge policy in care homes. So at the outset of the pandemic, as we've discussed, it was always envisaged that that would be a potential route in terms of relieving pressures within the NHS in Wales. There was draft

extreme surge guidance included as part of the paused pandemic planning?
A. Yes.
Q. That was later to be published in relation to Covid in April of 2020?
A. Yeah.
Q. But again, is it right that that did not provide any guidance to the adult social care sector on how to accommodate discharges, or any relevant IPC infection prevention and control measures?
A. In relation to the surge guidance, I think there were some helpful issues and support in that guidance for social care. I believe that, from memory of the guidance and from the conditions at the time, that it was focused on some of the key issues that would have emerged around pandemic planning but with the early day learning around what Covid-19 was transmitting, et cetera.
Q. There was no specific guidance contained within that in relation to the adult social care sector, was there, as in specific guidance as to what they would do in the event of a discharge?
A. Not in terms of discharge. There was guidance, as I said, in there that I think was helpful to the social care sector. The hospital discharge guidance then

comes, it is separate to that, yes, and you'll have the dates of that, of course, within my statement as well.

Q. Thank you. Now, turning then to 13 March, that was when Mr Gething announced the Framework of Actions. One of those actions, of course, was to expedite the discharge of vulnerable patients from acute and community hospitals. Now, in relation to that, ministerial advice was subsequently produced around a week later on 20 March. Why was there a need to produce that retrospectively?

A. Well, we would be, as a government, we would be preparing ministerial advice so there's a record of this decision. I think that in relation to the framework announced on 13 March that predominantly that was a system response from the NHS in Wales and therefore from a policy perspective that advice did follow, informal advice up to the minister, shortly after that announcement of the framework.

Q. Thank you. If I can just look at that with you for a moment. That's INQ000366593, and if we can go to page 3, please, this sets out the hospital discharge policy here, and what we can see is the need to expedite?

A. Yes.

Q. It says -- and in relation to that, the other actions

are to relax regulation requirements, to commission vacant nursing and residential home capacity, to suspend the choice protocol -- that relates to an individual being able to have a choice, effectively, of which care home or facility to go to?

A. Yes.

Q. And then easement of social work hospital discharge assessments.

Now, just dealing with that, what we do not see there are any, and more broadly within this, any mention of any risks in there to care homes or patients -- residents in care homes; would you agree?

A. So this advice, of course, is not my policy area. I did not lead on this, I'm sure it's important to just clarify that today.

Q. Of course.

A. I think that this was very early thinking from the NHS, understandable in the circumstances, knowing that they were in a very difficult position with the reasonable worst-case scenario, knowing what they knew at the time around what was coming their way in terms of demand for, you know, acute healthcare. Within this, then, in answering your question, you know, there is limited, in terms of statements around the adult social care sector, but of course, that was then quite quickly where, as

a government, as a team, we were involved with other colleagues, medical and scientific.

Q. And really what I'm asking about here is that the advice that's been written in relation to hospital discharge focuses on the issue of discharge from hospitals and creating capacity. What it doesn't do is look at it through the other end of the lens with those individuals being taken into those care homes and what challenges and risks those care homes might face; is that a fair summary?

A. That's a fair summary.

Q. Thank you. Now, in relation to discharge of individuals with symptoms, you provided your advice and views, and I just want to draw up an email that you sent in relation to a query from a care home.

And that's INQ000336324, and it's going back to 23 March, and if I can go to page 3 first of all, please. Thank you.

As you can see here, it's a query that's coming up in relation to patients from what they consider to be a Covid-19 positive hospital, so we can take from there there's been at least an outbreak or they have diagnosed Covid-19 patients in -- within the hospital.

And there's a query coming up because:

"They are not showing symptoms but the home feel to

protect the 69 people they have the new patients should be either isolated or tested. They are also concerned that no testing is also available for staff who are ill."

That comes up, and if I can go back to page 1, please, and what we -- what -- we're asked initially if Public Health Wales, who the Public Health Wales contact would be, were they involved in this?

A. They were involved. They were involved because at that time we were very committed to producing discharge guidance that would support care homes.

Q. Thank you. If I can scroll up to the top, please. What you have to say about this, and it's progressed on to a conversation about symptoms as well, is you say:

"I don't think we can say do not admit with symptoms as the health service will collapse within a day ..."

And you say:

"... wouldn't this be self isolation and PPE? [And you're] Happy to discuss."

So, at this point, the overarching priority from your perspective is to discharge individuals because otherwise the healthcare system may well collapse, if you're met with those sorts of objections; is that right?

A. So this was a very difficult time for families, for

loved ones. We had very clear advice, medical, scientific, that we could safely discharge from hospitals to care homes, but not without having, as I've mentioned here, some, you know, safeguards in place to protect people, you know, as I've highlighted, PPE and self-isolation.

Q. Thank you. And in relation to those with symptoms, we see that there was indeed guidance in relation to self-isolation and individuals wearing PPE were there to be a Covid-positive patient discharged.

But in relation to those individuals who may not have been presenting with symptoms, there was no such guidance.

A. Well, the advice at that time, and that's important to look, in terms of the history, then, of -- you know, the very complex history of asymptomatic, symptomatic, you know, the advice at that time was that -- for asymptomatics, was that we didn't need to do anything at that particular point in the cycle of Covid-19.

Q. So at that point --

A. Yes.

Q. -- what you're saying is that the advice was that there was no concern in relation to asymptomatic infection or, more to the point, transmission?

A. And as we see it develop, we see that change over the

next, I would say, six to eight weeks.

Q. I'm going to return back to the issue of asymptomatic in due course, but do you now consider that there ought to have been guidance in place -- looking -- and, again, looking back in hindsight, I appreciate, from your perspective, but also looking to the future -- to isolate all admissions from hospitals as a precaution?

A. I think it would be very difficult to say today that at that moment in time there should have been a very different approach based upon the medical and scientific advice we had, but of course, I mean, as part of this process, I'm always keen to see what we could learn and do differently. And I think when you come on to asymptomatic, there may be some comments that might be helpful reflections that I can make.

Q. Thank you.

Now, in terms of those care homes that may not have been able to isolate, because, of course, different care homes have different capacities and capabilities, ought there to have been consideration of isolating those residents in other settings, as became later the position, as of around 29 April, when step-down was introduced?

A. Well, certainly at the time, you know, as I've mentioned already, it was a very difficult period for everyone

that was -- you know, the prospects of, you know, hospitals being overrun -- and it wasn't just about protecting hospitals. That was about protecting life. So these were very, very difficult judgements and calls to be made.

And, you know, anyone affected by that -- you know, I've always felt very deeply, and my condolences to each and every one affected during the pandemic, but I think that, you know, when we look back now, potentially that -- as we term it, as we often use jargon of "step-down facilities", I think that would be a really good thing going forward.

So the earlier we could introduce that, I think, that, to me, is a real learning point from this experience.

Q. And turning to testing, and prioritisation of testing --

A. Yes.

Q. -- because at various stages there was scarcity of testing and prioritisation had to take place, Professor Khaw told the Inquiry that Public Health Wales did not have access to the number of hospital discharges to care homes, because they didn't have access to that data source.

Now, they were also, at that point, advising on testing and allocation of resources; is that right?

A. Well, at that point they would not have had that information, indeed.

Q. No. But they were the ones who were also advising on it --

A. Mm.

Q. -- and how to use the tests that were available?

A. Yes.

Q. Should -- ought that information have been provided to Public Health Wales at the time to inform that advice?

A. Well, I think it would have been better to have that information available.

That information would have been held, I believe, at a local health board level. And indeed, there was modelling, then, undertaken retrospectively quite quickly, and I know that, for example, the NHS assisted in that modelling and that was shared with partners.

Q. And you'll be asked further questions about capacity in due course in relation to hospital discharges, but certainly with regard to those data flows, that's something that, would you agree, needs to be put in place, if it has not already?

A. Yes, the data flows around social care certainly have improved since the pandemic, from our learning, but there is no doubt that that data and information was a very weak area that did not help us at the beginning

of the pandemic.
Q. And it wasn't until 24 March, moving slightly towards now, that Public Health Wales were asked for advice, to provide a letter, it's gov guidance essentially, to the care home sector in relation to accepting admissions or returning residents, those residents that had been taken to hospital and then were set to return to their care homes.
A. Yeah.
Q. So at the time of the framework of actions, obviously sometime before, is it right that there was not yet any guidance in place for those care homes?
A. Well, those care homes would already have standard guidance around infection prevention controls. The Public Health Wales, to their credit, also had set up a -- what I'll term a kind of a national contact centre, as well, for care homes, care home providers, to be able to contact, so it wouldn't be that they would be operating in a system where they wouldn't be used to having -- and they have advice and standard procedures around infection prevention controls.
Obviously, Covid, as we know now, was a different type of virus, as we journey forward.
Q. Indeed. And obviously the framework was set out on the 12th.

A. Yes.
Q. And then this -- we're talking now about 24 March.
A. Yes.
Q. By that -- I'm sorry, 13 March, and now we're talking about 24 March.
But by this stage, consideration had not actually been given, had it, to care home-specific advice in relation to Covid and the discharge policy?
A. No, care home -- and that was the advice that I wanted to see.
Q. Indeed.
A. Yes.
Q. Why was there that delay?
A. I think, you know, in hindsight, difficult to give a precise answer today. My experience was just the sheer speed of things that were happening at that particular time. But as I say, you know, care homes did have advice and had advice available to them at that time, so it wasn't that they were operating in a total vacuum to standard operating procedures.
Q. Now, in terms of your communications and collaboration between the various agencies between your directorate and Public Health Wales, you and, indeed, Public Health Wales speak of various challenges that were encountered with confusion as to who held what responsibility in

some respects --
A. Yes.
Q. -- which individuals were the correct individuals in terms of what responsibilities and roles they held, and frustrations, in short, becoming evident in relation to progressing guidance, progressing advice for the sector. Is that a fair summary?
A. It is a fair summary, and one of my learning points here on reflection is, you know, if we were starting again, would be to really ensure those points were clarified and I think, as we journeyed through the pandemic there is evidence that we did improve that communication and flow between those -- us as partner organisations.
Q. Now, certainly, frustration is evident on your director's behalf --
A. Yes.
Q. -- in relation to the speed and pace at which Public Health Wales were working and operating in relation to guidance. Can you provide a little bit more insight into that?
A. I think, depending where your questions go next, and I don't want to pre-empt, but I think there were critical points where we probably found ourselves in either a misunderstanding or different position, but you're right to say that there were, at times,

frustrations, I'm sure on both parts, but equally, we were, you know, from my seat, as lead around social care, I was just really keen that we could get information, good information, quality information, out to support the sector as soon as possible.
Q. And we see one example of that, actually, in relation to the hospital discharge guidance, and if I can just call up INQ000336353, please. And if we can go down to the second paragraph, initially what we see here is:
"I am trying to progress this with [Public Health Wales] ... not getting very far -- it's extremely frustrating."
Obviously a conversation is then referenced with you speaking to different individuals also.
And then what we have is:
"I heard separately yesterday that the Chief [Executive] of [Public Health Wales] is planning to write a joint letter with someone from [Welsh Government] WG (I assume Albert) [you] to all care home providers covering admissions and a range of other issues."
They are trying to work out whether it is the guidance they have their team working on or there's a risk of duplication.
And so this is an example of the issues that your

team and, indeed, on -- we've heard some evidence, as I say, from Public Health Wales were dealing with at the outset, but do you accept that those sorts of issues could have had a real impact upon those care home providers who were struggling in the absence of specific sector guidance?

A. I think for care home providers, one of the real learning points through the pandemic was for them, and their staff, they were a real credit to the profession, the things that they did. They went above and beyond. There were many really good illustrations, and I think, you know, without a doubt, you know, this is a matter of days, sometimes, but from my perspective the earlier, as I've said earlier, the learning from this is the earlier, if you could bring everything forward, you know, that would be a good thing as a learning point for any future pandemics that we may face.

Q. And in terms of future pandemics, has there been any thought given as to how you'd approach that in the future to ensure better working, better delineation of roles, and good communication so that you can get guidance out swiftly to a sector that needs it?

A. Yes, indeed, and of course, the only caveat I would say to that, which there is one, is that a lot of people I worked with during the pandemic, they have already

moved on. So the learning about the experience of the pandemic, I think, from this Inquiry will be invaluable to us all in terms of what we do in preparedness for the future.

Q. Now, just dealing with some evidence that we've heard from Public Health Wales, they explain that in relation to this, there should not have been any confusion because as far as they were concerned, they had a clearly identified incident director rota, and that rota was available to the Welsh Government. Was that rota available to you and your team within the Welsh Government?

A. Certainly, I can't recall seeing that rota myself, personally.

Q. Now, if I can turn then, please, to slightly later, on 2 April, the UK Government published its guidance on the admission and care of residents in care homes. Public Health Wales's guidance was not published until 8 April. Do you know why there was that delay, that further delay?

A. Well, that's very much on the point that you've just been questioning me on. It's to do with, you know, working through the detail, points of clarification, and, you know, the guidance was then issued on 8 April.

Q. And if I can just touch now in relation to something

that you say in your witness statement at paragraph 308. And it's dealing with the issue of testing.

A. Yes.

Q. You say:

"It was clear that if discharges were not made, hospitals would not be able to function effectively ..."

And we've seen that already from your emails at an earlier stage. And you said:

"In the absence of advice to the contrary from health experts and evidence regarding asymptomatic transmission, while testing of all patients would have been preferred, without sufficient testing capacity, it was not possible."

So what you're saying here is: ideally it would have been good to have tested everybody but insufficient capacity; is that right?

A. Well, I think there are two points to clarify here. One was the science and the medical advice was still indicating very strongly around who to test and who not to test, and what was required.

My professional view, of course, is that the earlier we can use testing to build confidence -- get a clearer picture, manage Covid-19, would have been my preferred choice, but of course, you will see and you will know this very well, I'm sure, but from my perspective, the

testing capacity takes some considerable time to really allow us, then, to do that wider-base testing that begins to emerge in the May and June period.

Q. Indeed. What I want to focus in on, if I may, with you, is, in terms of your view that testing would have been preferable, but you didn't have sufficient testing capacity, at this time, firstly was the decision not to test made, effectively, on scientific advice that you shouldn't test or was it made on the basis that it would have been desirable to, but we don't have capacity so we have to prioritise?

A. It was made based upon the medical and scientific advice.

Q. And so is that your view in hindsight, effectively: it would have been preferable to have tested but we didn't have capacity?

A. That would be my view in hindsight. It would be.

Q. Thank you.

Now, in terms of further hospital guidance that was published on 7 April, Professor Khaw again told the Inquiry that PHW was not consulted and it would have been helpful to, because of course it involves their roles and responsibilities. Do you know why they weren't consulted by that point?

A. Could you just repeat that question, please?

Q. Of course.

So there was hospital discharge guidance that was produced by the Welsh Government -- that's why I'm asking you about it, as opposed to the NHS --

A. Yes.

Q. -- dated 7 April. And Professor Khaw explained that Public Health Wales was not consulted in relation to that. Do you have any understanding as to why that would have been?

A. Well, the guidance that published around 7, 8 April, was guidance that -- certainly my understanding was that Public Health Wales had been sighted on that guidance.

Q. Would you have expected it by that point? Were those earlier issues about communication ironed out at this stage or were they still there?

A. Well, in the early -- I think the communication issues, possibly there was some point -- you know, between the March and April period, but by May we begin to see that among forward. But certainly on that guidance -- and I'm happy to be corrected afterwards -- but my understanding is I think Public Health Wales were sighted on that particular guidance. But that, again, may reflect the different communication channels within Public Health Wales.

Q. Professor Khaw explained that, from his perspective, the

policy decisions of the Welsh Government remained quite unclear for some time. And that was escalated up the chain to you at one stage, do you recall, by way of an email?

And if I can -- I can call that up for you if it would assist. It's INQ00499632.

And what we see -- it's under the words "A few points", about a third of the way down, first bullet point:

"Several references below to not having clear steer/instruction from [the Welsh Government] ... been provided in e mails to PHW from both Marion and I. It was reiterated at the meeting this morning. However, Andrew kept saying that from a meeting he'd attended yesterday this was not Vaughan's position."

So were you reliant at that point still on just discussions and emails as opposed to formal structures and communications?

A. So the earlier question related to a different guidance --

Q. Yes.

A. -- which I'm pretty sure they had sight of.

Q. Yes.

A. This relates to a change in our knowledge around testing on discharge. You will have seen Tactical Advisory Cell

had met I think on the 14 April date, and had certainly from SAGE and others begun to understand more around discharge into care homes from hospitals.

On 15 April the policy changed in England, an announcement to test all discharges into care homes from hospitals. And at that point -- both myself and the CMO wanted a change in policy. So this relates to that request. That request went in an email on the 15th and then was followed up in a further email from the CMO's office by Dr Marion Lyons on the 16th. So that's what this relates to at that point.

Q. My question in relation to it is just that these problems were continuing. I'm going to turn to the 15th guidance in a moment, but this is an indication that still, at this point, those issues are continuing?

A. I think that's absolutely correct, and I've acknowledged earlier we would have wanted to do that differently. But I think on this occasion, just to say from a policy perspective, I think we were clear on the 15th, and I think we were clear on the 16th.

Q. Now, turning to the policy implemented on 15 April, as you say to test all discharges from hospital, that took some time, actually, to be implemented, with the guidance being produced effectively two weeks later, on 29 April.

A. Yes.

Q. Now, it's been accepted that there was obviously that delay by the Welsh Government. Why was that policy not implemented immediately, rather than waiting for updated guidance, which obviously took some time?

A. Yeah, and I think the first thing to say is, look, you know, we are deeply apologetic for the length of time that that took. I know that I was personally concerned at the length of time at the time. And, you know, in terms of the experience for anyone who suffered during that time, you know, I, on behalf of Welsh Government, are deeply sorry for that.

The reasons, I think, are, to me, related to actually Public Health Wales, our communication with them at the time. Clearly, as I've mentioned, I think we -- that's a learning point for us all. But we were asking Public Health Wales around, you know, testing capacity, which they were, in a sense, the custodians of. So I think there was -- there were questions that we needed to answer, to understand, to work through, and some of that took a lot longer than I certainly would have liked to have seen.

Q. My question is, really, why did you just simply not implement that policy, rather than wait

-- (overspeaking) --

A. And I did try to answer, but maybe not as clear as I could have been --
Q. No, that's all right.
A. -- so my apologies.
I think that's because we needed to understand about testing capacity and some of the wider -- and it wasn't just one question we were answering. I think that's why we were able to go ahead with the discharge and get that completed from the Welsh Government perspective. But we -- but I was interested at that time around global testing of care homes, for example, so I was looking at potential wider protective features. And I think --
Q. We're going to move on to that -- (overspeaking) --
A. -- by putting things together that maybe didn't help get the clarity as quickly as we should have done.
Q. And when do you say you had the capacity to test all patients on discharge? Can you recall when that was?
A. Well, in terms of the capacity to begin to do the testing, that was really from the May, the May 15/16 period into June.
Q. So I'm talking just about discharge at the moment --
A. Discharge -- no, we were able to do that then, we were.
Q. Now, I want to move on now to ask about the move to asymptomatic testing within care homes, if I may.
Initially, obviously, there was the Easter 6 study

that was conducted by Public Health England that raised and concluded that symptoms were poorly predictive of infection, and therefore a poor control -- trigger for control measures. And that's plainly speaking to potential asymptomatic infection there.
Now, when were you first made aware of that study? Do you know?
A. It would have been, you know, quite quickly, because the team were picking up on things. So, as soon as that started circulating in SAGE papers, et cetera, I was alert to that.
Q. Thank you. And it was published on 18/19 April, so that -- (overspeaking) --
A. Yes, that would feel about right.
Q. Indeed.
And if I can just ask you in relation to this, it appears that the decision within the Welsh Government to test all patients, asymptomatic residents and staff, was prompted by the UK Government's announcement; is that right?
A. I think, yeah, there was a number of times where UK Government, based upon SAGE, had moved, and we would follow on that advice.
Q. And so that announcement from the UK Government came out on 28 April, if that assists.

A. Yes.
Q. And so that was to apply to -- all residents and staff would be able to get access to a test regardless of whether they had symptoms, and it was the 2 May in Wales that there was an announcement that there would be further testing in care homes but at that point it was symptomatic individuals and they would be combined with isolation pending results, and then testing, effectively, where there was somebody with symptoms of Covid, but also the care home had in excess of 50 beds. So the larger care homes; do you recall that?
A. Yes, I do recall that very clearly.
Q. So at that stage, there's not a rollout to all homes of asymptomatic testing. Why was there a delay?
A. Well, I wouldn't say there was a delay. The decision at the time based on the medical advice and the science was still indicating that we did not need to move to testing of all asymptomatic, and that is again, I've mentioned, learning points, the question going forward is, you know, at what point should you begin to test for asymptomatic? You may be coming on to this, but we then see the science change in certainly that second week in May, where we have, I think on 12 May, around that date, a SAGE meeting and advice coming through which clearly indicates, in the language I think that was used at the

time, the value in testing asymptomatic. And therefore, the policy changed in Wales around that mid-May point, around 14, 15 May.
Q. What I'm really asking about is the fact that obviously the UK Government, nonetheless, announced this on 28 April --
A. But their policy, you'll recall, I'm sure you will -- yeah.
Q. I was going to say, it evolved, effectively, but what we saw from the Welsh Government was 2 May, that expansion, but it was not until 16 May that the Welsh Government then implemented and announced all testing for asymptomatic care residents --
A. But I could stand corrected on this, but in the meeting of 30 April, my understanding was that the announcement on 28 April from the UK Government wasn't the position that was being held. So that all asymptomatics, my understanding was that that was not the position of the UK Government on the 30th.
Q. As I say, it evolved over the next few days.
A. Yes.
Q. But it was certainly the case that the UK implemented it before Wales, and that's why I'm asking about the delay.
A. Well, you know, and I've answered that question I believe, I hope I have, and I'm certainly happy to go

back over it, but it was where the science and advice changed around 12 May that was critical for the Welsh change in the, in the guidance around the testing.

Q. Now, I want to just turn now, if I may, to experiences of care homes where they had patients discharged to them who did, indeed, demonstrate symptoms of Covid and later were to test positive for Covid.

If I could just bring up, please, the Every Story Matters record, and that's INQ000587564, page 65.

Just to ask you about the experiences, as I say, of some care homes. So here we can see, if I can go down, I'll just choose the one mid-way down actually:

"The hospital would say they didn't have it."

So that's a reference to an individual being discharged being told they did not have Covid.

And:

"Then when they literally came through the door to us and we would test them and they would be positive for Covid. I believe the hospitals couldn't manage the amount of patients they had, so it was easier for them to just let the residents go back to their care homes and leave the carers and the nurses to deal with them."

Now, obviously, putting aside the issue that a test on one day can give a different result, these are themes that recur in relation to discharge of patients.

That also, perhaps, fed into those concerns that the overriding concerns of the Welsh Government were the -- preventing the collapse of the NHS, and very much secondary, if not much further down the list, was the care sector. What do you say in relation to that?

A. Yeah. Well, I think some of the experience were -- experiences that we would not have wanted to see happen, and I take the care home experience here.

Certainly from my role, and my directorate, you know, I would say there were lots of illustrations where we were actively supporting social care, engaging with the social care sector, and also advising Welsh Government, whether that was the CMO or other parts of Welsh Government, in relation to the importance of, you know, ensuring that the social care sector was well supported at this time.

And I think, you know, there is lots of evidence of the role of my directorate in that position.

Q. And then also, just if I may, on the testing, then, that did take place in care homes of people with symptoms --

A. Yes.

Q. -- so before asymptomatic testing is rolled out and testing is limited to just those individuals with symptoms. And we've heard previously from Ms Hough, a care home owner and nurse, that they would request

tests, but then those tests would arrive late, often sadly after their resident had died. Were you aware of those issues?

A. I was certainly, you know, in that scenario, that is quite a dreadful scenario. So I think that has impact for us all. I was aware of many illustrations during the pandemic of times where things were difficult, challenging, and around, sometimes, test results coming back, as well. So although there was a high rate of test results coming back, it wasn't a hundred per cent, and so those issues were real and challenges that we were facing.

Q. And what, if anything, did the Welsh Government do in response to that, was there an attempt to expedite tests and things of that nature?

A. Oh yes, very much so. Very active indeed.

Q. And we've also heard that when those tests were received, they were unable then to be repurposed for anyone else. Now, this was at a point where there was said to be a scarcity of testing, so every single test mattered or counted. Why was that the policy?

A. Well, testing wasn't my policy area, I'm afraid. I know there will be others who are better placed to give you a good response on that.

Q. Of course, thank you.

If I can move, I appreciate it's not your policy area, you cover it to quite some degree in your statement and I appreciate the reasons why, but what you do say in relation to testing specifically, and this is where you are involved, is that -- and this is more broadly across the sector:

"In the early stages it was ... difficult to be clear about who was making what decisions for testing and where, and therefore difficult to ensure social care testing policy was optimal ..."

So in that respect, why was there that lack of clarity of who was responsible for testing, testing policy? Because as we see, those problems appear to persist nearly all the way throughout 2020.

A. I think in the early stages, you know, my assessment is that, you know, this was new, it was a different type of challenge, so that between ourselves, Public Health Wales and others, it was difficult to know who was leading. From conversations I had with the Director General, I know that he took steps then, you know, for example he appointed Jo-Anne Daniels to lead, and from that point onwards I think I have seen, you know, I've seen a considerable change in terms of understanding and grip, as well.

Q. Can we talk about a specific example, please, and that's

in relation to domiciliary carers.
A. Yes.
Q. And it's an example that you provide, and what we can see is that, in Wales, the weekly testing of all care home staff was rolled out on 15 June 2020. Domiciliary carers were not a part of that rollout or that programme; is that right?
A. That is indeed correct.
Q. And you certainly, within your directorate, had considered their inclusion. Had you considered their inclusion prior to the rollout or was it something that took place afterwards?
A. No, we were considering domiciliary care workers very early on. I've got, you know, clear illustrations where I and others were raising issues around domiciliary care early in the pandemic.
Q. Indeed, in a paper, a written case in support of testing domiciliary carers was provided to the government testing cell on 10 July of 2020 from your directorate.
A. Yes.
Q. But it was not considered. Do you know why it was not considered?
A. I do not know why it wasn't considered but I know it was re -- it was brought back to their attention.
Q. And you continued, you say, in your statement, to press,

and it was resubmitted a couple of weeks later, on 28 July.

And in relation to that, if I can just set it out, what was the pressing rationale to your -- in your view, as to why domiciliary carers ought to be tested at that point?

A. So my rationale with this -- you know, obviously I'm not a doctor, I'm not a scientist, but my rationale was that -- and there's this long answer and a short answer -- I'll go for the short answer and see if that helps -- is that, you know, domiciliary care workers are mobile between different dwellings. They're going in a different people's homes, coming into contact with lots of people. And my issue was also about protecting them, of course it was, but it was also recognising that they worked with very vulnerable people, and it was about protecting those vulnerable people first of all.

So I felt that a testing regime -- and that's why, personally, when -- one of the big moments in the pandemic for me was the introduction of lateral flow devices. And it was at that point that domiciliary care workers were part of that testing regime.

Q. Indeed. And that's not, however, is it, until 23 November 2020?
A. No, it's not.

Q. So it's quite late then?
A. Yes.
Q. You submitted, as I say, the initial paper on 10 July, resubmitted it on 28 July. You set out the rationale as you've described, effectively as you've summarised now. It was also noted that there was a clear disparity between that testing available within social care settings, care homes and the like, that was not available for domiciliary care.

And within that advice, it's set out that, in regards to that disparity, there was no clear rationale for that disparity. Was that your view?

A. Can you just repeat that again? I just want to be clear --
Q. -- (overspeaking) -- I probably confused you.

Sorry, what I was saying was, within your written case, it's set out that there was no clear rationale as to why there was a disparity between testing within -- of all care home staff that was rolled out, and domiciliary carers. So it's that disparity. And there being no proper justification for it.

Was that your view at the time?

A. Well, I would actually say no. My view was that domiciliary care workers should be tested for the reasons that I've set out, but the decision back was

based upon the medical, scientific advice.

There was all sorts of analyses around the percentage of domiciliary care workers versus the population of people infected. I think not seeing them as entering closed settings. But there will be others who will be better placed on the side of those that were offering that advice.

My constructive -- and purposeful challenge was that I felt that domiciliary care workers, and indeed, one of my learning points is -- that I would like to see, in the future, domiciliary care workers seen in the same capacity as we would view the importance of testing care home workers.

Q. You've referred to scientific advice in relation --
A. Yes.
Q. -- to the testing of domiciliary carers. Do you know if there was sufficient testing capacity at that time?
A. Well, I wouldn't have been able to answer that question at that time. Testing was improving, the scale and scope. So, you know, again, others would be better to say, "Yes, we had capacity" or "No, we didn't". I felt by that period we probably had more capacity than we certainly had at the earlier stages.

I don't believe it was just a -- I don't believe it was just a capacity decision, however. I think it was

the decision from, you know, Technical Advisory Group and others, was that they did not need to be tested.

Q. Thank you. Now just dealing with one of the other rationales that was put forward, or the other arguments for testing, you had evidence within your directorate of domiciliary care packages refused by users because of their anxiety over potential transmission by those care workers entering their homes; is that right?

A. Yes.

Q. And do you accept that that in turn could potentially pose risks to those disabled people in terms of having their needs met, if their anxiety was overriding the actual provision of that care?

A. Indeed.

Q. Did you or your department within the directorate make any further enquiries or take any action to seek to research those people that were in receipt of domiciliary care?

A. That would be the responsibility of the local government, those that are providing the delivery and the care.

Q. Was any guidance or information provided to local government?

A. I don't believe we provided any information, nor do I think we were asked for any information.

Q. Now obviously at care homes, that attracted a significant amount of attention, and indeed, and staff and ingress routes and those sorts of policies, but was this is an example of domiciliary care being a bit of a blind spot, the fact that it was not being prioritised in the same way?

A. No, I don't think it was a blind spot, because then I would -- you know, as I say, obviously we'd promoted and had the discussion as we've just described around testing but we were providing PPE and other support. So whilst I've answered the question in relation to testing and individuals, it was quite clear that we were supporting dom care workers as we would do the other workforce, especially around personal protective equipment.

Q. You've explained that obviously all of these people that are being cared for have vulnerabilities in relation to Covid?

A. Yes.

Q. And potential risks in terms of infection. What about unpaid carers? Were they being considered actively during this time? Because they are obviously also providing care to individuals who may be at greater risk of infection or more serious consequences of infection?

A. Yes, I mean unpaid carers during the pandemic were

absolutely tremendous, but also had impacts. They were isolated. They had other hardships, financial. But we were very mindful throughout the pandemic around support to unpaid carers.

Unpaid carers were able to access PPE, there was criteria that was developed to access PPE. And also, there was other supports that we put in place, you know, through hardship funding, working with some of our key partners to get respite services and support in other ways.

So they weren't -- for me, they weren't -- I think what was your word? It was un ...?

Q. I'm not sure -- well, it would certainly have been -- (overspeaking) --

A. Unseen, or --

Q. -- being considered --

A. They were definitely being considered during the --

Q. But specifically in relation to testing is really what was my question.

So were they, during this period, being actively considered in relation to potential rollout of routine testing in the same way that you were looking at domiciliary carers?

A. There were a lot of groups that we were looking at in terms of when we should be able to test, and I think

that was again what I mentioned, that kind of lightbulb moment, which, you know, for me, was so important. I think the development of the lateral flow devices then opened up the ability to do much more around supporting unpaid carers and others around testing.

Q. Indeed, but that was to the general population in November.

A. Yes.

Q. What I want to know is whether, in effect -- was there a specific time at which unpaid carers were specifically considered for potential routine testing?

A. Well, I was -- I wasn't involved in all of the testing decisions, as I've mentioned. I didn't lead on testing. But I know that my policy officials were looking at number of groups around testing, and I know that they were also thoughtful and mindful to raising issues around where we support and how we support our unpaid carers.

Q. But am I right that you cannot actually assist us on whether or not unpaid carers were being considered -- (overspeaking) --

A. Others will be better placed on that, I'm afraid. My apologies.

Q. And just to complete the chronology, it was in November, effectively, that, because of your concerns, you say in

your statement, over testing, and coordination of testing and responsibility for testing, and those issues with papers not being considered and so on, that you had discussions more broadly with Public Health Wales, the Chief Medical Officer, the Welsh Government Testing Senior Responsible Officer, to try to seek a more coordinated group, and that resulted in the Social Care Testing Infection Prevent and Control group in November of 2020 which --

A. Yes, I set that up.

Q. Indeed. And you chaired it initially?

A. Yes, I did.

Q. Thank you. Now, if I may turn to a new topic, and that engages the role of Care Inspectorate Wales.

A. Okay.

Q. And the cessation of inspections within Wales. Now, within your statement you explain that you were supportive of Care Inspectorate Wales' decision to suspend those routine inspections, and we've heard evidence from Care Inspectorate Wales as to why that was. But that you were reassured that safeguarding issues and other concerns would continue to be investigated.

Now, looking back now, on that decision, and just taking your perspective, putting aside those of Care

Inspectorate Wales, do you still believe it was the right approach for Care Inspectorate Wales to suspend those inspections?

A. Well, I mean, obviously, it wasn't a decision for me to make, but I still do believe that was a balanced decision that Care Inspectorate Wales made.

Q. And did you, or anyone else, consult care home residents and their families about the suspension of those inspections -- (overspeaking) --

A. That would have been for --

Q. -- been for Care Inspectorate Wales?

A. Yes, it would have been.

Q. Now, a number of Core Participants, including Covid Bereaved Families for Justice Cymru, in their corporate statement, have raised concerns about the suspension and general reduction of those inspections over the course of the pandemic. They are concerned that without regulatory oversight it's difficult to know whether their loved ones were provided with proper care or if there were any safeguarding concerns?

How were you assured about that care provided in Wales in the absence of inspections, as Chief Social Worker, and all of your responsibilities that your role involves?

A. Yes, you know, I think it's a great question, a great

challenge. I think at the time, you know, we look back and we know that care homes were isolated, but I think, for me, you know, what reassured me during that period was that, you know, Care Inspectorate Wales weren't operating away from the sector; they were operating to the sector. So they had their check-in weekly calls, there was lots of communication. And I was regularly in touch with Care Forum Wales, for example.

There were a lot of contact points about, you know, standards of care. You know, it was very active around promoting visiting, balancing the rights to protect individuals with the rights of people to see their loved ones. So I think our contact around care homes and the environment was very lively, very active, with lots of partners. Obviously, I wouldn't be sighted on individual care homes but I know that where issues were raised, they were acted upon by Care Inspectorate Wales.

Q. Thank you. Now, if I may, I'm going to move now to visiting restrictions in care homes. That is an area that your department, indeed you were very heavily engaged in during the pandemic in terms of promulgating guidance.

And that first guidance on visiting in care homes was issued on 23 March 2020.

If I could just bring that up, please, it's

INQ000336332. Thank you.

And here we see a letter going out to the providers dealing with guidance for visits. And what we see within here are, effectively, that visits are going to be limited to essential visits only, I'm paraphrasing, but that's essentially what it amounts to; that non-essential providers or contractors such as hairdressers and builders, whoever it may be, could no longer enter. That also applied to professional visitors, unless it was essential.

A. Yes.

Q. Doctors and the like, health professionals.

Within the guidance you say you:

"... recognise the importance of relationships with family and friends in emotional wellbeing and cannot reinforce strongly enough the crucial role visitors can now take in ... [protecting] their family and friends by not visiting, while continuing to support emotional wellbeing in alternative ways."

You explain that this is going to be individual case-by-case basis, decisions to be taken by care home managers, those are who the requests should go to.

So that's where the decision making is taking place from your perspective; is that right?

A. Yes.

Q. At the very local level --
A. Yes.
Q. -- within the individual care home?
A. Yes.
Q. You appreciated that there were going to need to be sensitive discussions in regard to end-of-life care for those residents. And that you'd hope that these restrictions would be in place and undertaken for the shortest possible period.

At that point in time, were you expecting these restrictions to be a matter of weeks as opposed to prolonging over more than a year, two years?
A. Certainly, at that stage, I never -- I wouldn't have foresaw that we would have 14 versions of guidance for visiting. So, you know, absolutely did not foresee it being over that length of time.

But also, even at the very beginning, I was aware of the importance of visits and contacts and wellbeing, hence it wasn't a blanket approach. And also, I know that we supported a number of, you know, tablets and other digital material to try to help care homes and loved ones keep in touch.
Q. And just dealing with the guidance that was promulgated, as you say, a number of iterations?
A. Yes.

know, given the length of time that had already occurred between the beginning of, you know, that lockdown, the 23 March restrictions on visiting, and, you know, this is where good working across partner organisations, we were able to work, you know, Care Inspectorate Wales, you know, held a group. A group itself doesn't achieve everything, but within that group critical stakeholders were able to really bring alive and make sure that we could balance the rights of individuals.
Q. Thank you. I'm just going to deal with some of those iterations, and as I say, they align broadly with what restrictions may have been in the wider community.

So 1 June, when the Stay at Home message was changed in Wales to one of Stay Local, at that point, there was permitted outdoor visits and you sent -- your guidance, at that stage, encouraged the facilitation of those outdoor visits.

That was then followed up again in various iterations.

Version 3 of the guidance came on 28 August. That saw a move to permitting indoor visits, and that again reflected a change in national restrictions. So they're following the national restrictions broadly; is that right?
A. Yes, broadly.

Q. Each iteration of that guidance was developed within the parameters of what the national restrictions were or the local restrictions were at any given time; is that right?
A. Yes, it is right, but there were points, for example, the firebreak that took place, I think end of October, beginning of November. You know, a reasonable excuse was a visit to a care home where that was deemed to be appropriate.
Q. Indeed. I'm going to move to some of the issues that you had in the firebreak in due course but I'm just concentrating, if I may, at the beginning of that guidance and how it developed.

So on 27 May you met with the Older People's Commissioner, Heléna Herklots, who we heard from yesterday.
A. Yes.
Q. And you agreed at that point that guidance should be co-produced in conjunction with the sector. Obviously that's going to be more time consuming. Why did you consider that to be important?
A. I think, you know, firstly, I think the Older People's Commissioner played a very important role during the pandemic. I was very grateful for advice and challenge. I felt that at that stage it was really important, you

Q. So what we've got there is the availability to speak to -- to meet indoors. But by this stage you'd had fairly significant correspondence, more broadly, from both individuals who were subject to these restrictions and their loved ones but also the Older People's Commissioner with significant concerns being raised. And what was your view at that stage?
A. Yes --
Q. So this is the August moving into September?
A. So August moving into September, those that took their time to write, I was very grateful to them sharing their stories and position, and I thank them for that. I know it was very painful for them. But we were able then to, I think, advocate for that balance, recognising the rights of individuals to see their loved ones and to balance risks. So we talk about dynamic risk assessments, and certainly, for me, we were moving then to, you know, indoor visits and without leading on too far, because you may be going there on future questions, you know, we did a range of actions that supported and enabled visiting to take place.
Q. I'm just going to ask you, if I may then, about the September local restrictions before we pause for a break, and in relation to those, local -- the local restrictions were introduced in various areas within

Wales in response to rising infection rates.

A number of those, of local authorities, decided, however, to cease all visits, so put a blanket ban, effectively, on visiting, at a point when, in terms of the more broader restrictions, outdoor visits were still permitted. So we see that in Caerphilly, for example.

And those were, you explained, decisions taken typically in collaboration with the incident management teams and Public Health Wales.

A. Yes.

Q. But when you were aware of those effective blanket bans being put into place, what did you do, if anything?

A. Well, I took action. Both myself and the chief inspectorate, Care Inspectorate Wales, wrote out to all local authorities across Wales. We were very clear in our expectation and supporting. We spoke with Welsh ministers and we spoke with key stakeholders.

Q. And indeed, slightly later in September, it became clear that at least two of those local authorities had imposed bans on visits without the incident management team input or any input at all, actually, from Public Health Wales. And in those situations, did you write to those local authorities as well?

A. We wrote to all authorities in Wales and we were very clear. I think where you've got the decision made by

the incident management teams, I think we can understand that restrictions are because of the local prevalence, so we can understand the decisions being made. What we would not want is those decisions to be made in isolation, nor for any length of time that is unduly.

Q. And you referred to it briefly earlier, but at that stage, in addition to the more broad ability to visit outside or to see people outside in terms of the broader regulations, under the actual coronavirus regulations, visits to care home residents were an acceptable reason to nonetheless visit, weren't they?

A. Mm, yes.

Q. You could -- it was an exceptional reason to travel. You could travel under compassionate grounds. That included visiting end of life, or where those absences could have a significant impact upon those residents?

A. Yes.

Q. And notwithstanding that being effectively within the regulations, we still saw -- or you still saw within Wales, in some areas, those blanket bans?

A. Well, you certainly saw decisions being made that were contrary to the guidance at that time. Some of that, I understand -- not justifying, but understand that individuals were, you know, cautious, anxious, worried. But it's quite clear that we gave good advice based

upon -- well discussed with both, you know, the Public Health Wales colleagues and other partners. We gave good advice to try to support and enable visiting to take place in Wales.

Q. Thank you. And in terms of the guidance that you wrote out, certainly you were informed that the Older People's Commissioner was content with that guidance, and reported back to you that there had been an increase, then, in facilitation of those -- at least the outdoors visits --

A. Yes.

Q. -- and indeed, in some cases, those more exceptional visits?

A. Yes.

MS CECIL: Thank you.

My Lady, is now a convenient moment for a break?

LADY HALLETT: Thank you very much indeed. I shall return at 3.20.

(3.05 pm)

(A short break)

(3.20 pm)

MS CECIL: Thank you.

My Lady, if I may now pick up, please, on where we left off on visiting restrictions. We had reached the point of the imposition of local restrictions within

Wales and the impact those had on visiting restrictions.

A. Yes.

Q. So we were looking at, effectively, the period up until September of 2020. I now want to turn, if I may, to the firebreak because you say there were significant concerns, and they became fairly acute in relation to visiting restrictions when the firebreak was imposed in Wales. Can you explain why that was and how it became particularly acute?

A. Yes, so, you know, thank you. The firebreak was described as a circuit breaker to try and interrupt the spread of Covid. We certainly negotiated that an exception was to have visits to care homes, but I acknowledge that that was, whilst permissible, was during that period more challenging because of the spread of the virus at that point. But it wasn't, again, as I mentioned earlier, it wasn't restricted but was on an assessment between the provider of the care home and the families themselves.

Q. And in practice, what did you see start to emerge? Did you see the same sorts of issues that had taken place during the imposition of local restrictions in September, reemerge during that firebreak period in November -- October through to November?

A. I think it was probably, actually, a quieter break for

those issues because I think there was an understanding across Wales of the need to try to interrupt the spread of the virus, so during those, what I would describe as a three-week period, I think where possible, visits continued but obviously some visits wouldn't have taken place during that period.

Q. Thank you.

Now, throughout this period various other avenues were explored.

A. Yes.

Q. You've touched upon some of those earlier in relation to the use of devices, obviously?

A. Yes.

Q. And we've heard a lot of evidence in relation to the use of technology. Also the use of pods.

A. Yes.

Q. There was a pilot in relation to pods that was rolled out, and then also pilot LFT testing of visitors as well that was rolled out --

A. Yes.

Q. -- prior to the Christmas period, and you described that as being particularly important because of the value of Christmas, essentially, to those residents and their loved ones.

A. Yes, I mean, it's interesting, I love Christmas, I'm

a Christmas person. Not that my Lady needs to be aware of that, but recognise that the pods especially were a longer-term investment by government and that was really recognising that, you know, the need and the wellbeing needs of individuals to see their loved ones. So, you know, certainly I and my colleagues in the Civil Service worked really, really hard to try and support and, you know, I was really pleased that ministers, you know, financially supported both purchasing pods by us, but also I think it was something like 55 were financed in addition to that, as well.

And as you've mentioned using lateral flow tests.

Later into the spring period, you know, we'd support volunteers, as well, to support visiting, and really good work across the sector.

Q. Now, I want to turn, if I may, to the period surrounding Christmas and going into January, so effectively infections are rising, notwithstanding the firebreak.

A. Yes.

Q. It's essentially coming towards the peak of the second wave, and alert levels were then put in place, essentially, for social care services, as well, and in relation to those alert levels, the guidance aligned to those alert levels. And that was a first sector-specific plan you describe within the UK seeking

to provide clarity over the changes in visiting guidance.

To be clear, and just to explain, that Coronavirus Control Plan alert level document in terms of Wales' social care services, linked social care testing, infection prevention and control arrangements, and so it was clarity in two respects, firstly over the testing requirements and secondly over the IPC requirements that were to be put in place, including visiting.

A. Yes, it was.

Q. Now, at this point, visits continued to be allowed in exceptional circumstances. They were not limited to end-of-life care?

A. No.

Q. But notwithstanding that, there was some initial confusion, and, further, reluctance on the part of some care homes to allow visits at all. And indeed, we've heard some evidence in relation to that.

A. Yes.

Q. With individuals not being able to see their family members throughout that period.

Why? Did you understand why these care homes were reluctant at that point to allow visitors in --

A. Yes.

Q. -- notwithstanding the guidance?

A. Yes. No, thank you.

I do understand why they were worried, concerned. I think it was very natural to be worried, concerned. I think the second wave is probably the most painful wave for a lot of us, because the first time we had gone through, we had learned so much and put in so many different features to support. But still, as community transmission rose, so did the prevalence within care homes. And I think that's why it was, at that stage, there was a nervousness.

What we continued to do was try to support and enable and maintain that openness to supporting visiting.

Q. In terms of the use of exceptional circumstances, or the term which was contained within it, which was "absolutely essential", in terms of permitting visits, do you think that contributed to some of that perceived lack of flexibility for care home --

A. I actually thought the plan was really helpful. I think the alert levels were really helpful. And I think as we move into '21 and levels changed within Wales, I think it was also clearer, in terms of being able to, you know, step down the alert levels as well, and open up. So I think, actually, I found it -- I found it a helpful plan, especially as we move into 2021.

Q. In terms of looking to the future, are there any particular recommendations that you -- or lessons that you've learnt from that process, including the alert levels document, the framework, that you think would be helpful in a future pandemic, and can work on those be done now?
A. Yes, I think definitely. Yes, I would agree.
Q. Now, I'm not going to go through the subsequent iterations, but suffice to say there were a number all the way through, essentially, all the way through including Omicron, and then coming out of Omicron and then the learning to live with Covid strategies or Covid-zero within Wales. Just in terms of care homes and their capacity to manage visits, to what extent were practical constraints a real consideration within Wales, for example the layout of the home, whether they have outdoor grounds to accommodate outdoor visits, all of those sorts of issues?
A. Yes, all of those issues were definitely being taken into account and, you know, because Wales has a different profile around care home owners, a lot of owners with one or two homes, you know, we were then having to accommodate workaround support around different physical environments. But they were offered advice, assistance and, as we had mentioned, you know,

visiting pods and other things that we thought would be good enablers to creating and maintaining those relationships between the loved ones.
Q. If I can just pick up on visiting pods, which were obviously a very good innovation for the sector, we've also heard that some care homes were creating their own visitor pods --
A. Yes.
Q. -- earlier, effectively, in the pandemic. Obviously the pilot was rolled out in November of 2021. Is there some learning to be done there, and could that have been effectively put into place much earlier? And the reason I ask that is not least because of the particular vulnerabilities of many of those in the care home sector, in terms of cold and being outside and all of those sorts of issues.
A. Of course I wasn't quite sure I got the date right there, so -- just to say, because my understanding is that we did the care home pods in November 2020, leading up to that --
Q. Apologies, I meant November -- (overspeaking) --
A. Yes, I wasn't sure I heard -- my hearing sometimes, I wasn't sure if I heard the date correctly.
And I think -- you know, again, all of the learning will be -- you know, hopefully we don't have to face

this any time soon. Please. I hope so. But if we did, we've learned that if we can do these things earlier, then we can enable -- so there's no doubt that that was a good thing to do and, you know, something that, again, as I mentioned, as -- as lessons learned, you know, you can certainly look at what worked well and can you do that earlier in the cycle.
And they were much more protective and supportive, and, you know, arrangements for cleaning and all the things that go with that were well in place.
Q. And just to deal with the timing of that being November 2021, were these -- were pods or anything of that nature, accommodations to assist care homes in providing visits, considered at a much earlier stage or was it something that really came about in the autumn to winter period?
A. In truth, it had really come about in -- at that period. I did think we were being innovative and supportive.
Q. Now, if I may, I'm going to turn to the care homes and action plan.
A. Yes.
Q. There will be some further questions upon this in due course, but if I could just deal with it in this way.
It was published on 30 July 2020.
A. Yes.

Q. The aim of the Care Homes Action Plan was to directly address the challenges that were being faced by those care homes during the pandemic. So this is at a point where, to place it in context for you, the restrictions were being relaxed coming out of wave 1 into the summer period.
You explain that that was a product of your directorate and aimed to learn from the first wave to prepare for a further wave?
Now, the Older People's Commissioner for Wales, Heléna Herklots, had called for an action plan in a letter dated 14 April 2020.
A. Yes.
Q. Were you aware of that?
A. Yes, I was.
Q. And indeed, she had sent you an email also, hadn't she, following up on that, explaining that she -- and that she wanted an action plan like that announced in England? What prompted that Care Homes Action Plan?
A. Well, I think at the time, when the Older People's Commissioner helpfully raised that, the Deputy Minister was able to consider, we were still very much in a position where our staffing capacity wasn't really in a position where we could have said, "Right, we'll do an action plan today", because actually what we were doing

was largely working, you know, flat out on the actions that ended up being the actions within the action plan.

So it wasn't that work wasn't being done, because it was being done, but once we hit that summer period, you know, the Deputy Minister was really keen that we develop an action plan -- set that up -- from us, was very clear in June that she wanted it and, you know, she was very much about people's rights and promoting and supporting. So that was at the stage then where the minister was keen for the action plan to be developed.

Q. Indeed. And if I can just draw up on the screen, please, INQ000253707, this is the update provided to ministers on the summary of the progress that's been made against the action plan, so looking at what was achievable and what were the next steps.

And I just want to deal with, if I may, the first one which is the development of a clinical contingency template to provide further advice and support for individual care homes. So that's really dealing with IPC management, how to manage individuals with infections within the home, as it says here, it will include environmental staff management, minimising staff movement, personal protective equipment, PPE, testing, considering their own resident group, staff group, environmental layout and service delivery.

You may already have touched upon the lack of capacity in your team and that may be the reason, but why was this only taking place now, effectively, with a target date of October 2020?

A. Well, I think, I think IPC advice was being given to care homes much earlier than that date. But what this was about was developing what I'll term as a toolkit that could be used with further training and support. That toolkit was produced. Subsequently, a lot of work across Social Care Wales, Public Health Wales, and that work has been progressive to this day. We now have a, you know, a work book and training materials that I've endorsed alongside the Chief Nursing Officer, but it would be fair to say that work was taking place, you know, before this but it was about the toolkit which we did produce.

Q. Thank you. Just dealing with that toolkit that was produced, it became a checklist; is that right?

A. Yes.

Q. And there was a further update following on from this update in October, in December, and at that point that had still not actually been completed albeit that an initial checklist had been developed but not rolled out and it was later confirmed that the checklist was then sent in January to be circulated onwards.

So we're talking about a fairly significant period in getting that --

A. Yes.

Q. -- checklist together. Now, you've explained the work that was being undertaken?

A. Yes.

Q. But would you agree it would have been obviously a very useful tool, you've described it as a toolkit, for those care home providers and individuals concerned with the provision of care to have had earlier?

A. Absolutely. But important to bear in mind that, you know, environmental health officers were going into homes who had infection control issues twice a week. There were a whole range of other measures alongside that. But I do believe it was a very important step forward and hence why I personally endorsed -- I'll call it the workbook. I know it's got a proper title, but I've endorsed that and it's really taken -- you know, it's taken steps further forward from 2020.

Q. Indeed. And your directorate would not have produced it had it not been considered to be an important, valuable tool for that sector to use?

A. No, and indeed --

Q. That's why I ask --

A. -- working with Public Health Wales and partners who

have been instrumental in this.

Q. If I can also deal with the rapid review that was taking place alongside the development of the action plan, that was a review by Professor John Bolton, an independent review to look at the experiences of care homes during the pandemic.

Now, there were concerns raised by Heléna Herklots, the Older People's Commissioner, that the review would not sufficiently engage with what had gone wrong and instead would overly focus on what had gone right in the pandemic.

What do you say about that?

A. Well, you know, to be fair, it's really important that the Older People's Commissioner raises concerns and issues. That is good for us because we are able to consider and respond. You will have a copy of, you know, the material that was sent out at the time. That clearly talks about weaknesses, gaps. And, you know, I think, you know, Professor Bolton did a really good job at, you know, speaking directly to regions, gathering what worked well but gathering what needed to be improved, and come up with a very clear set of recommendations and advice, which I found very useful, and also the team found very helpful, because we were able to incorporate that into the care action plan work

as well.
Q. Thank you. That deals with my next question, which was how was it used.
If I may, then, turn to one aspect that was identified within the action plan, and that's the one of staff movement and the risk of transmission.
So staff movement, we've heard, is a significant challenge.
A. Yes.
Q. It's an ingress route for infection across the care sector in that respect. Now, it's been a longstanding understanding within the adult social care sector in relation to other infectious diseases, hasn't it?
A. Yes.
Q. So this understandably was a significant concern for those in receipt of care, and we've touched upon those in receipt of domiciliary care, and the concerns and anxiety that they expressed at the time.
If I could ask, please, for the witness statement of Catherine Griffiths to be pulled up on the screen. Page 9, please, paragraph 30. Thank you.
Here, it sets out that:
"A significant concern of [Covid Bereaved Families for Justice] Cymru was the risk of staff spreading the virus between homes. The use of agency staff was

commonplace."
Firstly, if I can stop there, that's correct also, isn't it, of the situation in Wales, the use of agency staff?
A. Yes, yes.
Q. "This inevitably led many staff to move between homes or even region to region."
And just again pausing there, there was a point, wasn't there, where individuals were moving from region to region because of workforce shortages within Wales?
A. There was certainly, you know, at a critical point in the pandemic, where we were actively encouraging, you know, allocation of workers to single homes only, but there was no doubt, and it's something that is about workforce planning for the future, for the now, we clearly -- there were times where the sector could not prohibit the use of workers across, because of the pressures that they were under. And that is a very sad thing to say, but I know a lot of work was done to try and keep it to the absolute minimum.
Q. Indeed, and if we continue on, we see that the concern is that the continuous source of movement likely contributed to the spread of virus between homes, and we've seen that that's certainly is the findings of the Vivaldi Study, and we've heard from Professor Shallcross

that it's one of the ingress routes, and here it's a reference to your evidence, your witness statement, where you accept that despite the risk posed, as you said, the pressure on the system put the social care sector into a position in which they could not prevent it, and so that was particularly frustrating to their members, who found that many care homes were also still accepting patient discharges from hospital at the same time.
So these were concerns of those residents and their loved ones in relation to restriction, but essentially there was just simply not enough capacity within the workforce to enable the policy to limit staff to one home only.
A. Certainly at the early stages of the pandemic, you know, from the feedback that I had from the sector, was that was not possible. However, I did write out in August, I think it's August 17, really clearly setting out the expectation around, you know, allocation of agency worker to single homes. I felt that was doable then because the rates, if I remember correctly at that stage, of allocation to individual homes was something like 90% of agency workers in Wales, so that was really pushing home that message about risk and how to manage risk.

Q. Certainly at the outset you explained that had you instituted such a policy barring the transfer, the working between different homes, then you would not have been able to implement the hospital discharge policy, for example, at all, or other policies, including and down to just delivering basic levels of care?
A. It would have had impact across those systems, as you say, the whole-system thinking, of course, but importantly, it would have had impact on the quality of care within those care homes themselves.
And that was the advice that was coming from, you know, care providers to me at that stage.
Q. And looking to any future pandemic, specifically, is there anything that you consider that could be done to resolve that position?
A. Well, I think, I think -- yes, I do. I think the whole workforce planning and the whole workforce investment is absolutely critical. There are challenges that the sector faces that I think we can address, but perhaps I'll come on to some of those, I'm sure, during the discussion. Thank you.
Q. Of course. And related to that, were issues in relation to staff absences.
A. Yes.
Q. And again, if I can call up the same witness statement

but paragraph 33. It picks up on your earlier comments about the sector being fragile but it explains that the absences resulted in a dramatic drop in the quality of care afforded to their loved ones. Certainly we've seen some evidence of that from ADASS and organisations, with limitations to what they could achieve.

And then it continues to go on through that:

"... Denbighshire saw 15% of its local authority social services workforce take time away from work due to COVID-19 ... staff absence varied between 10 to 35% through the relevant period ..."

And that's when it really resulted in the need for staffing, mutual aid or the introduction of agency staff.

So again, increasing the infection rates.

A. Yes.

Q. And you've dealt with the issues of workforce capacity. Just picking up on the ability to self-isolate, we've heard about financial concerns of individuals within the sector. Is that something you've given thought to?

A. Yes. That was. There was concern, and I know we were able to support, through the enhancement to statutory sick pay, and I know that we were able to support with particular payments, recognition, rewards to workforce who were, during the pandemic, working above and beyond

any expectations at that -- what they were doing was absolutely fantastic.

Q. Thank you. If I can turn, then, to the issues of infection prevention and control and PPE.

A. Yes.

Q. The initial advice was that PPE was only required when dealing with those Covid-positive cases. In hindsight, do you think that was the correct advice?

A. I think I accept that as the advice that was at the time -- accept that as the advice.

Q. I just want to, again, touch upon, if I may, that certainly the possibility of asymptomatic transmission was discussed within the initial Health and Social Services Group Covid-19 Planning and Response Group as early as 20 February. Given that, and the potential for asymptomatic transmission, why were social care providers not advised to wear PPE when caring for all residents discharged from hospitals, as a precautionary measure?

A. No, it's a very fair question. My response is that the continuing advice to us, in terms of, you know, the medical advice, the scientific advice, as you will have seen from my statement, continues to recognise the risk differently between symptomatic and asymptomatic.

Q. Was that based on scientific advice or was it more to do

with the lack of adequate PPE at the time?

A. No, certainly my understanding was -- throughout that period was based upon the -- the scientific advice rather than the amount of PPE.

In fact, I think the efforts around supplying PPE, you know, were gone to at great lengths.

Q. Now, the Inquiry has heard significant and received significant evidence of PPE shortages in care homes beyond March 2020 --

A. Yes.

Q. -- beyond the initial period but for quite some time. So, for example, in April 2020 Care Forum Wales sent a letter to Mark Drakeford saying barely receiving any sufficient PPE. Chris Llewelyn of the Welsh Local Government Association similarly refers to shortages, care home managers provide evidence that they were locking PPE away, stockpiling it, and we've heard some evidence that social care workers were reduced to using one mask per shift as a consequence. Equally, care homes becoming reliant on people in the community making masks and gowns. And we've heard some further evidence this morning about difficulties in relation to what the NHS central supply chain was able to provide at that time when the government took it over?

Do you accept that there remained widespread PPE

shortages in care homes after the Welsh Government assumed responsibility on 19 March 2020?

A. I think it's a challenging question, do I accept? And thank you for the question, by the way.

I think what I would say in response to that is, you know, the duty to provide PPE, the government stepped into that space, so we stepped into a space that was occupied by local government and providers themselves. I think that was the right thing to do and I think that was important.

There was always enough PPE in the system.

I had the very helpful military, asked for them to do an assessment. They did the assessment between something like 8 April to the 18th, provided a report on the 21st. Logistics to making sure. And I think there were lots of -- this was the first time in that chain, almost like a supply chain, if I can put it in that jargon term, which no one had done before, so people were sometimes stockpiling, and it took time but PPE was getting out.

So I don't think there was a shortage, actually, overall, of PPE. We run very close, however. And I was personally involved in conversations with, you know, the Shared Services from the NHS, and we come very close on occasions, but the -- with a matter of days in

provision, but we never did run out, and we always got -- and when, you know, directors of social services phoned me up late in the night saying, "I'm worried, I need PPE", I was able to phone the Shared Services and they responded.

We got into different regulated beat with the sector, which did begin to ease those worries, but you're absolutely right, there were lots of challenges, but there was PPE, although recognising how close sometimes we come to the wire.

Q. And presumably that PPE, where you say it was sufficient, that was based on whatever guidance was in place at the time?

A. Yes, of course.

Q. So whatever the guidance said, you're saying that was sufficient to accommodate that?

A. And we scaled up, and I think -- I think actually one of the learning points -- forgive me for coming back in, but one of the learning points is how that national approach really benefited around PPE.

Q. Thank you. I've just got one last question on this topic before moving on, if I may, and that is, in terms of care homes and their ability, firstly, to isolate, and, secondly, their ability to provide good ventilation, just very shortly, what is your

understanding of the provision within Wales?

A. Yeah, it's mixed provision. I've been in many care homes in Wales myself personally, and I know that providers are always working to, you know, have good ventilation, good standards. The Regulation and Inspection of Social Care Act also has set higher standards than previous legislation as well.

Q. Thank you. I now want to move to the final topic, if I may, that I have questions for you in relation to, and that is on DNACPRs, so do not attempt cardiopulmonary resuscitation notices, please.

I understand that you and your team had limited involvement in the policy and guidance, but I just wanted to pick up on where your team did intersect for those issues.

Now, Gillian Baranski, the chief inspector of Care Inspectorate Wales, has provided evidence with regard to the inappropriate use of those notices, certainly in one respect being used as a proxy for do not treat.

And so, again, we've also heard evidence from Mrs Hough, she described the challenges she faced in terms of taking residents to hospital because they had those in place and that care home providers believed that those notices were resulting in automatic non-admittance to the hospital.

If I can just call up, please, INQ000500163, go to pages 2 to 3. And this is being escalated to you, essentially, from Care Inspectorate Wales.

If I can go over the page, please, to page 3. These are concerns about a recent death at a care home, and they explain that paramedics were called out but, because that notice was in place, they were not admitted to hospital.

No palliative care package -- and I'll move to that in a moment, was put in place -- controlled drugs were not issued, and they passed away within 24 hours, and it deals with the nature of that. And obviously a far less dignified death than one would have hoped for or would have been typically the case within an adult social care setting.

And in regard to that, it explains that they're residential services, they're being asked to operate outside of their registration by becoming nursing homes, and these were homes without those nursing capabilities operating like a mini hospital ward.

"We all know that we have to do our bit to help the NHS save lives but they are asking too much in this instance."

If we go back, please, to page 2 -- and page 1 of it, sorry, apologies.

What we see here is it's being described as there being a race by GPs to put in place notices. Now, there are concerns about blanket DNACPRs and also that such notices were being put in place without any discussion with residents or their families. No engagement, in short. What did you do in response to those concerns? They're coming to you in your office.

A. Yes, so although I didn't have, we didn't -- I don't have a remit, I wasn't responsible for the policy, you know, I was, like anyone would have been, deeply affected by the stories, the impact coming to me. Certainly, I raised it within the executive team that I'm a part of. I had discussions with colleagues who held responsibilities. And I think it was accepted by everyone that one case was one case too many, actually, I think. And although, you know, looking back I think they were a small number of examples, they were examples that we would not have wanted to see in Wales.

And so the Chief Nursing Officer, the Chief Medical Officer, you know, wrote out to the system clearly explaining, and I think that was, again, around 17 April.

Q. Thank you. And one aspect of this was also the use of the clinical frailty score. Now, Module 3 has heard evidence on that, and you provide various observations

in your statement, but just to deal with that in conjunction with these notices, Covid Bereaved Families for Justice expressed the view that many members felt that they were being disproportionately affected, they were being neglected on the basis of age, they were being viewed as too old, and there were similar concerns expressed by disabled people some of whom also had notices being put in place including in circumstances where they plainly ought not to have been.

Was there a lack of care and respect for older people or those more vulnerable to Covid?

A. I think the answer back to that one is that there was a few examples which we would not have wanted to see in Wales, but the approach certainly of the Welsh Government, both at a minister level and an official level, was one of wanting to support older people, support people with disabilities across the board, and a number of actions that we tried to take were in the supportive arena.

Q. Thank you. And again, we saw from that email, and indeed from other evidence that the Inquiry has received, that there were care homes without nursing; they did not have sufficient end-of-life care; they had a lack of medication stocked, oxygen being a particular issue. To what extent can anything be done about that

to help, in terms of a future pandemic?

A. Yeah, I think it should happen, you know, it does happen day in, day out, and it must happen day in, day out. It must happen today. So anyone who has, you know, a palliative care, an end-of-life pathway, deserves dignity, respect, support, and there's a whole range of measures, so although I'm not the policy lead, I am familiar with the policy and I can see within that that, you know, if we adhere to that policy and that framework, then that is about working together with people and their loved ones around these decisions.

Q. Thank you.

And then my final question, please, in relation to the use of these notices. The CQC undertook a review, obviously that was in England, and subsequent to that, several reviews have taken place of these practices in Wales. But each of these recent reviews concentrate on health boards and NHS trusts. There's been no review in relation to the situation within social care. Do you consider that that's something that is necessary?

A. I think the consideration of those in terms of -- because these are clinical decisions, these are medical decisions. So I think starting from that basis is the right basis. But then, of course, you should always consider what the setting is for the individual, but

within that, that individual should be caught within those policies.

Q. I've just been asked if I may very briefly, Mr Heaney, to clarify one matter that goes back, actually, to questions I was asking at the beginning, and that's in respect of the decision to test all patients on discharge on 15 April. You said that at that point both yourself and the CMO, Sir Atherton, wanted a change in policy.

Can you please clarify, who actually made that decision -- (overspeaking) --

A. Good question. Thank you for asking.

So on the 14th there was a, you know, clear, I think it was a Technical Advisory Cell advice, and often coming from SAGE, very clearly identifying the risks. England, as I mentioned earlier, changed the policy. There was a ministerial meeting held on relation to social care on the 15th.

Q. There was.

A. Yes, and in that meeting we discussed the testing and discharge from -- discharge, that's where Frank Atherton, Sir Frank Atherton, the Chief Medical Officer of Wales, was tasked with going away in terms of looking at that policy, and then there was a cabinet meeting held that discussed it further on 22 April, and I

believe it was in those settings where that decision to move forward on the discharge testing was agreed.

MS CECIL: Thank you very much.

My Lady, those are my questions.

LADY HALLETT: Thank you very much, Ms Cecil.

Mr Stanton, should be straight across the hearing room, Mr Heaney.

THE WITNESS: Thank you.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

My Lady, Mr Heaney has already covered very fully two of the three permitted questions so I just have one question.

LADY HALLETT: Thank you.

MR STANTON: Good afternoon, Mr Heaney.

A. Good afternoon.

Q. I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. The single question I have for you relates to asymptomatic testing in care homes, which you've already touched on some aspects of in your answers.

Can I refer you, please, to an email from Margaret Rooney, the Deputy Chief Inspector of Care Inspectorate Wales, on 24 April 2020, which is at INQ000198311.

This email sets out Ms Rooney's views about the need

for asymptomatic testing at that date, and states:

"In terms of the global testing: having read the document entitled 'Covid-19 in care home settings: Enhanced Prevention and Outbreak Management' and heard feedback from the other inspectorates (in particular Scotland) about staff with no symptoms testing positive, I think all staff (and residents in care homes) should be tested whether they are symptomatic or not and in truth, these tests need to be repeated at regular intervals.

"Appreciate the capacity to do this needs to be there, but I think the situation seems to have escalated to the point where this sort of intervention may be warranted."

Mr Heaney, I think I'm right in saying that very shortly after this email, that statement was broadly in line with your own personal position; is that right?

A. Yes, I think I actually might be earlier in this email chain but I could stand corrected, you know, certainly I was asking very similar questions to my colleague in Care Inspectorate Wales.

Q. However, the First Minister, Mr Drakeford, took a different view and repeatedly stated on 29 April, and 6 May in the Senedd, that there was no clinical value in asymptomatic testing.

And my question for you is: are you aware of any scientific or ministerial advice at this point in time that stated that routine testing in care homes had no clinical value?

A. I am aware of advice going up to the minister. I'm certainly aware of advice that went up in detail, on 30, I think, of April, that went into a wide range of considerations and was quite open, actually, in some of the changes in the science, but where we were. So the comments that First Minister then was making and the minister were making, were based upon the advice that was still coming to them. As I mentioned earlier, the critical determination around the change in decision then happens on 12, 13 May, with some real clarity coming forward. But then just supported the earlier thinking that was around in some parts. If that makes sense. I hope it does.

Q. It does. It's helpful. Thank you.

Can I just clarify, Mr Heaney, you're not saying that the ministerial advice of 30 April indicated that asymptomatic testing had no clinical value, because that was an advice that contained studies such as the Public Health England Easter 6 study.

A. Yeah. No, and it wasn't, you know, I know we wrote the advice, but that advice was very thoughtful and based

upon the medical advice and the scientific advice at that time.

MR STANTON: Thank you.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Stanton.

Ms Morris, who should be just slightly to your right there. There you are.

Questions from MS MORRIS KC

MS MORRIS: Good afternoon, Mr Heaney.

A. Good afternoon.

Q. I ask questions on behalf of the Covid Bereaved Families for Justice UK. I have three short topics for you, please. The first is touching, again, on the Care Homes Action Plan.

A. Yes.

Q. Ms Cecil King's Counsel ascertained with you this afternoon that Ms Herklots had called for a care home action plan in April and by the time it came out in July 2020, it was coming out as restrictions were being lifted. So why had it taken until July 2020 for one to be issued?

A. So the Deputy Minister for Social Services agreed in June 2020 to develop a care home action plan.

Before that date we were active in the actions and busy in the actions, but we just really didn't have

capacity at that particular stage to go into a Care Homes Action Plan. As soon as the minister felt that was the right thing and the timing was right, we did that, but that is not to say that actions that ultimately you will see taking place, weren't taking place, because they were.

Q. So Heléna Herklots, the then Older People's Commissioner, for Wales --

A. Yes, of course.

Q. -- told the Inquiry yesterday that she was told initially by the Welsh Government that the plan would add "no value". And she said yesterday that she found this disappointing and didn't address the urgency of the issue.

So why did the Welsh Government feel that that plan wouldn't add value?

A. So I think it's -- I would ask us perhaps on this one to go back to the original letter that the Deputy Minister sends to the Older People's Commissioner, because I do not believe that is what is said within that letter. I don't believe the wording of that letter from the Deputy Minister says "no value". I believe, at that time, what the Deputy Minister was saying was: at this time, will it add value?

And it's about discussion.

And she didn't write out saying that we wouldn't -- she wouldn't be doing it in the future, but at that -- so I would probably suggest we need to just go back and check the wording of that letter, because I'm not sure that that is a representation of what actually the Deputy Minister and the government was saying.

Q. I'm not going to take us back to that because the Inquiry had it in front of Ms Herklots yesterday and has had that evidence, but your position is that you don't know whether that was in fact what was being said in the letter; is that right?

A. I don't believe it -- I'm being clear, I don't believe that -- I do not believe that's what's said in the way that it's worded within the letter. No, I don't.

Q. Thank you.

Second topic: visiting guidance. So between June 2020 and March 2022, you've said that there was 14 versions --

A. Yes, there was.

Q. -- so 13 revisions --

A. There was.

Q. -- before transitioning to a longer-term plan.

Do you agree that this amount of revisions would have been confusing for the majority of people, and in particular for those who were trying to put if it into

operation?

A. I agree that that was a challenge, absolutely. And I think for many families, I know that families communicated with me directly, and I tried to help and explain where we were. So absolutely understand that impact. And, you know, really feel for those families, as well.

What we tried to do to learn, as we did, was that early in the pandemic we were issuing it very quickly, so we tried to use, you know, the First Minister's press conferences to lead and to communicate, so we took a little bit of time to explain the changes.

And as counsel asked me earlier, I think when we went to the alert stage, I think that ultimately become more helpful for families in knowing what could happen. Thank you.

Q. Thank you.

Third and final topic, please, protecting the NHS. Ms Cecil gave an example of an Every Story Matters contributor, who said that, in their view, they felt that the Welsh Government put the needs of protecting the NHS from collapse ahead of those in care homes, and in fact it was the view of Melanie Minty, the senior policy adviser at the Care Forum Wales, is that --

A. Of course.

Q. -- the Welsh Government's focus was on protecting the NHS, which had then had a disproportionate affect on the adult social care sector.

Now, in March 2020, you attended a Covid core group with the First Minister, where the NHS were projected to reach maximum capacity within four or five weeks, which you said reinforced the need to take urgent preventative measures to prevent the NHS from becoming overwhelmed.

Does that approach confirm that you were in fact prioritising protecting the NHS?

A. I think it's a really good, searching question, so thank you. And pausing and reflecting on it, my thoughts then were, although we used the title "protect the NHS", for me it was "protect the NHS, protect social care". So that was the ethos that I was always working in. And I do believe -- I really do believe this -- that we were faced with some really difficult choices.

But the capacity within the NHS, you know, having seen the reasonable worst-case scenario, having seen the images from Italy in the hospitals and having understood the kind of conversations that I was involved in, it was actually -- you know, I do believe that we were -- you know, Welsh Government was trying to support the NHS to be able to deliver to save people's lives. So I don't think -- I don't see it as a straightforward choice of

protect the NHS, not protect others. And I really genuinely believe that that was one of the most difficult times and difficult, you know, decisions that anyone had to take.

But as you said quite rightly in your question, we had a number of weeks where we knew we would be at full capacity, and having seen the reasonable worst-case scenario figures, that was very frightening indeed.

MS MORRIS: Those are my questions.

Thank you, my Lady.

A. Thank you.

LADY HALLETT: Thank you very much, Ms Morris.

Now it's Ms Jones, who is probably further to the right of -- or your left.

THE WITNESS: Thank you.

Questions from MS JONES

MS JONES: Thank you, my Lady.

Mr Heaney, I ask questions on behalf of John's Campaign, Care Rights UK and The Patients Association.

I want to ask you first about problems with data collection and understanding of the care sector, and you've referred in your witness statement to the challenges that are faced by the adult social care sector and steps that are being taken by the Welsh Government to improve the collection of social care data

to provide a clearer picture of service delivery and to support your ongoing work.

I want to know what challenges did a lack of reliable data about adult social care present during the pandemic, and what are the concrete steps that the Welsh Government's been taking to try to address that weakness.

A. Yes, thank you for the question.

So, you know, I think, you know, the challenges were around, you know, workforce capacity in care homes, a whole range of issues from that set of data was -- was difficult. We introduced the care home capacity tracker, if I can call it that, to get an understanding of capacity. That helped during the pandemic.

I had discussions with directors of social services early on and, in fairness, I asked for more data at that point, which I think benefited us during the course of the pandemic.

I know at that stage some of my director colleagues were uncertain about that, but they did -- they did support the direction of travel.

We've worked with Social Care Wales to improve data and we're continuing to work with them. And we've recently developed the National Office for Care and Support, which has a data focus. So very much learning

from where we were to improve the data and data understanding.

Q. And are there any specific examples you can give us of problems that you faced due to a lack of data, or improvements that would have been possible if you'd had better data during the pandemic?

A. Yeah, I mean definitely, and a very helpful question. I think for me, it's about, you know, I would have liked to have better data around, you know, the workforce within care homes. We're very fragmented, different owners. I would like to have a national picture of what that looks like. You know, sickness absence and real live time data.

So I appreciate the challenges, but where we would like to be in the future is probably in a different place to where we were at the beginning of the pandemic. And we're starting to make some of those tracks now through, as I mentioned, the National Office.

Q. How do you envisage decisions made about the sector might have been different if you'd had that --

A. Yes, of course. Of course. They could be. I can't say they would be for certain but I would like to have had that data, because it may have -- it would enable us to have a richer base on which to make decisions upon.

Q. And do you agree that there ought to be a national

centralised database of data about the care sector, and a system should be established to ensure that data about the sector is complete and accurate and available to decision makers?

A. Yes, I do. And that's why we have developed the National Office for Care and Support in Wales.

Q. Thank you. I'm going to move on to a different topic now, which is a specific question about the visiting guidance.

You've stated in your statement that version 3 of the visiting guidance, which was introduced in August 2020, included an integrated impact assessment which considered how providers could safely facilitate visits while addressing growing concerns about the emotional, mental and physical health impacts of prolonged separation from loved ones.

You say that this impact assessment and then the version 3 of the guidance took into account the experience of people living with dementia, based on evidence provided by the Alzheimer's Society. And I just wonder if you can help us with exactly how the Alzheimer's Society's position was reflected in the guidance and the impact assessment associated with it.

A. Yeah, I think I would have to take -- the detail, I'd have to take that away and really reflect upon that.

What I can say more generally, you know, I think, is that, you know, some of the reports produced, I read them personally, they were very powerful, very helpful, really raising the voice.

What I tried to do, what my team tried to do, was also ensure that voices were widely heard.

We'd commissioned partners to actually being able to raise the voices of individual groups, older people, younger adults as well. Some of those we commissioned through Age Cymru, you know, voices from care in Wales, All Wales People First. So we used resources like that to really make sure we could, you know, have a richness of understanding lived experience.

Q. Thank you, Mr Heaney, and that might be part of your answer to my next question as well, which is about the Care Homes Action Plan.

You stated at paragraph 165 of your witness statement that you wanted the Care Homes Action Plan to align with the concerns and recommendations that were made in the Older People's Commissioner for Wales report on Care Home Voices. I wanted to ask how you ensured that action plan reflected those concerns and recommendations, and whether you took any steps to obtain the views of people who rely on care in formulating the action plan?

A. Yes, thank you for the question.

One of the longstanding traits of the policy area that I work in is co-production, working together with people heavily involved in legislation and policy over many years.

And certainly at the outset of the pandemic, that -- those traditional routes were really troublesome to us, difficult, because of the restrictions. And what we did do, we did commission partners to -- particularly during those pieces of work that you've mentioned -- to do that work for us, and to feed that through.

Separately to that, I also had regular engagement points. I chaired a weekly meeting with lots of partners from the sector and they were constantly raising up the voice of their particular, you know, populations that they represented, and that was really important and really powerful.

MS JONES: Thank you, Mr Heaney, those are my questions.

THE WITNESS: Thank you.

MS JONES: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Jones.

And lastly, Ms Beattie. Further behind Ms Jones.

Questions from MS BEATTIE

MS BEATTIE: Thank you, Mr Heaney. I ask questions on behalf of Disabled People's Organisations. And I'm also

asking about the guidance on visits to care homes.

So if I can take you back to your letter of 23 March 2020, which you've already been asked about, where you said that visits should only occur when absolutely essential, and as I understand it, that letter went to call care homes, directors of social services, and health boards, is that right?

A. Yes.

Q. And you said in the letter that there should not be what you call "routine visiting as previously experienced at care homes". Now, do you agree that that guidance did not expressly accommodate the needs of disabled people who were reliant on visitors, including for daily communication needs? And just to give a concrete example of that, for example, an individual with a cognitive impairment who does not communicate or does not communicate primarily via speech, perhaps, and for whom, therefore, a visitor may be a key interpreter of non-verbal signals and provide key insight into whether they're experiencing pain or discomfort and other health and welfare needs?

A. And I think that guidance at that stage was at the same time that we went into lockdown. So you're absolutely right to raise that as a concern. That was done with the intention of trying to protect at that particular

stage. But I do agree that we would have always, you know, and I think that's what we would support it throughout, our care home visiting -- you know, was where it was enabled to support, especially people, you know, disability, you know, to support.

So I think that, you know, from your point is a really good one. I don't think we were intending to, you know, prevent people from being able to communicate, and, you know, obviously I recognise it was a very difficult time.

Q. The letter, I think probably understandably, referred to the importance of emotional wellbeing and trying to facilitate that.

A. Yeah.

Q. But I mean, would you agree that what perhaps was needed was some more formal or structured guidance to care home providers in order to be able to make a decision for an individual about visits that were really essential in order that their needs were met, and so that reasonable adjustments could be made and those needs met and rights protected?

A. Of course, and I know that partners we worked with were offering advice and support, and as I mentioned in a previous question, some of these were the issues that very helpfully were raised with us at the Planning and

Response Group by some key stakeholders, as well. I recall, you know, a number of illustrations that allowed us to really understand the impact of some of the policy decisions, as well, that we were taking, and as we revised policy, we were able to take into a wider consideration of some of the impacts.

Q. So looking forward, and for any future pandemic, or any visiting guidance of any sort, would you agree that that kind of structured guidance is what is needed?

A. Yes, I agree. I do agree. I really do.

Q. And in your evidence earlier I think you said that later on there'd been some really good work across the sector on visiting.

A. Yes.

Q. But is it right that the All Wales Forum survey about people with learning disabilities found that even by as late as August 2021, there remained very significant restrictions on visits experienced by people with learning disabilities living in care homes and supported living, with 23% of respondents to that survey not being allowed any visits, 76% only allowed partial access, and only 1% had said that they were able to have full access to visits from friends and family.

Were you aware of those results?

A. Yes, I've read that survey myself. I am aware of those

results. And, you know, clearly that's very upsetting, especially given that our policies enabled visiting to take place. So you will see over the different revisions, how we have really worked really hard to open up Wales to having, you know, that opportunity of people seeing their loved ones.

Q. But in the case of people with learning disabilities, it seemed that that continued to have very long-lasting impacts?

A. Yes. No, I'm not disputing that for one moment, and that is something that all of us would want to, and should, you know, pay attention to on a number of fronts. Not just about pandemic planning, but in terms of engagement on any policy development.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Beattie.

Mr Heaney, that completes the questions that we have for you today. Thank you very much indeed for your help. I appreciate the burden it always places on people coming along to assist the Inquiry, so I'm very grateful to you.

I don't know if you're travelling back to Wales tonight?

THE WITNESS: No, I'm staying over this evening, my Lady.

LADY HALLETT: Oh, right, okay. Well, I won't ask what

you're up to. Safe journey back when you go.

THE WITNESS: Thank you.

LADY HALLETT: Thank you very much.

I shall return to start again tomorrow at 10.00 am. Thank you.

(4.19 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X